



Office of the Public Advocate

**Glenside Hospital Site Redevelopment
Development Strategies for Consideration from the Office of the Public Advocate**

**The Public Advocate is an independent official accountable
to the Parliament of South Australia**

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1 INTRODUCTION

The South Australian Office of the Public Advocate is responsible for reviewing programs and identifying areas of unmet need, as well as promoting the rights and interests of the people of South Australia, including consumers of mental health services and people who experience mental illness. Advocacy is provided for people with mental illness who may be unable to look after their own health, safety or welfare, or who because of this are subject to involuntary treatment under the Mental Health Act 1993.

Public advocates in other Australian states have drawn to the attention of Parliament, and the wider community, gaps in services, and have provided an independent contribution to the development of state policy. For example, the Queensland Public Advocate has contributed and reviewed state policy in areas such as suicide prevention (Howard, 2008) and seclusion and restraint within mental health settings (Howard, 2007). Reviews of adequacy of housing provision for high needs populations have also been undertaken.

The Victorian Public Advocate has set advocacy positions informed by the observations gleaned from the state's Community Visitor Scheme, which has been in operation for 22 years (Pearce, 2008). This has included demonstrated shortages of acute beds, secure rehabilitation beds, community accommodation options, and problems with the delivery of services for people with more than one diagnosis (Gardner, 2006).

In October 2008, the Office of the Public Advocate made a submission to the Select Committee of the Legislative Council enquiring into the South Australian Government's proposed sale and redevelopment of the Glenside Hospital site.

In the submission, the Public Advocate argued that much of the discussion about Glenside Hospital, and how the benefits of the site might be shared, has focussed on people who have a mental illness, who would currently receive a mental health service. The Public Advocate pointed out that there is also a wider group of people with different disabilities who would have received care at Glenside in the past. This includes people who have had a brain injury, developmental disability, neurological disease or dementia. At the present time, services for people with high needs who have a combination of a mental illness and one of these disability groups needs particular consideration. The Public Advocate sought consumer input, which was submitted as a separate document for the submission, but which has been included in this document for ease of distribution.

This document presents the Public Advocate's positions and recommendations, which include:

- **Endorsement of the importance of redeveloping Glenside Hospital.** The current hospital is dated, and the need for a new state of the art facility is unequivocal. The new development must proceed.
- **Protection of the dignity and rights of consumers.** Community visitors schemes currently operate in other states of Australia, which empowers members of the community to visit institutions and community residences to identify abuse or neglect, advocate for the best possible assessment and treatment, assess the standard of facilities and their care for people, and ensure that there are maximum opportunities for recreation, occupation, education, training and rehabilitation. A Community Visitors Program was recommended in *Paving the Way*, the review of South Australian mental health legislation, and there are provisions for these visitors in the new Mental Health Bill. The new Glenside facility should be open to trained community visitors.
- **Adequate space in the new Glenside Hospital to meet consumer priorities.** These priorities include access to fresh air and sunlight, sufficient space to provide privacy, adequate sized bedrooms and communal areas, and room for activities - including gardens to walk in, and a gymnasium to exercise in. The land allocation should be large enough to allow for buildings that meet these priorities.
- **Adequate space for future expansion.** While current bed estimates are evidence-based, needs can change over time and an expansion capacity should be included in the design. For example, in Victoria there is currently a proposal to build at least 60 new forensic mental health beds on the Heidelberg Repatriation Hospital site. If South Australia were to follow this lead in the future, space would be needed for at least 15 forensic mental health beds. Further examples are provided in Section 7 of this paper.
- **Space for social firms.** Social firms employ people who have a psychiatric disability. There is a strong movement in Europe, the UK and United States to develop affirmative businesses. Real wages are paid for real work, but work conditions are flexible. Industries include tourism (hotels and cafes), landscaping, gardening, printing, and a range of service industries. Some space on the Glenside site could support social firms.

- **Research.** Priorities include basic research such as collaborating with scientists of other disciplines, research about therapies and services research. Consumers should help set the agenda, and be closely involved in the oversight of research activities. A central new research centre should not set back other mental health research needs elsewhere. For example, other states in Australia have prioritised rural and remote mental health research and education, setting up centres in rural locations. A rural and remote mental health centre could be established in Port Augusta or the Riverland which could link with a Glenside hub.
- **Housing.** “Housing First” research demonstrates the critical role of housing. More high-needs housing is required in South Australia that combines the provision of accommodation with support services. The new Glenside housing estate will use a planning strategy “inclusionary zoning” to create new housing opportunities. While this approach sets an often used limit, more housing could be provided in other ways - either off site, or in innovative developments such as “Common Ground” type apartment buildings which are mixed communities of people with high needs and other people such as innovative ‘shop top’ developments. South Australia has already shown national leadership in this area.
- **Income stream as an alternative to land sale.** Mental health consumers may no longer require all the land for a hospital, but can benefit from the land into the future. The new need is for services, not property. The alternative to sale is to keep the land and use it as an investment funding source. This strategy has been successfully followed by non-government organisations that have been land-rich but income-poor. Retail use, tourism, short-term rental and retirement villages are development strategies to keep ownership of land but receive an income stream into the future.
- **A model of integrated governance.** The Social Inclusion Board report, *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012*, suggested that there should be a model of integrated governance to optimise the social, economic and environmental value of the site. A Glenside Mental Health Trust could be established to link the private sector, mental health sector and government. The trust could optimise investment income from the land, and allocate bonus funds to services such as psychiatric disability services for people who have high needs, early psychosis services, Aboriginal mental health or other priorities set by the trust.

2 THE NEED FOR A NEW HOSPITAL

The Guiding Principles for the Glenside Redevelopment were outlined by the Social Inclusion Board in *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012*. These Guiding Principles are:

1. The primary purpose of the site will be to provide modern, state of the art facilities that meet the service needs of people with a mental illness or people with a drug and/or alcohol dependency.
2. The mental health services remaining on the campus will be of sufficient size to achieve clinical sustainability and viable staffing arrangements.
3. Other services should only be added to the site if they can enhance the primary purpose of the site.
4. Design of facilities will optimise the benefits of the healing space of the gardens and grounds of the Glenside Campus for mental health clients and their families, all who work on site and the local community.
5. The design, location, scale and form of buildings will provide an environment that is as home-like as possible, which facilitates multi-purpose opportunities and the ability for flexible adaptation over time.
6. The redevelopment will design and locate facilities in a manner that supports service partnerships to enhance improved mental health and drug and alcohol treatment outcomes.
7. Site planning and building design will meet best practice standards in ecologically sustainable design resulting in more efficient use of energy, water and other natural resources.
8. Landscape and environmental design features will be used to promote recovery protect privacy and provide safety.
9. The redevelopment should strengthen community support and acceptance of the importance of the range of health services provided on the Glenside Campus and maintains and enhances the relationships with neighbours to the site.
10. Optimise the social, economic and environmental value of the site by establishing a model for integrated governance.
11. Develop facilities in a manner that supports cost-effective and efficient service provision and that matches the level of care and management required by clients, as these change over time.

12. Build partnerships with other government agencies and local government to deliver environmental outcomes that contribute to broader state and regional natural resource management objectives.
13. Encourage the positive engagement of the private sector to optimise the economic benefits of their investment in the realisation of the master plan in accordance with these principles.

Guiding Principles One and Three are particularly relevant to the case made in this paper. With respect to the first principle, the “primary purpose of the site will be to provide modern, state of the art facilities that meet the service needs of people with a mental illness or people with a drug and/or alcohol dependency”. The Third Guiding Principle states that “other services should only be added to the site if they can enhance the primary purpose of the site”. This provides guidance for examining how surplus land might be used.

The Public Advocate believes that the need for a new facility is unequivocal. A modern, state of the art mental health facility is desperately needed. Whatever happens, the facility must proceed.

Current accommodation for both mental health and drug and alcohol clients is aged, uncomfortable, and built at a time before many modern treatments for both mental illness and substance use disorders were available. Whether one considers the use of buildings that are nearly 60 years old as acute mental health wards, or some of the converted facilities used for drug and alcohol services, there is a pressing need for a new facility, as they have outlasted their expected life span.

This obvious, but critical statement is made because plans for mental health redevelopments in both the UK and interstate have often been controversial and protracted. The people who suffer the most during such unnecessary delays are patients in the outdated facilities.

It is common in the UK and Australia for excess land to be sold to pay for new psychiatric hospital developments. In most cases, old and outdated facilities would be rebuilt anyway, even if there was not another source of income.

The South Australian plan to sell land is similar to proposals or implementations in Sydney, London, and other centres in the UK. It is a standard government approach. This paper advocates an alternative strategy so that consumers can receive ongoing benefit.

3 THE DIGNITY AND RIGHTS OF SERVICE USERS

The new hospital will need safeguards to ensure that care is dignified, and the rights of patients in the hospital are maintained.

This is relevant for two reasons. First, there are risks in any care setting of abuse and neglect. Second, the world history of institutional settings in mental health has been poor. Most institutions operated in an environment of overcrowding, physical restraint and deprivation of liberty. For the most part, large psychiatric hospitals operated with staff who lacked training and who were left to cope as best as they could. This is described well by past leaders of mental health.

While there have been many good and dedicated people who have served the mentally ill at Glenside Hospital, the new facility will need a culture break from its institutional past.

And while many patients and families were pleased with the essential care they received in South Australian psychiatric hospitals, at both Glenside and Hillcrest, and of having their lives changed for the better, we must still remember the lessons of history. In other areas of our institutional past, such as the abuse of state wards, people have come forward to tell their stories. This has generally not been the same with psychiatric hospital care. This is because of people's illnesses, fear of retribution, and, because of the reduced life expectancy of people with serious mental illness. Sadly, many who have experienced the deprivations and traumas of the past are no longer alive to tell their stories, even if they could.

Overseas, the formation of survivors groups and a conscious effort by some historians to interview surviving staff of institutions has resulted in more information about the experience of patients in the different decades of the twentieth century.

We have seen new problems in recent years, as described in the *Not for Service Report* (Mental Health Council of Australia, 2005). These have been the failings of an under-funded and poorly designed community mental health system. A nostalgic return to the past can be wishful thinking and ignore that people were largely forgotten by the community once they were out of the public gaze.

Although some people now complain about the existing negative publicity about mental health, the level of interest in the welfare of individuals who have an illness and whether or

not they can get treatment is positive. For example, in the past there could be spates of suicides within institutions that would escape critical analysis. This was before the routine use of Critical Incident Reviews and Root Cause Analyses to learn how events could be prevented. Now there is deep community concern to prevent suicides.

The new Glenside facility will need to acknowledge its past, good and bad, and step into the future. It may be stand alone, but it will need to be well integrated into both the mainstream health service and part of the community. Importantly, it needs to be open to the public, with key protections in place for the future.

In *Paving the Way*, Bidmeade (2005) recommended the introduction of a Community Visitors Scheme to ensure contact with the broader community. In this approach, community visitors are trained members of the public, who regularly visit psychiatric hospitals, mental health wards in general hospitals, supported residential facilities and other accommodation. They also have a significant role in the disability sector by visiting institutions and group accommodations.



Photographs: Long serving Victorian community visitors receiving long service awards, and a picture of the new Austin Hospital mental health unit built after many years of community visitor complaints about the inadequacy of the previous structure. (Community Visitors Program Annual Report, 2007)

Community visitors bring community standards into the institution. They are an addition to usual accreditation or regulatory inspections performed by professionals. In centres with longer-term patients, consumers are able to develop a trust in their community visitor and gain the confidence to raise issues, knowing that if there are any problems after the issue has been raised the community visitor will be back in two to four weeks for a follow up visit.

In Victoria, the mission of the state-wide Community Visitors Program is to promote and protect the rights of people with a disability and reduce exploitation, abuse and neglect

(Office of the Public Advocate, 2007). During 2006-2007, community visitors made 1,251 unannounced visits to mental health units to advocate for the needs of patients. The visitors are appointed by the Governor in Council; in the mental health stream their work is governed by provisions of the Mental Health Act.

Some consumers viewed the introduction of a new Community Visitor's Scheme as a trade off for the longer detention periods proposed under the new Mental Health Act. Hence, the Bidmeade Report recommended both - a regime of longer detention periods, but the commencement of a community visitors program as well.

Currently, there is concern that we don't know about issues affecting people with mental illness in South Australian institutions and accommodation because we do not have community visitors to report back. In Victoria last year, community visitors reported on bed shortages, delays in maintenance and cleaning, inadequate trained staff, and shortage of low cost rental accommodation. The community visitors report directly to Parliament, and their influence matters.

While last year their focus was on such matters as bed numbers, the visitors and the board that they report to, can address individual advocacy matters. Their goals include looking at opportunities for people to participate in recreation, occupation, education, training and rehabilitation, rather than just receiving minimal care. Further information on the goals and objectives of the Victorian Community Visitors Scheme is available at Appendix C.

The annual report from the Victorian Community Visitors Mental Health Board contains examples of individual issues that have been raised, such as prolonged seclusion, failure to provide skilled rehabilitation or lack of accommodation.

Many of these issues are dealt with on the ward at the time of the visit, some are raised with management at regular meetings, and others need to be escalated to the department, ministers and local politicians.

The need for a Community Visitor Scheme at Glenside is similar to the need elsewhere in the system. However, with the concentration of beds in one location, and the inherent risks associated with institutional settings, it is even more critical that visitors have access to this site.

4 THE BENEFITS OF CO-LOCATION OF SERVICES

By bringing together Mental Health and Drug and Alcohol Services, people with a mental incapacity and substance use problem can benefit significantly from integrated treatment of dual diagnoses.

South Australia already has considerable expertise in this area through developmental work of the Drug and Alcohol Services South Australia, on the relationship between mental illness and drug use. For example, extensive work has been completed on the topical but previously poorly understood area of best practice in the management of amphetamine induced behavioural disturbance (McIver et al, 2006). This provides a sound academic foundation for clinical work.

This co-location should be a catalyst for integrated drug and alcohol and mental health care across the system. In the past, mental health and drug and alcohol interventions were delivered sequentially. People were expected to recover from their drug and alcohol use prior to receiving mental health care, or conversely expected to have their mental health condition stabilised before being admitted to a drug and alcohol service. The modern practice is to deliver both cares together.

This practice can apply to any substance. For example, when alcohol use and mental illness are both present, psychiatric interventions and alcohol interventions need to be delivered simultaneously (Baigent, 2005).

The co-location should also set new Australian standards of collaborative care. In particular, some of the current demarcation of roles between psychiatric hospital care, detoxification centres, and general hospital medical wards could be diminished.

A consumer who primarily needs treatment for mental illness, but also needs management of detoxification from alcohol, benzodiazepines or other drugs, could stay in a psychiatric ward, and gain access to nursing and medical expertise from the Drug & Alcohol Unit next door. Current practice in many Australian centres is for a person's primary psychiatric care to be disrupted when they are transferred to a detoxification unit or medical ward for the period of risk during the withdrawal.

Conversely, if a person who primarily requires detoxification and management of withdrawal also develops psychiatric symptoms during this process, such as thoughts of suicide or

persecutory fears, they too can stay in situ and have their primary problem treated without needing transfer by virtue of the specialist psychiatry help next door.

These are only illustrative examples. The anticipated strategic benefits of co-location can be described, and performance against this, measured. This could mitigate the risk of having two separate services on site practising as distinct entities. While each area has a substantive interest in coordinating dual diagnoses well, there is a small risk that must be managed.

In addition, existing efforts in Adelaide to integrate homelessness services with mental health, drug and alcohol and general health services can dovetail with the Glenside redevelopment. Research shows that the high needs group who may be homeless, drug and alcohol dependent and have a mental illness are also at high risk of dying early (O'Connell et al, 2005).

Glenside Hospital has traditionally cared for people who are homeless and who have a mental illness. In the future, a redeveloped facility can provide potentially lifesaving treatment for at risk people who need care for both psychiatric conditions and life threatening substance use disorders.

The redevelopment at Glenside has the opportunity to herald a new era of integration in the provision of community care. Traditionally, drug and alcohol services have been outpatient clinic based. People have attended when they are ready to change. Many people who have a significant psychiatric disorder do not see the need to stop using alcohol, benzodiazepines, marijuana, amphetamines, or whatever substance they are using at the time.

There is now a move – both in Australia and internationally – towards case management of drug and alcohol conditions generally (for example, Vanderplasschen, et al 2007). This involves coordinating services and providing programs for people who have yet to decide to stop using substances, to motivate them to make this decision, and then offer the relevant motivational support or cognitive behavioural therapy to assist them when they do.

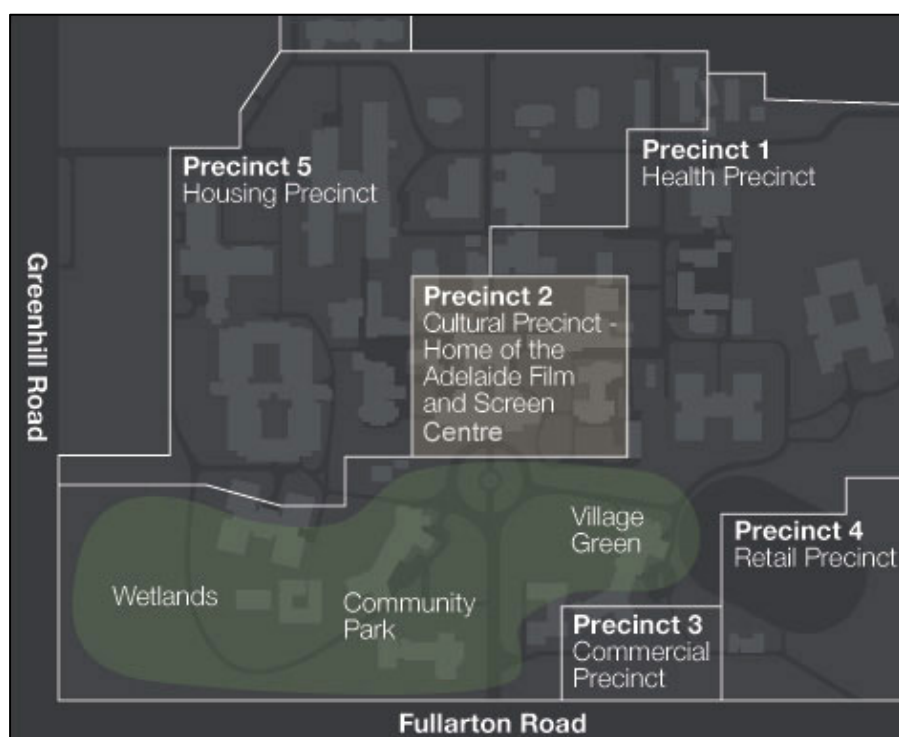
This approach can benefit people who have both mental illness and substance use disorders, or are otherwise in a high-risk group, such as those who are homeless. Therefore, while the issue of physical co-location of inpatient services is important, even more vital is how the entire system of care for both inpatient and community services is integrated.

The work of an existing network of government and non-government providers of services to homeless people in the inner city provides a template for future integration and collaboration between services (Brayley, 2008).

In preparing this paper, a formal analysis of the level of unmet need in this area has not been undertaken. Drug and alcohol workers and services are in high demand, and workers rush to provide basic interventions. With new expectations of providing case management, assertive care and treatment to people with high needs, additional drug and alcohol workers would be needed for this work. For example, in at least one centre overseas, a trial has commenced to provide assertive drug and alcohol services to homeless people (Stuttaford Doherty, 2007). The opportunity of rebuilding the Drug & Alcohol Services at Glenside can link to further review of community drug and alcohol services that will interact with it. In the context of the areas of focus of the Public Advocate, this would particularly apply to high risk people, such as the creation of a team to assertively address drug and alcohol problems for homeless people, or the provision of more expert drug and alcohol services for people with dual diagnoses generally to complement the initial investments that have already been made in this area by drug and alcohol services and mental health.

5 DESIGN FEATURES OF THE GLENSIDE HOSPITAL

The diagram below illustrates the Master Plan Outline for the site (Department of Transport, Infrastructure and Energy, 2008).



The Select Committee of the Legislative Council had previously asked for feedback from professional staff on the proposed Master Plan.

While the Office of the Public Advocate recognises expert opinion as a valuable resource, it also wishes to acknowledge another source of expert opinion - consumers. Their expertise comes from “lived experience”.

The Office of the Public Advocate invited eight service users to an in-depth discussion on the Glenside redevelopment. This was held on Monday, 13 October 2008. The outcome of this consultation was described in Part B of the submission – *Consumer Viewpoint*. The consumer content is reproduced in Appendix A of this document.

Such consultations are a common strategy in facility planning. The purpose of this independent consultation was to record consumer priorities that should be met in the new design.

Each of the consumers had experiences of psychiatric inpatient care, and six had significant experience of Glenside Hospital as it now is, as well as new Community Rehabilitation Services.

Currently, a building design is not available. The Master Plan layouts and similar diagrams do not show an anticipated building footprint. While the Public Advocate acknowledges that many of the items raised during the consumer consultation process will be considered by the planners, recording items now can help to ensure that the eventual envelope of the building is of sufficient size to provide these features, and that the space around the building will meet the outside requirements.

Many health facility planners and architects skilfully use the space that they have available to maximise space for patients, light and access to the outdoors. When facilities are built at general hospital sites, or in settings in the United Kingdom, space may already be limited and the creativity is applied to maximising the benefit from the land that is available.

In the case of the Glenside Hospital redevelopment, the hospital as the original occupant of the land is not constrained. The best practice design should sit comfortably on whatever allocation it requires, and this should be optimal compared to what is usually the case when land is acquired, and mental health is not the primary occupant.

Consumer priorities include access to fresh air and sunlight, physical comfort within the building, sufficient space to provide privacy, adequate sized bedrooms and communal areas. A space should be large enough to support a positive culture. Cramped wards that have glassed-in areas that separate staff and patients should be avoided.

Good food and access to kitchens, room for activities within the building, sports and outside activities, and onsite medical facilities should be included.

The gardens should be given a high priority as a relaxing natural environment for walks, as well as fresh air that can be appreciated from inside and outside. A recreational facility including a free gymnasium for patients would be of great value.

Because the community garden is some distance from the ward, immediate access to garden space surrounding it will still be important, both for outside use and creating the ambience for consumers looking out.

Consumers have seen compromises in general hospital mental health construction. This is a common issue around Australia and internationally. Units can be placed out the back, often next to workshops and plant equipment. The ambience is not a healing one.

Understanding the planned use of the film and screen centre might also influence the amenity of the hospital design. In particular, with two sound stages to be built and a set construction workshop planned, these developments should be placed and built so that the amenity for patients is not disturbed. If there is any choice, the sound stage buildings and the workshop should impinge on the hospital as little as possible.

Consumers would like to see onsite drama and artistic facilities benefit people who use the hospital site.

Referring to the map, earlier this year the location of the hospital and proposed residential development were swapped. Now the community gardens abut the residential area rather than the hospital. While consumers want to share garden spaces with the community, the garden is now slightly less accessible than if it were immediately adjacent to the hospital.

6 MEETING AUSTRALIAN AND NEW ZEALAND SIZE SPECIFICATIONS

Psychiatric wards built in recent times often lack sufficient space. This is true for facilities in Australia and those in a number of other countries, and applies in particular to units that have been built in cramped general hospital spaces.

The importance of space cannot be understated. Some people who are distressed and agitated will settle if they can get away from others. People's clinical situations can worsen when two or three agitated people have no choice but to run into each other on the ward.

Similarly, while some people are overactive when unwell and need space, others can be timid and vulnerable and similarly need a safe area. Much of hospital design is about creating space while ensuring that safety is preserved through having a good line of sight and other systems so that staff can observe patients in a larger area.

It will be important that the space allocated for consumers and staff meets the latest standards used in Australia and New Zealand for designing facilities. The Office of the Public Advocate is encouraged by the reports that this will be the case.

In this case, reviewing proposed sizes against both these standards and the size of existing units in South Australia and interstate could be informative when a design is available. Key measures include a total area of communal space for consumers, the area of activity space, and bedroom size. In addition, the land allocation needs to be sufficient to allow a building of sufficient footprint that will not impinge on surrounding gardens.

7 ENSURING ADEQUATE BEDS IN THE PSYCHIATRIC HOSPITAL

This will determine the space required both now and into the future. Bed numbers are based on the Social Inclusion Board report, which in turn has been influenced by *Andrews et al, (2006) Tolkien II Analysis of a Stepped Care Model for Mental Health Services*.

There are many assumptions behind these models, including access to necessary community mental health care, and community beds (so called Step Up, Step Down), and the provision of evidence-based interventions. This includes giving people access to cognitive behavioural therapy, dialectic behavioural therapy, psychosocial skills based training, rehabilitation and the provision of appropriate pharmacotherapy.

There are competing bed models, including the Mental Health Care and Prevention Model promoted by the NSW Department of Health (Centre for Mental Health, 2008), and the use of agreed benchmarks, comparing numbers based on agreed best practice.

The bed allocations for the new hospital are outlined below, as taken from the Department of Health submission to the Select Committee. The new hospital will include:

- 40 secure mental health care beds;
- 6 mother and infant mental health beds;
- 23 rural and remote acute mental health beds;
- 20 other acute mental health beds;
- 10 intensive care mental health beds;
- 30 drug and alcohol services beds; and
- Mental health administration.

The need for secure rehabilitation beds is a particular concern. This was highlighted in Victoria by the Auditor General when performing a Performance Audit of Mental Health Services for People in Crisis (Auditor General of Victoria, 2002), who described a lack of long-term beds along with a lack of acute beds. By 2005, the Auditor General had noted a response to his recommendations with increased acute and secure rehabilitation beds (Auditor General of Victoria, 2005).

Yet, last year community visitors in Victoria were still describing access block to secure extended care beds (Community Visitors of Victoria, 2007), which the Victorian Public Advocate raised in the media (Gardner, 2006).

It is encouraging that the South Australian Government is choosing to build 40 secure rehabilitation beds. This is the upper range of the 30-40 beds suggested by the Social Inclusion Board. If only 30 beds were provided, the situation in Victoria would be replicated. An additional 10 beds can be critical.

It is useful to reflect on the history of these bed number calculations. For a population our size, based on traditional benchmarks, South Australia would have only required 30 beds. However, there is a prevailing view that the original estimates did not fully take into account the needs of people with dual diagnoses. In particular, there is a group of younger people with severe illness, using marijuana and amphetamines, who can make significant gains if hospitalised for three to six months, and during this time given the most effective available treatment for psychosis (in particular the drug Clozapine which can be particularly effective for people who have not responded to other treatment), and have a period of not using illicit drugs.

The result is a progressive upward revision over time as more young people with psychosis have needed this care. Hence, the benefit of constructing 40 beds.

The question, however, is: what might happen in the future? If 40 beds is the current estimate, could similar forces occur at a later time? Even with best projections, this is possible. To deal with this, there should be space for an expansion capacity. This would require room for both additional bedrooms and communal environments in the future.

This way we can respond to potential future needs, as has been the case in Victoria where the presence of access block and an awareness of greater needs has led to the construction of new beds.

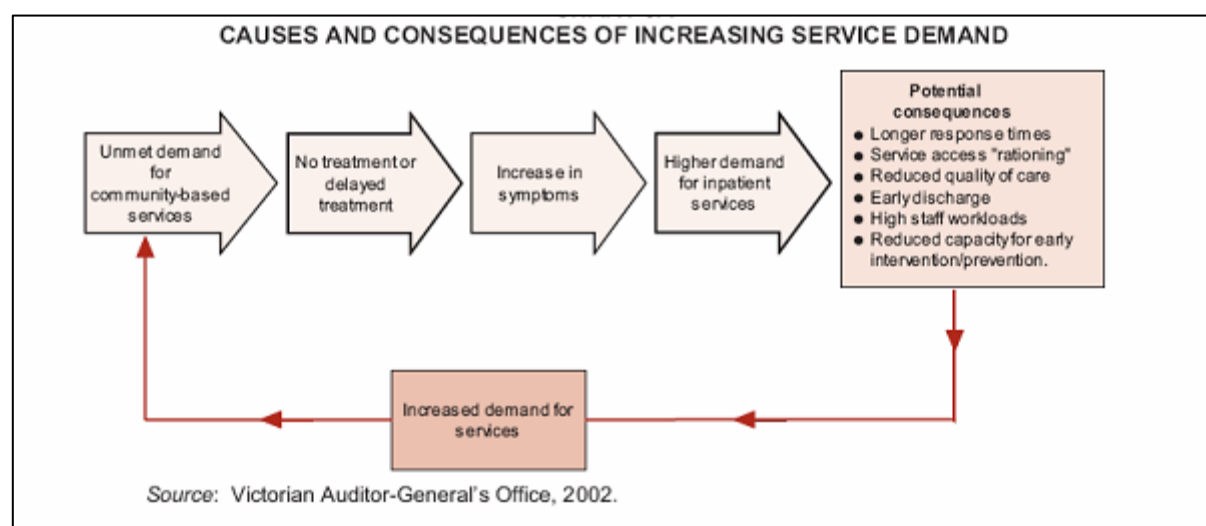
This process has been helped by external monitoring, first from the Auditor General, and then from the Office of Public Advocate's community visitors raising matters with the Department, Victorian Government and Parliament.

Getting the number of long stay beds right cannot be underestimated. The arithmetic is basic, but the importance of this "long stay outlier" effect was first highlighted in South Australia by clinical epidemiologists analysing flow through of general hospital beds. It was mathematically demonstrated that a small number of long stay patients, called "long stay outliers", in acute beds can lead to queues in the Emergency Department.

In mental health the same principle applies. If there are insufficient secure extended care beds, then long stay patients will spend longer in acute beds. Say, for example, a person stays for three months in an acute bed in a unit that normally has an average length of stay of 14 days. This person would occupy the bed for the same period that normally would have accommodated six other patients. If there are 10 patients like this throughout South Australia, then 60 extra patients must be accommodated in the remaining acute beds to compensate for the non-availability of these beds.

This clearly illustrates why having 40 rather than 30 beds is desirable, with the ability to expand in the future. The questions for the future are whether further small increases might be needed and how this might be accommodated.

The experience in NSW is relevant to reflect on. The Auditor General (2005) noted the increase in demand for services that were absorbing increased mental health funding. Understanding the reason for this demand is an analysis in itself. Some of it is due to greater willingness within our community to seek mental health care as there is less stigma in seeking mental health care. Other reasons include a failure of early interventions, so that people who could have been treated sooner are not and instead present when they are more unwell. This is illustrated in the chart below, which was prepared by the Victorian Auditor General.



In NSW the Mental Health Clinical Care and Prevention Model has been used, but this model, as noted in the Auditor General's report, is subject to revision to better take into account community services.

The Social Inclusion Board has used the latest modelling, which considers a balanced step system, and the provision of the latest treatments. This will need further monitoring and adjustment as the years go by. There are risks either way in having an unbalanced system. Insufficient beds put added pressure on community services that cannot function properly. Building too many beds creates an opportunity cost, because there will be less early intervention and community care to stop people arriving in hospital.

The solution is to use the existing models and best judgement at the time, but consider the need for further expansion.

8 SPACE FOR FUTURE EXPANSION: MEDIUM SECURE FORENSIC MENTAL HEALTH BEDS

Recently in Melbourne, the South Australian Public Advocate met community visitors who work for the Victorian Public Advocate. These community visitors were preparing to attend a community consultation about a proposal to build 120 beds at the Heidelberg Hospital Repatriation site, which will accommodate at least 60 medium secure forensic mental health beds.

The community visitors strongly supported this Department of Human Services and Government initiative, and wanted to help address neighbourhood concerns about the new facility.

This proposal is a new development in Victoria, and it is indicative of the types of development that South Australia theoretically may need to plan for in future years. Of course, the numbers in our state would be less, adjusting for Victoria's population of approximately 5 million people. For example, based on the Victorian proposal, South Australia would need the capacity some time in the future for an additional 15, possibly 20 beds, on the Glenside site.

Victoria has arguably Australia's best forensic services. The Thomas Embling Hospital, which has 118 beds, has been built on a campus model over eight hectares. It has high security, but within this high-tech parameter is a therapeutic hospital setting for people who are ill and need care, rather than punishment. In addition, there are a further 16 beds at the Melbourne Assessment prison (Forensicare, 2008).

The proposed Heidelberg Forensic beds would only be used by forensic patients - that is, people who have not been convicted of a crime because of their mental illness. They would not be used for prisoners who have been convicted and have a mental illness. They could also offer a step down for people who have had care in the Thomas Embling Hospital.

Glenside Hospital currently has a forensic role. In South Australia, the purpose-built forensic facility, James Nash House, has 30 beds in suburban Oakden. There are an additional 10 overflow beds at Glenside. Extra patients with a forensic history are managed in the Extended Care Wards. Forensic mental health care at Glenside is very much an existing use of the site. Glenside currently has a step down function which enables people preparing

to be released from James Nash House to spend time in the less secure Glenside Hospital before returning to the community. This can be a graded and monitored process.

The arguments have not yet been had about whether or not we need medium-security forensic beds within the metropolitan area. Yet, this Victorian development is a potential scenario for the future in South Australia. In Victoria the proposal has been to build at the Heidelberg site, as this was one of the last remaining sites in the Melbourne metropolitan area where there was sufficient space for a development of this type.

We have had increasing demand for Forensic Mental Health Services, a trend that began in the 1990s after amendments to the Criminal Law Consolidation Act which opened up a Mental Impairment Defence for a wider variety of crimes. There are access difficulties within the current system to our Forensic Mental Health Services.

Therefore, it is reasonable that space should be earmarked somewhere in the metropolitan area for medium-security forensic beds. Allowing for the existing plan to build 40 beds at Mobilong, it would be reasonable to consider that a 15-20 bed unit may be required in some time in the future.

Glenside is an obvious choice. There will be natural benefits in co-location with both Mental Health and Drug & Alcohol Services. Also, depending on the availability of other hospital land, which is very limited, it may be the only practical site.

It is important to reiterate that this information alone does not justify an immediate request to build a unit. It does justify consideration in current plans, so that in the future there is space to create added capacity to offer a metropolitan transitional step down location for forensic mental health care.

If the strategies regarding accommodation, integration and employment opportunities were abandoned, the benefits of co-location would be entertained.

9 ASSESSING the BALANCE OF ACUTE BEDS ACROSS REGIONS

The Social Inclusion Board's stepped plan rebalances the system. In the Health Department's Stepping Up response, a certain number of acute beds will be closed, and a greater number of intermediate care beds opened.

The local access to intermediate care and acute beds will be important on a local area basis. Just as the state as a whole needs to have a balanced system, each region and sub region needs to maintain balance. Benchmarks can consider the socio-economic disadvantage of local area which will alter bed numbers (Auditor General, NSW, 2005).

As plans progress for the opening of new intermediate care units, and the closure of small numbers of existing beds occur, balance will need to be retained within geographical regions of the city and the state.

The Glenside development will have newly built acute beds, and a new intermediate care facility. While it is reasonable that people travel to Glenside as a central location for state-wide services, the benefits of local acute beds easily accessed from hospital Emergency Departments and local community mental health clinics remain.

The acute beds at Glenside serve the eastern region of South Australia (excluding the designated beds for rural and remote areas). This includes supporting the homeless population of the inner city, and other patients who are considered to have "no fixed place of abode".

Without knowing which general hospital acute beds are to be closed, there is anxiety within some clinicians that areas in the north, west and south might have a different level of access to local beds than in the east.

At this time, there is nothing to indicate that this problem will occur, but it is a matter for review and checking as the Step Up System is implemented. Such review can ensure that the benefits of a properly balanced system are realised by each of the population groups served and local imbalances are minimised.

10 SPACE FOR DRUG AND ALCOHOL BEDS TO MEET CHANGING NEEDS

The development recommends an expansion in the number of beds from 22 to 30. In the future the way these beds are used may change, so sufficient space needs to be allocated for the beds to be arranged flexibly.

As more detoxification is undertaken in the community, it is possible that the space will need to be used for people receiving longer-term interventions. In particular, accommodation needs must be met for people who need stabilisation in the medium-term – a time in care for a few weeks or longer - and those who may need longer term care for a period over months.

Such flexibility may be needed to cope with emerging needs of people with a drug and alcohol conditions who are homeless. Both drug and alcohol conditions and mental illness are more prevalent in the homeless population and frequently co-exist.

For example, a Sydney study demonstrated that about a third of homeless people surveyed had a substance use disorder related to other drugs (cannabis, opiates, sedatives, stimulants, cocaine and hallucinogens), and 35 per cent were dependant on alcohol (Teeson et al, 2003).

The same researchers studied the prevalence of mental illness in a Sydney population and demonstrated that 73 per cent of men and 81 per cent of women had a mental disorder, and of the total population, 23 per cent of the males and 46 per cent of women had schizophrenia (Teeson et al, 2004).

People who have a drug and alcohol disorder, mental health disorder and physical illness (which is commonly associated with the former two) are at a greater risk of death. (O'Connell, 2005)

More assertive approaches are likely to find more people who might require stabilisation admissions, and longer term rehabilitation. While long-term work occurs in therapeutic communities in country areas, there is a potential for longer-term input to be needed in the metropolitan area.

Another development that may influence future needs is the use of involuntary care. Traditionally, drug and alcohol services have been provided on a voluntary basis, but the success in recent years of court diversion programs, and compulsory intervention for drink drivers indicates that interventions can work, even when people are made to attend rather than being motivated.

In NSW, an Upper House Standing Committee on Social Issues recommended short-term (7-14 days) involuntary care for people with severe dependence to protect their health and safety (Standing Committee, 2004). This would be used in exceptional circumstances. A subsequent national report by the Australian National Council on Drugs supported this conclusion, and recommended a national approach (Pritchard, 2007).

The Office of the Public Advocate is focussed on preserving people's rights and autonomy, and has not formed a position on this matter of involuntary care for addiction. Evidence would need to be carefully reviewed. Involuntary treatment should not be an alternative to developing accessible and desired voluntary systems.

Yet in this context, this discussion about involuntary care used in exceptional circumstances needs to be noted. It would place a different demand on facilities. Used judiciously, it would provide an intervention for people who would otherwise die. People who respond to a short period of involuntary treatment might then request a longer period of inpatient stabilisation on a voluntary basis.

As with the mental health examples, this material justifies further consideration of future need – in this case to provide buildings that might initially be used for detoxification, but could in the future cater for longer-term admissions.

11 THE IMPORTANCE OF SOCIAL FIRMS

Vocational rehabilitation has been poorly addressed in Australia. This is in part due to divisions between Commonwealth and State Government responsibilities. State governments generally provide clinical and support services, while the Commonwealth provides the majority of return-to-work services.

The importance of work and recovery has been extensively studied. New models have shown the benefit of having vocational rehabilitation experts as members of the clinical and rehabilitation team so that there is an absolute integration of clinical and vocational services.

While there is debate about whether assisting people with mental illness to gain employment should focus on individual placement in the open job market, transitional programs or other forms of supported employment, there are some key guiding principles emerging from best practise. These are:

- Client characteristics and preferences;
- Individual choice;
- Integration of vocational rehabilitation with mental health care;
- A goal of competitive (open) employment; and
- Ongoing support to maintain employment.

Consumers of mental health services can also be trained as peer workers and peer specialists to provide an active and valuable role in supporting others with a mental illness and in advocating for services.

Programs that find ongoing employment for people in mainstream industries benefit the individual. Traditional programs that are specifically focused on the needs of people with a mental illness continue to have a significant role. Although they have not been subject to the same intensive evaluation as newer programs, programs such as Clubhouse have particular strengths. These services have a long history of providing real work for people.

The strategic creation of specific businesses to provide employment for people with a disability, and in particular a psychiatric disability, was first developed from Italian cooperatives after the closure of psychiatric hospitals in Italy. These programs have now extended around the world (Warner and Mandiberg, 2006).

Affirmative business and social firms are relatively new to Australia. These enterprises modify the design of the workplace and through an integrated workforce promote both the social and commercial goals of the business. At least a third of staff – and often more – experience a mental illness or labour market disadvantage. All staff are paid award wages or higher. They aim to provide a safe niche somewhat separate to the mainstream labour force, creating an important employment opportunity for some consumers.

Research suggests that the criteria for their success includes locating the right market niche, selecting labour intensive products, having a public orientation for the business and having links with treatment services. These can empower individual employees, foster a sense of community in the work place and enhance worker commitment through the organisation's social mission.

In Australia, northern Sydney has the Macquarie Area Rehabilitation Specialties (MARS), a not for profit incorporated organisation set up by the rehabilitation team of the Ryde Community Mental Health Service. MARS operates three strands of business: garden maintenance, nursery and a cafe.

REFERRALS TO CREATE

The CREATE team is a multidisciplinary rehabilitation Service that works to develop partnerships with other organizations to provide opportunities and access in the areas of work, recreation, leisure education and training.

We are not restricted by area health boundaries.

REFERRALS - you can be referred by:

- Your Care Co-coordinator
- Your Health Centre
- Your Doctor
- Ring yourself 9816 0393
- Or LNS office 9448 3262
-

The create team links with: TAFE, Dept of Housing, Centrelink, CRS, PEP, STEPS, Pioneer, other health services



MARS Inc

(in partnership with the CREATE Team to provide employment and training for people with psychiatric disabilities)

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- Rivercat from city or Parramatta
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- 288 from Farring / city

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Community Mental
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These groups are located at different places.



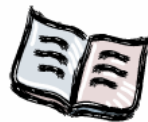
Education Access

CREATE has partnerships with TAFE, in particular with Outreach, OTEN and the Disabilities sections.

Courses include:

- Barista / Coffee Shop skills
- Computer skills
- First Aid

If you are considering University or TAFE, contact the CREATE Team and we will pave your way, giving you assistance with contacts to the counselling services, and inform you about the availability of additional funding for people on DSP.



Training and Employment

CREATE staff are responsible for the managing and training of MARS Inc employees. MARS Inc is a non-profit, business enterprise set up to create work for people who have a psychiatric disability.

About 50 people are employed on a wage linked to the award wage (calculated according to skill) in catering and horticulture. These are fully commercial enterprises operating out of Cornucopia Café.



The usual pathway to employment is through gaining experience either in TAFE courses or by voluntary work experience. Work is also accessed through CRS, STEPS, PEP and Pioneer Clubhouse.



MARS pays people Award wages, and the business is operating well. It turns over \$450,000 annually, and is making profits. In its horticultural business it has approximately 10 people working in garden maintenance and landscaping in the Sydney suburb of Turramurra, and 15 people working at Gladesville. At its base, a former psychiatric hospital, six people work in a nursery that grows trees, and 15 operate the cafe.

Many other examples of successful programs are available worldwide. This year, international speaker, Jacques Pelletier, presented to the National Disability Service Conference on accommodation and social participation on the benefits of social enterprises (Pelletier, 2008).

Pelletier described a number of social enterprises in Geneva that are operated by people with a disability, with 80 per cent having a psychiatric disability. These businesses are built on real jobs, are up to 80 per cent self-sustaining and are not dependent on government subsidies. Pelletier outlined the work of the Jardins d'Humily (The Garden), the oldest business with the lowest profitability, but which grows vegetables to be sold to the community. Individuals buy shares in the company, and in exchange, get fresh vegetables delivered once a week for eight months.

Other businesses include L'imprimerie (The Print Shop) which is the most profitable business, employing 16 staff carrying out three million photocopies per year.



Another example outlined by Pelletier is the operation of hotels such as the one in Geneva outlined below (Pelletier, 2008)).

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BIENVENUE

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Social firms now operate in Canada, the United States, Europe and Australia. It is possible to establish social firms to operate or to open a franchise.

There are already non-government organisations operating vocational programs in Adelaide for people with a psychiatric disability. The potential to create a true social firm, with consumers taking on roles in management, office coordination and on the shop floor is one that could be considered with the Glenside redevelopment.

Some of these businesses require land for vegetable gardens or tree nurseries. Others require access to retail premises. While a true social firm will be self-sustaining, the initial provision of key assets such as land or shop space can help ensure the success of the business.

Social firms can provide services to other occupants of the Glenside site, such as gardening, landscaping and tree planting, as well as expanding into the Council area.

If it were decided to use land to establish businesses that generate revenue for additional mental health services, these businesses could also employ social firms to undertake their work. For example, servicing and maintaining short-term accommodation, or establishing tourist villas such as holiday apartments that might require staff. For this reason social firms could be considered as an integral part of the Glenside redevelopment.

12 RESEARCH

The Select Committee has made an interim finding recommending the establishment of a Research Institute. This is consistent with the recommendations of the *Shine Young Report into Health and Medical Research in Adelaide* (Shine & Young, 2008).

Research can create centres of excellence, support advocacy, be a catalyst for innovation and stimulate best practices.

To provide state of the art facilities it is necessary to have adequate research and development investment. This needs to be closely linked to the day-to-day provision of care, so that through the nexus of research, teaching and provision of clinical care and rehabilitation, consumers benefit from the research investment.

12.1 The need to strategically define goals

A careful planning process should consider the strategic goals of the research institute. These should benefit consumers directly.

Over the years, consumers have been keen to learn about our local research, and have shown appreciation of the benefit of internationally recognised basic research that can help better understand mental illnesses and find improved treatments.

Baroness Greenfield, in her recommendations on maximising the value of science in South Australia, has highlighted our strengths in the neurosciences (Greenfield, 2004). Therefore, any research institute should potentially be multi-disciplinary, and not only engage clinical researchers but relevant basic scientists.

The next area is the provision of clinical treatments. Consumers have wanted holistic care (Mental Health Council of Australia, 2005), and a balance of both drug and non-drug treatments. There are significant developmental research budgets already allocated by the pharmaceutical industry. Focussing on psychotherapies, and rehabilitation, and how they might work either individually, or in combination with modern pharmaceutical treatments, could deliver better combination responses – the holistic biopsychosocial model.

Finally, mental health services research should not be overlooked. While there is often extensive research knowledge about what treatments work, the evidence based on how best

to organise and deliver services and implement new innovations is comparatively sparse. How to design teams, place services so that people in the population can access them, and get the best possible outcomes are key policy and operational decisions. Huge sums are invested in models of service design where evidence is limited. The area of health services research is only now starting to come of age in Australia, and mental health services is one component of this.

It is clear from speaking with consumers that they would like to have a part in setting the research agenda. While some research questions are applied and technical, the priorities of areas of knowledge can be informed by consumers' experience.

Glenside will also be a site for Rural & Remote Mental Health Services. The need to enhance the academic input into the mental health of country people has been noted in other states. Usually, this means establishing academic units in rural locations that become a focus of centres for excellence. Arguably, South Australia needs a greater mental health rural academic presence, and there is a risk that in concentrating research resources at Glenside, opportunities to fund future developments in country locations might not be realised.

Ideally both should proceed. For example, for some years there has been discussion about the benefits of establishing an academic unit, with a professorial post in rural and remote and indigenous mental health in a city such as Port Augusta. With the recent impact on climate change, similar arguments could be made for the establishment of a mental health academic unit in the Riverland.

Universities have already shown the way by using rural locations for teaching, and this would provide a further base for research development. This need should be considered as well if decisions are to be made about Glenside.

12.2 University investment

Models exist for combined university and state government investment. It is worth noting that the latest plan for Callan Park in Sydney, involved the creation of a university campus on the former psychiatric hospital site. Recent South Australian suggestions have been more focussed on mental health. Press reports in October 2008 have suggested that university investment in capital works, including the University of Sydney's planned investment in the Callan Park psychiatric hospital site, may be delayed because of a reduction in investment returns (Trounson, 2008).

Nevertheless, universities could potentially bring Commonwealth funding and other investment income into the development of an institute.

12.3 Linking research to better services

In discussions between the Public Advocate and people on the front line who are supporting and advocating for consumers and their carers, there is a significant scepticism about the proposal for a research institute.

Those workers see consumers missing out on basic services which would help them to live their lives fully. They do not see value in supporting extensive research industries, when basic services are not provided to consumers, and simple well-researched treatments and therapies are not routinely applied.

The planning of the institute would need to ensure that these risks are managed, because this scepticism is justified, and the outcomes from establishing such an institute should flow on broadly to service provision.

13 THE IMPACT OF REDUCED AVAILABLE LAND

13.1 Housing

It is relevant to consider the importance of housing as it has been subject to significant research. The concern of the Office of the Public Advocate is of access and supply of high needs housing. The housing development will include 5 per cent high-needs housing (places for 20 people), and 10 per cent affordable housing (for people who earn less and \$59,000 per year).

The comments of Jim O'Connell, President of Boston Healthcare for the Homeless, epitomises the importance of housing, above and beyond other services. He said:

"After two decades of doctoring to the homeless poor, I believe that I could best improve the health of my patients by assuring access to housing and supportive services as core components of their treatment plans. In addition to prescribing an antibiotic or insulin or a blood pressure medication, I dream of writing a prescription for an apartment, a studio, an SRO (single room occupancy), or any safe housing program, good for 1 month, with 12 refills". (O'Connell, 2007)

In the last few years, we have witnessed a major evidence-based policy shift from housing ready programs to Housing First. Traditionally, the focus on homeless systems was on providing support for people while they were homeless, with housing arranged at a later point when they were ready. Soup kitchens and shelters are part of this system, providing a vital service for people who drift in and out of homelessness. For people who are chronically homeless, it is current best practice to solve their homelessness by providing housing, rather than investing in ongoing support.

Programs to house people with mental illness such as the award winning "Pathways to Housing Program", have demonstrated the success of this measure (Pathways to Housing, 2005). With Housing First, there are no conditions on being given a house. There is not a prerequisite of being abstinent from substances, or taking mental health medication. However, the outcomes for people are no worse than when this is made a prerequisite. In fact, they get housing sooner and have more choice. It is critical that there is an adequate support service so that their housing placement succeeds.

Mental Health and Drug & Alcohol Services which may be difficult to deliver while a person is itinerant, can then be provided to the person when they are at their home. It is not necessary to have steps and barriers for people to go through, such as success in boarding houses, before being allocated housing.

The success of a Housing First philosophy is illustrated by Malcolm Gladwell in his article “Million Dollar Murray – Why Problems like Homelessness might be easier to solve than to manage” (Gladwell, 2006). Housing First puts forward sound economic arguments that it is cheaper than the alternative – an alternative which is life on the streets with extensive admissions to Emergency Departments, hospitals and gaols which cost more than providing a house and supports.

The concept of high-needs housing is described by Haggerty (2005).

“The idea behind supportive housing is simple. Years of effort showed that neither affordable housing or support services alone could reliably provide stability, self-sufficiency and improved health for homeless people with complex needs. Yet the combination of the two has proven stunningly effective. Retention rates in housing typically exceed 85 per cent for even those with the most difficult problems. And wherever it has been developed, supportive housing is far less costly to provide than allowing homeless people to remain so. Studies documenting the cost of repeat encounters with health, mental health, substance abuse, shelter and correctional services – facts of life for a rough sleeper – make clear that supportive housing is not only a more humane, but a wiser investment of public resources”.

High needs housing improves quality of life, and makes economic sense. Evidence about improved life expectancy is not yet in, (Hwang, 2007), but it makes sense that if people are off the street and away from harm, as well as receiving mental health, drug and alcohol and physical care, that their health status should improve.

Assessing the need for high needs housing requires a formal analysis, which would encompass the number of people waiting for public housing reported by public and community housing association, reports by service providers and by considering some of the cases where people are not receiving a house or support services.

In spite of the major advances in South Australia, more houses and more supports are required. Haggerty's (2007) report recommended the development of a production timeline for 3,900 units of special needs housing in this state.

Also, many of the 500 approximate people with mental illness in supported residential facilities are in inadequate housing, and might otherwise be housed in modern single bedroom units or bed-sit accommodation in mixed developments with on-site support.

By way of context, South Australia is a national leader in this field, with homelessness services coordinating care and finding housing using Housing First principles. The state has new partnership developments such as Common Ground that provides mixed housing in newly built accommodation.

More high needs housing is required. Sectoral enquiries reveal hold-ups through delays in finding suitable housing stock. For some organisations, there may not be funding for a person's mental health or disability support needs, even once a suitable house has been secured.

There is also a wish for a greater variety of houses from both consumers and advocates. While satellite housing scattered through communities is appreciated, cluster housing can provide an alternative for those who wish to live near understanding neighbours or with a support worker on duty.

Elsewhere in this paper, the Office of the Public Advocate has put forward strategies for developing an income stream for mental health support services. Given that supported housing both requires a house and support, this strategy would also contribute to supported housing in an ongoing way by funding support. If all the proceeds of the development were redirected into the construction of houses alone, there would still be the question of the one-off benefit, as opposed to ongoing benefit from the land if income from it can then fund support services for people wherever their house is located.

13.2 Creating a mixed community

Inclusionary zoning will be adopted for the Glenside development, therefore adhering to the 15 per cent housing requirement (5 per cent high needs, 10 per cent affordable). This is in keeping with recommendations from Haggerty (2007), and the Office of the Public Advocate understands that South Australia is the first state to implement this requirement. It applies to government developments, major developments and the up-zoning of land. The 15 per cent minimum figure is used in Canada, as well as some other countries, and creates balanced communities (Minton, 2004).

What began as a minimum figure for major developments is now also seen as a suitable mix of housing, with one house in eight either affordable or high-needs.

There is however evidence of significant limitations on the benefits of planning solutions. They are seen as a low cost “technical fix” to the delivery of affordable housing; whereas other options such as the provision of more social housing is more likely to be effective. This has been reviewed by Andrew Beer and his colleagues at Flinders University (Beer et al, 2007).

While the one in eight figure is generally applied to this type of development, it is worth noting the other types of housing that can support a broader mix. In apartment groups, there has been successful mixing of people who need support for psychiatric disability and other citizens such as students or artists. In South Australian developments at Avalon in Marion and Chestnut Grove in Clovelly Park, the breakdown is 50 per cent supported housing and 50 per cent community occupancy and work.

Similar proportions can be achieved. Sometimes, modern apartment buildings or renovations of older structures work well for these developments, so that people have modern, comfortable accommodation with support on site. This principle underlines the Common Ground approach, of which South Australia is a national leader. In Australia there are proponents of “shop top” residential developments. If this were applied to this plan, a significant number of people could live in a mixed community on top of the proposed retail development. “Shop tops” do have some developmental constraints, but are an option when the proposed shopping centre is already immediately opposite the high rise Arkaba Tower.

In conclusion, the current proposal does have a mix of housing typical of major developments, which would now be expected of any major development in this state. Other solutions for more housing could be considered either on or off site, such as “shop top” developments along the lines of the existing Common Ground developments, and cluster accommodation to fill a gap recognised by consumers and providers. The support required for extra supported housing could be funded through an income stream from the hospital land.

Lastly, the best practice redevelopment of former psychiatric hospitals is still developing. The proposal for the redevelopment of Boston State Hospital Campus is promising, with the range of accommodation options, services and industries offered (see text box on the following page). All this will be located in a 17-hectare site and has a higher proportion of housing that is high needs and caters particularly for people with a mental illness and the elderly. While we cannot provide information on the outcomes of this development (a check of mental health and homelessness colleagues in Boston did not come up with further information) the plans themselves have a variety of uses for the size of land.

Olmsted Green Development, Boston, Massachusetts, USA.

The redevelopment of the Boston State Hospital Campus, formerly a mental health facility, is integrating housing, commercial and institutional uses on a 42-acre site, to develop a unique community setting dedicated to promoting inclusiveness. The plan offers housing, recreation, human service and economic benefits, while respecting and preserving the natural open space, traditional use and characteristics of the site. It includes:

- Building approximately 500 units of housing for sale and rental at various income levels and for seniors and clients of the Department of Mental Health;
- The housing mix is to be 287 market rate townhouses and condominiums, 153 affordable apartments and 83 units of rental housing for seniors;
- Economic development opportunities with the establishment of agriculture and aquaculture businesses, a job-training centre and a recreational facility;
- The refurbishment of a heritage building will commemorate and support efforts aiding people with mental illnesses;
- Expanding an existing community centre to include a four-season athletic and recreation facility; a job training and education centre and services including childcare, youth and senior programs and homebuyer classes;
- An 11,000-square-foot building for Department of Mental Health programming and exhibition space for the New England Alliance for the Mentally Ill;
- Creation of housing, employment and job training opportunities for those with mental illness; and
- A 123-bed skilled nursing and mental health rehabilitation facility.

A key focus of the design is sustainability and conservation. Collaboration with the Boston Nature Centre will preserve and enhance the environment on the site and an adjacent sanctuary. An Urban Farm will provide year-round agricultural and aquaculture production, a small farm stand and market area. The development aims to create more than 400 construction jobs and 400 permanent positions.

Source: Boston Redevelopment Authority (BRA), City of Boston, Massachusetts News Release: May 2006

14 SALE vs INCOME GENERATION FROM SURPLUS LAND

14.1 Developing an income stream from land as an alternative to sale

Insight into this issue comes from the “Save Callan Park” campaign in New South Wales. Psychiatrist Allan Rosen and mental health consumer Leonie Manns have written about this issue (Rosen and Manns, 2003), and in particular note in their abstract:

On the surface it appears that the debate over Callan Park is over. In the face of a noisy ‘Save Callan Park’ campaign, the NSW Government relented and subsequently passed legislation to protect this site from development ‘forever’ (Sydney Morning Herald 21.10.2002) amended by the Upper House to prevent long-term leaseholds (December 2002). Both sides of this debate have been misguided, obscuring three important issues:

- (i) that the site is not ‘terra nullius’ and does not, as has been often claimed, belong ‘to the people of NSW’ but ‘to the people in NSW with mental illnesses’;*
- (ii) that most people with mental illness are better off being cared for in the community than in psychiatric hospitals; and*
- (iii) that providing such alternative care requires much more government investment, equivalent to the value of such sites. Either selling or giving away psychiatric hospital sites without proper recompense to people with mental illnesses is unjust.*

This analysis is insightful, and similar arguments are currently applied in South Australia. Rosen and Manns define three forces. The first two thrived in NSW - the benefit for the ‘state as a whole’ or the benefit for the neighbours. Their paper highlights that benefits for the mentally ill were ignored in that state.

This is not a land rights claim, as such. The unequivocal traditional owners of the land are the Kaurna people, not mental health consumers. However, over the last 140 years the site has been used for mental health care.

People with mental illness may not directly need this space anymore. They need best practice care in the community, and the resource of the land could be specifically reinvested for their benefit.

The Office of the Public Advocate strongly contends that the redevelopment of land at Glenside should benefit people who have a mental illness.

In South Australia, this is reflected already in the Social Inclusion Board's Guiding Principle One, (defining the primary purpose of the site) and Three (other uses to enhance the primary purpose).

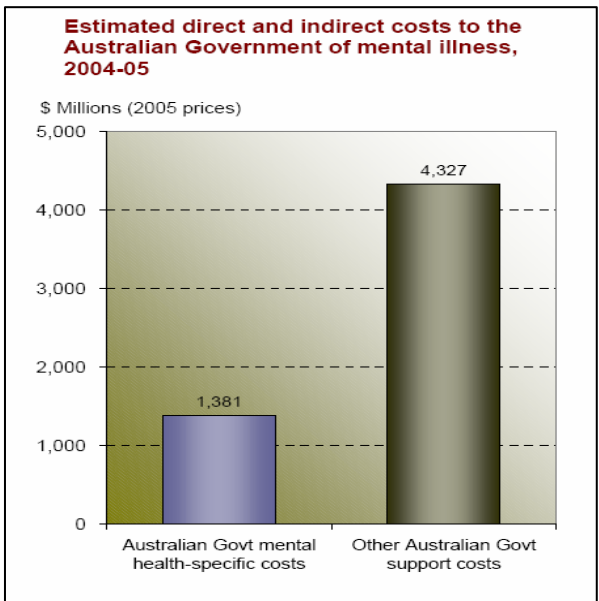
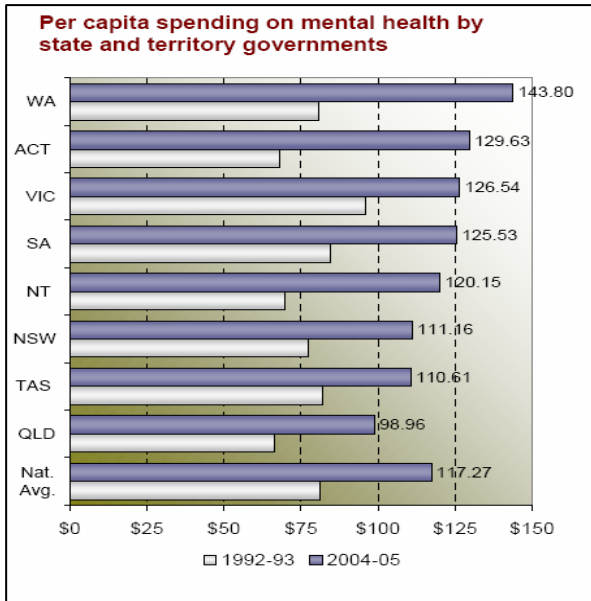
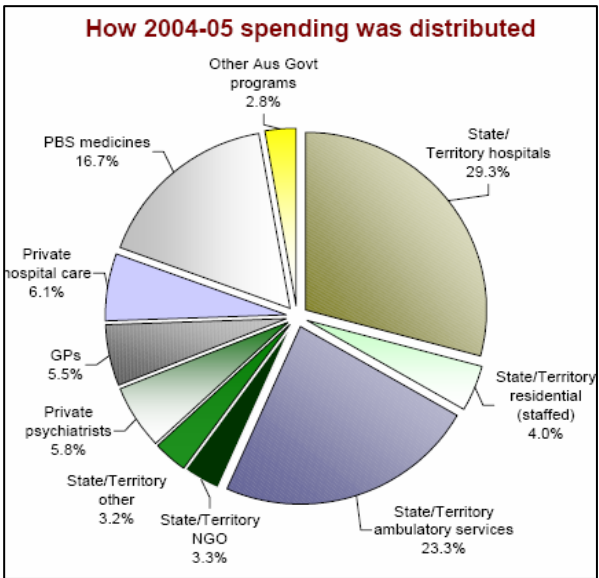
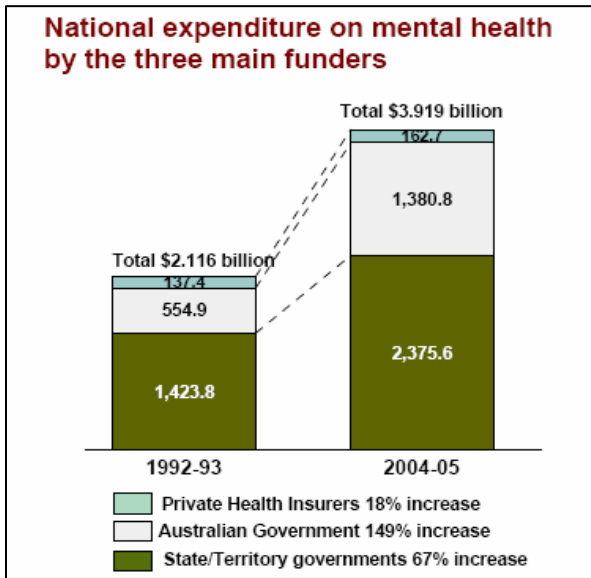
14.2 The counter argument: selling the land

The counter argument to the one outlined at Section 14.2 is that mental health services have received significant additional funding in recent years. Therefore, any claim for ongoing benefit from an asset should take this into account.

As noted, existing facilities are now so old that it is reasonable to conclude that they must be rebuilt regardless, without the need for funds from the sale of land, as is the case with general hospital redevelopments.

Analysis of national funding suggests that mental health still needs an extra boost. Earlier this year the Australian Government published the 2007 National Mental Health Report, which described 12 years of progress of national mental health reform in Australia.

The diagrams on the next page illustrate the national expenditure on mental health by the three main funders, and alongside that the distribution is depicted.



While there has been a significant overall growth in funding over the 12 years in question, mental health expenditure remains at 7 per cent of the total health budget. Given that mental health has come off such a low base, and considering the frequency and levels of disability caused by mental illness, this progress – just keeping pace – is insufficient. This is a pattern that has been noted repeatedly in successive national mental health reports.

These are Australia-wide figures, not South Australian figures, and do not reflect the last two years. It is reasonable, though, to assume that the national trend would apply in South Australia. In particular the graph reflecting per capita spending on mental health by state and territory indicates that South Australia is mid-way in per capita mental health spend.

Since then, there has been a substantial additional investment in national mental health in both capital and recurrent funds, associated with the 2006 Council of Australian Governments (COAG) National Mental Health Plan. States by and large matched Commonwealth funding on a per capita basis. At the same time, there have been substantial increases to general health expenditure. As a result, a reasonable assumption based on this information would be that the pattern described in the Australian Government publication from earlier this year would still apply.

There is still considerable unmet need. The Social Inclusion Board reform continues, and without doubt, people have benefited from additional Department of Health and non-government support services, with people now accessing new services such as the Community Recovery Units. People who have complex needs, who are homeless or have more than one disability, are regularly receiving support from psychiatric disability funding managed by the Department for Families and Communities.

In South Australia, as is the case across the country, the need for additional services remains for people with high needs, dual diagnoses, with problems overlapping different disability areas, and drug and alcohol use, as well as early psychosis.

There is a potential for this asset to be used to assist people with mental illness into the future. It is true that the land is no longer needed for hospital care; however there are other creative opportunities that could be capitalised to ensure a good outcome for both people with mental illness and the broader community.

14.3 Generating income for mental health as an alternative to the sale of surplus land

Mental Health consumers are now living in the community, and need clinical services and added support. They do not need the land per se. Land, though, can generate an income that could support additional services for people most in need.

Income from this land could be a bonus for particular groups, such as high needs groups who may have a combination of mental illness and other disabilities, or people who would benefit from the provision of additional early intervention services. Such additional income could be a bonus source of extra services in specific areas of need, not a replacement of recurrent funding.

It is not the role of the Office of the Public Advocate to develop a business case for generating income from this land. Yet it is necessary to give some details of what can potentially be achieved, to support the viability of these ideas so that they can be given consideration.

There are precedents for this approach. Some non-government organisations that have had significant land holdings have not wanted to divest them. Once the land is sold, the future value is lost. These organisations have wanted to keep their land, but developed it to generate income.

Historic examples include the development of retirement villages by disability sector non-government organisations. An organisation can keep the title of its land forever, and with good business and development acumen, have a steady income stream for services.

Land could be leased for short term rental, holiday apartments, other tourism ventures, commercial uses, or be used for retirement villages. Typical calculations follow, with income stream possibilities including retail development, short term residential and retirement accommodation provided on a loan and license basis.

With the development of retirement accommodation, an initial capital return of approximately 80 per cent of the land value can be received. In addition, the operator retains 20 per cent of the price each time the properties are resold. This provides an income stream after 7-10 years, when units are turned over.

There is risk in developing a mixed used project, but one that could be carefully managed through prudent project leadership.

Another benefit of this strategy is that people with mental illness would benefit from further incremental rises in the value of land. With the limitation of new land available in Adelaide caused by limits in urban growth, further increases in land prices could occur within a few years, which would be lost to people with mental illness if a sale were to occur now.

Depending on the return, it is possible that a recurrent income of \$8-10 million might be generated from this land. This could be dedicated for a number of relevant uses where bonus funding is needed, including:

- Funding an expansion of the Department for Family and Community Services Psychiatric Disability program operated through the Exceptional Needs Unit. This is already providing excellent support for people with high needs, who often have more than one disability, but could assist more people. It is a program that could be expanded to more people in need of higher needs support, particularly those with more than one disability.
- The provision of additional clinical and support services to Aboriginal people in remote communities.
- An expansion in designated early psychosis capacity within mental health services. This will be a future point of reform across Australia, with the recognition that people are still presenting for care late, and experiencing unnecessary risk and long-term impairment.

These approaches to land have been used in the past, outside of mental health. A recent press report (Booth, 2008) in the *Adelaide Advertiser* is worth noting, as it suggests that such proposals still have a place. This article describes the plan by MINDA Incorporated to develop its 36.4-hectare Brighton site, without any intention of selling the land.

There is a direct parallel between this, and the potential use of the 30.05-hectare Glenside site. There is a need for income for additional services. The mission to serve vulnerable people is similar, although the population group is defined differently.

This is a pragmatic alternative. Returning to Rosen and Manns' argument, there are two options:

1. selling the land to developers, so that cash flows immediately to the state; or
2. retaining more open space, which in itself has an opportunity cost.

A third approach is to develop the land, but with a strategic goal to benefit people with a mental illness, and provide specific ongoing funding in areas that may not have otherwise received this support.

14.4 Risk of diverging interests by the new land owners

There are real risks that once the Glenside site has been handed over to new owners the significance of the historical link of this site with mental health will no longer apply.

It is possible that people with psychiatric disability could be excluded from parts of the site that once belonged to them.

Haggerty (2005) has described a vision of people in the future arriving at Glenside to be greeted by a mixed community. This is a powerful vision and one that, with the support of local leadership, can be achieved.

There is a risk that the reverse could occur. It is difficult to know what this risk might be, but it is inherent in the Village Garden suburb concept. In particular, developments such as Springfield Hospital in Southwest London and Glenside Hospital are based on the Village Garden approach (Southwest London and St Georges, 2008). The most well-known and longstanding example is Hampstead Garden suburb near London.

If a new suburb develops as an inclusive mixed community then it could have strengths that could make it an innovative model community into the future.

Minton (2004) describes how these ideals can be subverted to create social polarisation and exclusion. She reported that 18 months before two security services had begun operating there. One Ultimate Security USL charged about £1,000 per year per household and had 120 subscribers, while another London Community Services charges £600 and has 100 subscribers (Minton, 2003; Moore, 2004).

The service included vans and guards patrolling the streets, as well as 'meet and greet' by ex military guards wearing combat trousers, boots or reflective jackets. In September this year the companies merged (Editorial, 2008).

If this is the Village concept, it is possible, (perhaps not probable), that similar development could occur at Glenside if an opportunistic security company wished to exploit anxieties of high income residents. If this worst-case scenario were to happen, people with mental illness may feel uncomfortable wandering their locale to access and utilise parks and other facilities if there were such a private security presence.

This is a worst-case scenario, but it is real, it needs to be noted, and it involves the very community that is the model of town planning for psychiatric hospital redevelopment.

15 ESTABLISHING A GLENSIDE MENTAL HEALTH TRUST

The Social Inclusion Board's Guiding Principle Ten is to optimise the social, economic and environmental value of the site by establishing a model for integrated governance.

A model of integrated governance could help prevent the worst-case scenario outlined at Section 14.4. It could also be a vehicle for generating income from the site for mental health consumers and operating social firms.

An innovative model of governance would need strong collaboration between the community, private sector and government.

Mulgan (2008), in discussing innovation, notes the strong history of South Australia's innovative practice. He goes on to examine the need to progress beyond government to ensure that innovation happens. He says:

My research has shown that innovations of this kind grow in very different ways. Some grow in the public sector and others in the not-for profit sector. Some are the product of social movements like environmentalism or disability rights. But the most striking feature of these innovations is that they usually happen despite the systems governing public institutions, not because of them. There are very few sources of funding for radical social innovations, few institutions devoted to supporting it, and few if any committed to growing the ones that work. (Mulgan, 2008)

To help advance the discussion about what integrated governance for the site should look like, the Office of the Public Advocate proposes a solution that a Glenside Mental Health Trust be established.

The Trust should have private sector, development and business expertise, consumers and carers and mental health professionals. The purpose of the Trust should be to:

1. Oversee the management of the entire site (including the development zones and the hospital) to benefit vulnerable people who have a mental illness. This will be done in a way consistent with the 13 principles outlined by the Social Inclusion Board for the redevelopment.

2. It would retain control of the site that would have otherwise been sold, and manage this land to generate income for the benefit of people in South Australia with a mental illness. The Trust would follow the approach adopted by non-government organisations who have kept ownership of land but required income.
3. The Trust would select specific areas of investment for these funds that need an extra boost beyond usual government revenue – this funding could be used in areas such as additional high needs psychiatric disability services, early psychosis, Aboriginal mental health, or other areas that the Trust were to prioritise.
4. The Trust could oversee the operation of social firms that are based from the Glenside site – whether these are retail businesses, nursery and landscaping, or tourism and hospitality.
5. The Trust could underwrite the initial establishment of social firms, with the intention that they become self-sustaining.
6. The Trust could oversee the operations and priorities of a state-wide research centre in mental health.

By creating a Trust, integrated governance would be established, and people with real skills might be attracted to become board members. Such a Trust needs to be a vehicle for development, innovation and advancing the needs of people with a mental illness generally, and so contributions from a broad section of the community would be encouraged.

APPENDIX A: THE CONSUMER VIEWPOINT

Office of the Public Advocate Consumer consultation – Glenside Hospital

Introduction

The Office of the Public Advocate invited eight service users of specialist mental health care for an in-depth discussion on the Glenside Redevelopment. This was held on Monday 13 October 2008 at the Office of the Public Advocate, ABC Building, Adelaide.

This material is included in this document as an appendix. This is so the Consumer Consultation and Public Advocate's recommendations can be conveniently distributed as one document. However at the Committee two documents were submitted (Part A which contained the Public Advocate's recommendation and Part B, the Consumer Consultation). This was done to reflect the importance of the consumer material, which stands alone as a significant set of recommendations based on consumer expertise.

Each of the consumers who participated had experience of psychiatric inpatient care, and six have had significant personal knowledge of the current Glenside Hospital, as well as experience of the new community rehabilitation services that have commenced in recent years.

While it is acknowledged that the sample size is small, the approach of speaking with small groups in-depth is common in both service and facility planning – whether this be small groups of health professionals, consumers or mixtures of both. In this case, it is with consumers.

The Public Advocate had previously reviewed the transcripts of earlier witnesses at the Select Committee, and selected the themes based on the common questions the Committee asked those witnesses, as well as the Terms of Reference of the Committee. This included the topics of healing space, housing, and the sale of land.

Participants had past and present plans of the redevelopment to peruse. However, with no plan for the proposed building it is still difficult for anyone to be sure how well the current proposal meets the requirements of consumers.

The key requirements that emerged from the discussion are presented in this summary. While it would be expected that the building designers would consider many of these themes, this presentation describes them, and prioritises them from a service users perspective.

Each of the requirements has space implications. The total space of the new building should accommodate each of these requirements, as should the surrounding garden and open space.

The opinions of service users include:

Access to fresh air and sunlight

Some existing wards are dark, dismal and depressing. They look out onto other buildings. A view, light and access to the outside and fresh air is needed.

The outside area should have fresh air, an open space for people to meet and talk together.

There should also be a covered area for sun and rain.

There needs to be social space. A place to sit down and talk with people, without getting in each other's way.

Physical comfort

Existing Glenside wards are poorly air conditioned. They have been cold in winter, and warm in summer due to poor choices in heating and cooling. For people who are unwell constant thermal discomfort can be unpleasant. One person who also had diabetes remembers the discomfort when the room was stuffy, and his blood sugar started to fall.

Space and design to support a positive culture

The hospital design must support a healing culture.

Glass barriers between patients and staff make it them versus us. People feel looked out on, and not treated like a human. The design makes for bad dynamics.

In one ward there were three to four staff who would come out, but many would spend time behind the glass barrier.

Old institutional designs, lead to institutional behaviours. People tell stories of humiliation, harassment and bullying.

People understand why staff may become like this – what they have to put up with for many years. For example caring for patients in old, dismal rooms in some wards that have then been abused or soiled which is hard for the staff.

One way of helping break down the hospital culture is to have peer workers as part of the team.

Communal space and privacy

The ward should give people personal space and privacy.

The open areas of the ward need to be large enough so that people have space from each other. Crowding of common areas should be avoided.

Privacy involves having your own room. This can be a valued place of sanctuary, and reflection, but people should not stay in their own room all the time.

Simple access to a lockable cupboard can make a difference, so that a person can store possessions without needing to approach staff to get them from a safe.

Good food and access to kitchens

If you are unwell, and your appetite is poor, hospital food does not help. It does not contribute to a sense of well being, or improving health.

There are mixed experiences reported. Some people have enjoyed meals. Others have blamed the combination of months of eating unhealthy hospital diets, while taking diabetes producing antipsychotic drugs, as causing their diabetes.

Choices and options with food are needed. Providing good food is part of looking after a person when they are unwell.

Food needs to be considered in the design. Fresh food needs kitchens nearby can deliver a high quality product.

Wards also need kitchens for people to prepare snacks, or their own meal if they prefer, or if they miss a meal delivery. For people staying a long time meal preparation can be part of learning to cook again.

Bedrooms that are big enough

Personal space can be cramped. A spacious room with wheelchair access is desirable.

If possible the windows should look out on a view of parks and gardens, and not look out on the wall of a nearby building or hospital industrial plant.

There are other options including a theatrette. A person had noted this at a private hospital as a place for showing movies but having invited speakers, public education, and a relaxation room.

Room for activities

The communal, lounge and activity areas should be big enough for different groups to be present, doing different tasks. When people stay for longer times art therapy, and other activities, should be scheduled with space on the ward for this to occur.

When asked about the UK trend to have at least one women's only lounge, there was general agreement that women should have this option.

Furniture and fittings

People's mood is affected by the thoughts that have gone into furniture and fittings. In many wards furniture is old, damaged, and contributes to the dismal atmosphere.

At times in longer stay wards people may want to have some of their own furniture present.

Aesthetic, high quality, rugged but non institutional looking furniture should be provided.

A ward should have two television sets, but TV sets should not be in people's private rooms. People need to get out and socialise.

On site medical facilities

Access to general health care on site is valuable.

People have appreciated the visits of a dentist, who knows about the problems caused by psychotropic drugs on dental health (through dry mouth, etc), physiotherapist to deal with musculoskeletal problems, and an eye specialist.

This is part of making Glenside feel more like a health farm – addressing all the health needs of people who are being cared for there.

People in the community with a mental illness who cannot get care elsewhere might come to Glenside for the available physical health care, combined with the special expertise and understanding. This particularly applies to dental care which is a major problem.

Sports and activities

The existing gymnasium facility is valued. People can work out, and importantly if they are gaining weight on their psychotropic medication, they can tackle this in the gym, or by going for walks.

Having free access to the gymnasium is important. People at Glenside would not otherwise afford a gym membership. At other hospitals they need to pay to go to the hospital gymnasium usually run for staff to use. At Glenside it is free. This should continue.

The gym instructor helps with the exercise program, and also putting on camps and other activities.

For young men it is an important way to burn energy.

When asked about a swimming pool, which is currently not on site, it was noted that other centres have this for rehabilitation. Swimming would be another good option.

Gardens

The importance of gardens is noted above, in the priority for a relaxing and natural environment with fresh air, walks, and views that can also be appreciated from the building.

The Glenside oval has been valued as a nice space to walk around, particularly because of its surrounding trees. While the sports facilities may not have been used much by patients at the hospital, people consider it positive that they have brought the surrounding community into the Glenside space.

Housing

The housing option that is not readily available is cluster housing. This is a great idea, because people have independence, and more security. This is because a cluster of units will have some onsite staff.

It can also provide physical security in keeping other people out who may move in. More cluster housing would be valued.

There are some positive services, such as those offered by the ROOFS Housing Cooperative, and Housing SA. The housing supply though is inadequate, with long waiting lists. More housing needs to be available for people.

Housing onsite as a transition has been appreciated. There was an annex at Glenside that looked after six people, and gave them support and coaching in areas such as shopping, cooking, managing medication. From this people could also do other courses such as a computer course. This program was valued.

Sometimes there are basic ideas that make a difference – for example some old houses at Hillcrest that were used for transitional care, have chickens laying eggs, which are collected and then cooked, providing a pleasant but useful routine for people having rehabilitation.

Some people are aware of the new community rehabilitation centres, but do not know how they are working, or have a view about their success.

Supported residential facilities

Views about this accommodation option are mixed. Some people who are running them are trying to do their best but with too many people in their houses. People are aware that financial viability is an issue. The quality of food can be a problem, as well as nutrition.

Similarly lack of space, privacy and social areas, and a place to be left alone can be difficult. All of the issues that apply to people's views about hospital apply to SRF's.

The diet in SRF is a major concern. For those who are aware of what is being served in some SRFs this was described as appalling.

People are not sure about the correctness of proprietors giving out medication.

What is needed is more housing for people who have mental illnesses, and the need to create more private housing was not considered important, particularly if this was not linked to a benefit for people who have mental illness.

There was a strong view that selling Glenside land for private housing, if it did not somehow help people with a mental illness, was a problem. It should be used to create more housing for people with a mental illness.

There was not a strong view about where these houses should be, as long as the housing was created, and there was a choice of housing. New houses could be spread around the state.

People noted the importance of having proper supports.

Peer workers are an important element.

Money from Glenside can also go back into services, and this idea was supported.

Vocational rehabilitation

Jobs are important, but the volunteer work that people are doing now should not be ignored. Some people prefer their current volunteer work, where they can set their hours, and their own pace.

Suggestions for new areas of work include gardening, carpentry and cleaning work. Consumers could do this work for some of the new development.

The idea of setting up a sub agency was mentioned, and developing an occupational resource centre to help people gain job skills.

The example of consumers operating a club, that helped people learn work skills and life skills and help them to step into independent living in their own accommodation, and ongoing work of some type.

Service remodelling

There is a concern that services are being decentralised, and people are not being looked after, and not given the support they need.

Recovery way is the right way, but care and support is needed.

Also it takes time to get results, and people need to be given support over this time.

The psychosocial model used in recovery is good. It should also move into the new hospital and all hospital environments and be part of the way care is given.

People need individual care and should not be pigeon holed by diagnosis or other factors.

Peer workers have been a valued innovation. People who have had an experience of illness can provide support and education to peers.

Research and education

There is support for more research, both scientific research, clinical research and how services are delivered. This can be linked with training. There should be a dedicated building for research.

People who are consumers of services can contribute to setting priorities about what should be researched, and the running of research projects.

APPENDIX B: GENERAL FUNCTIONS OF THE PUBLIC ADVOCATE

The general functions of the Public Advocate are described within Division 3 of The Guardianship and Administration Act 1993. The functions are:

- (1) The functions of the Public Advocate are—
 - (a) to keep under review, within both the public and the private sector, all programs designed to meet the needs of mentally incapacitated persons;
 - (b) to identify any areas of unmet needs, or inappropriately met needs, of mentally incapacitated persons and to recommend to the Minister the development of programs for meeting those needs or the improvement of existing programs;
 - (c) to speak for and promote the rights and interests of any class of mentally incapacitated persons or of mentally incapacitated persons generally;
 - (d) to speak for and negotiate on behalf of any mentally incapacitated person in the resolution of any problem faced by that person arising out of his or her mental incapacity;
 - (e) to give support to and promote the interests of carers of mentally incapacitated persons;
 - (f) to give advice on the powers that may be exercised under this Act in relation to mentally incapacitated persons, on the operation of this Act generally and on appropriate alternatives to taking action under this Act;
 - (g) to monitor the administration of this Act and, if he or she thinks fit, make recommendations to the Minister for legislative change;
 - (h) to perform such other functions as are assigned to the Public Advocate by or under this Act or any other Act.

This independent position advocates for the needs of mentally incapacitated people. The definition of mental incapacity from The Guardianship and Administration Act is outlined below:

mental incapacity means the inability of a person to look after his or her own health, safety or welfare or to manage his or her own affairs, as a result of—

- (a) any damage to, or any illness, disorder, imperfect or delayed development, impairment or deterioration, of the brain or mind; or
- (b) any physical illness or condition that renders the person unable to communicate his or her intentions or wishes in any manner whatsoever;

The South Australian Office of the Public Advocate employs an evidence-based approach to advocacy, based on:

1. The lived experience of consumers of our services,
2. Evidence from the scientific literature, and practice literature that defines best practice, and
3. Reference to data.

APPENDIX C: GOALS, OBJECTIVES AND GUIDELINES OF THE COMMUNITY VISITORS MENTAL HEALTH BOARD, 2006-07

The goals and objectives have been developed by the Community Visitors Mental Health Board for Community Visitors appointed under the Mental Health Act. In achieving the goals and objectives, Community Visitors follow the principles and values of fairness, objectivity, integrity, honesty, conscientiousness and commitment to the public interest.

Goal One

To visit each mental health service providing residential services and 24-hour nursing care at least once a month with the objective of promoting the individual rights and dignity of people with a mental illness Community Visitors aim to meet this goal by:

- being alert to signs that the rights and dignity of individuals are not being respected;
- investigating complaints about treatment and care;
- following up referrals from the Office of the Public Advocate's Advice Service; and
- providing the required reports of visits and following up actions and outcomes of any issues of concern.

Goal Two

To advocate for the best possible assessment and treatment services and adequate human and physical resources in each mental health service Community Visitors aim to meet this goal by:

- raising issues of concern encountered in the admission process (including treatment in the emergency department);
- monitoring the availability and distribution of beds in the services;
- inquiring into access to treatment options for both psychiatric and non-psychiatric treatment with reference to specific clients;
- inquiring into discharge-planning procedures and the availability of suitable accommodation on discharge;
- regularly asking about the number of professional and ancillary staff and noting any shortages; and
- reporting on issues of concern both at the facility and systemically.

Goal Three

To assess and report on the appropriateness and standard of facilities for accommodation, physical wellbeing and welfare of people with a mental illness Community Visitors aim to meet this goal by:

- inspecting all areas noting levels of physical comfort, cleanliness, safety, privacy, maintenance and security;
- inquiring into clients' personal care needs (clothing, toiletries, dietary requirements);
- reporting on problems and following up on any proposed action to remedy deficiencies;
- observing the appropriateness of a facility and raising any concern if it is felt the facility is inappropriate for a specific client's needs; and
- inquiring into the incidence of serious assault and illicit drug use in the facility.

Goal Four

To assess and report on the opportunities for recreation, occupation, education, training and rehabilitation of clients Community Visitors aim to meet this goal by:

- observing the availability and suitability of areas for these purposes;
- inquiring into client satisfaction with programs and facilities; and
- discussing programs (such as Individual Service Plans and activities) with staff with reference to a specific client's concerns.

Goal Five

To assess whether the environment and the manner of service provision are the least restrictive and least intrusive possible, consistent with the clients receiving the best possible treatment and care appropriate to their needs Community Visitors aim to meet this goal by:

- understanding the provisions of the Act regarding a person's rights (including restraint and seclusion provisions) and being prepared to act on their behalf where there appears to be a breach of the legislative provisions;
- checking that clients are fully informed of their rights and assisting with appropriate information where this is needed; and
- observing whether the accommodation is the least restrictive environment possible (including the reasonableness of any restriction).

REFERENCES

Andrews G and the Tolkien II team (2006) Tolkien II, A Needs Based, costed stepped-care model for mental health services, St Vincent's Hospital Sydney, World Health Organisation Collaborating Centre for Classification in Mental Health, Sydney.

Auditor General of New South Wales (2005) Emergency Mental Health Services, NSW Department of Health, http://www.audit.nsw.gov.au/publications/reports/performance/2005/mental_health/MentalHealth-May2005.pdf

Auditor General of Victoria (2002) Mental Health Services for People in Crisis, http://download.audit.vic.gov.au/files/mhs_report.pdf Accessed 19th October 2008.

Auditor General of Victoria (2005) Follow-up of selected performance audits tabled in 2002 and 2003, Mental Health Services for People in Crisis: Progress Made on our 2002 Report, http://download.audit.vic.gov.au/files/mhs_report.pdf Accessed 19th October 2008.

Baigent, M 2005, 'Understanding alcohol misuse and comorbid psychiatric disorders', *Current Opinion in Psychiatry*, vol. 18, pp. 223–228.

Bidmeade I (2005) Paving the Way: Review of Mental Health Legislation in South Australia, <http://nla.gov.au/anbd.bib-an000041165619> Accessed 19th October 2008.

Beer A, Kearins B and Pieters H (2007) Housing Affordability and Planning in Australia: The Challenge of Policy under Neo-liberalism, *Housing Studies*, 22:11-24.

Booth M (2008) Minda commissions Brighton campus blueprint, *The Advertiser*, 9th July 2008.

Brayley J (2008) Preventing the death of homeless people, *Parity*, April 2008 Edition, Council to Homeless Persons, Melbourne.

Centre for Mental Health (2008) Notes on the Mental Health Clinical Care and Prevention Service Planning Model, NSW Health, <http://www.health.nsw.gov.au/policy/cmh/mhccp.html> Accessed 19th October 2008

Department of Health (2008) Department of Health Submission to the Legislative Council of South Australia Select Committee on Proposed Sale and Redevelopment of the Glenside Hospital Site, 9 May 2008.

Department of Health and Ageing (2007) *National Mental Health Report 2007: Summary of Twelve Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2005*. Commonwealth of Australia, Canberra. [http://www.health.gov.au/internet/main/publishing.nsf/Content/A2A5C2550522D30ACA25740400803643/\\$File/report07.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/A2A5C2550522D30ACA25740400803643/$File/report07.pdf) Accessed 18th October 2008.

Department for Transport, Energy and Infrastructure (2008) Glenside Master Plan, http://www.infrastructure.sa.gov.au/AFSH/project_overview/glenside_masterplan Accessed 19th October 2008.

Doherty, J & Stuttford, M (2007) Preventing Homelessness among Substance Users, *Journal of Primary Prevention*, 28:245-63, Accessed 20th October 2008, <<http://www.springerlink.com/content/q6w3051r7m547828/>>.

Editorial (2008) Worried Residents Welcome New Security Measures for Suburb, Ham & High 24, September 1, <http://www.hamhigh.co.uk/content/camden/hamhigh/news/story.aspx?brand=northlondon24&category=fsHampGardenSuburb&tBrand=northlondon24&tCategory=fsHampGardenSuburb&itemid=WeED01%20Sep%202008%2015%3A15%3A42%3A917> Accessed 19th October 2008.

Forensicare (2008) Description of prison services provided by the Victorian Institute of Forensic Mental Health, <http://210.11.218.25/CA2570BA0083006F/page/Prison+Services?OpenDocument&1=30-Prison+Services~&2=~&3=~> Accessed 20th October 2008.

Gardner J (2006) *Eight years later mentally ill patients still locked out*, Media Release of the Public Advocate of Victoria, <http://www.publicadvocate.vic.gov.au/News/Media-Releases/Eight-years-later-mentally-ill-patients-still-locked-out.html> Accessed 11th October 2008.

Gladwell M (2006) Million Dollar Murray – Why problems like homelessness may be easier to solve than to manage, New Yorker, 13th February 2006, http://www.gladwell.com/2006/2006_02_13_a_murray.html Accessed 19th October 2008.

Haggerty R (2005) Ending Homelessness in South Australia, Adelaide Thinkers in Residence, http://www.thinkers.sa.gov.au/images/Haggerty_1st_report.pdf Accessed 18th October 2008.

Haggerty R (2007) Smart Move: Spending to Saving, Streets to Home, Adelaide Thinkers in Residence Report, Government of South Australia, http://www.thinkers.sa.gov.au/images/Haggerty_Final_Report.pdf Accessed 18th October 2008.

Howard M (2007) “The Mental Health System” in *Office of the Public Advocate Annual Report to the Queensland Parliament*, Queensland Government, <http://www.justice.qld.gov.au/473.htm> Accessed 11th October 2008.

Howard M (2008) *Preventing Suicide Deaths of Queenslanders With a Mental Illness*, Office of the Public Advocate Issues Paper, http://www.justice.qld.gov.au/files/Guardianship/OPA_-_Issues_paper_Suicide_prevention.pdf Accessed 11th October 2008.

Office of the Public Advocate (2007) Annual Report of Community Visitors 06-07, Office of the Public Advocate, Melbourne, Victoria, <http://www.publicadvocate.vic.gov.au/media/docs/Community-Visitors-Mental-Health-Annual-Report-07-f2bae01e-0ba1-4746-a8f3-beff6f6faaa4.pdf>

O'Hara, A 2007, 'Housing for people with mental illness: update of a report to the President's New Freedom Commission, *Psychiatric Services*, vol. 58, pp. 907–13.

McIver C, Flynn J, Baigent M et al (2006) Management of Methamphetamine Psychosis, DASSA Research Monograph No 21, http://www.dassa.sa.gov.au/webdata/resources/files/Monograph_21.pdf Accessed 20th October 2008.

Mental Health Council of Australia (2005) Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia, <http://www.mhca.org.au/notforservice/> Accessed 20th October 2008.

Minton A (2004) Mind the Gap – Tackling social polarisation through balanced communities, Royal Institute of Chartered Surveyors, <http://www.rics.org/NR/rdonlyres/D7114E3D-45B0-4709-AA5B-31F7E050C9AD/0/Sustaincommpaper.pdf> Accessed 18th October 2008.

Moore M (2004) Private Security Firms Join Battle on the Streets, Telegraph, 2nd December 2004, <http://www.telegraph.co.uk/finance/2900883/Private-security-firms-join-battle-on-the-streets.html> Accessed 20th October 2008.

Mulgan G (2008) Innovation in 360 degrees: Promoting Social Innovation in South Australia, Thinkers in Residence Program, http://www.thinkers.sa.gov.au/images/Mulgan_Final_Report.pdf Accessed 19th October 2008.

O'Connell, J, Mattison, S, Judge, H, Allen, H & Koh, H (2005) 'A Public Health Approach to Reducing Morbidity and Mortality Among Homeless People in Boston', *Journal of Public Health Management Practice*, vol. 11, no. 4, pp. 311–316.

O'Connell, J (2007) 'The need for homelessness prevention: A doctor's view of life and death on the streets', *Journal of Primary Prevention*, 2007 28:199-203.

Pearce C (2008) *Community Visitors As Necessary As Ever*, Media Release of the Public Advocate of Victoria, <http://www.publicadvocate.vic.gov.au/News/Latest-News/Community-Visitors-As-necessary-as-ever.html> Accessed 11th October 2008.

Pathways to Housing 2005, '2005 APA Gold Award: Providing housing first and recovery services for homeless adults with severe mental illness', *Psychiatric Services*, vol. 56, pp. 1303–1305.

Pelletier J (2008) Social Enterprises: an employment alternative for disabled adults, National Disability Services 2008 Accommodation & Social

Participation

Conference.

<http://www.nds.org.au/conferences/ASP2008/Day2/Pelletier-SocialEnterprises.pdf>

Accessed 20th October 2008.

Pritchard, E, Mugavin, E & Swan, A 2007, *Compulsory treatment in Australia: A discussion paper on the compulsory treatment of individuals dependent on alcohol and/or other drugs*, Australian National Council on Drugs, accessed 19th October 2008, <http://www.ancd.org.au/publications/research_papers.htm>.

Rosen A and Manns L (2003) Who owns Callan Park? A cautionary tale, *Australasian Psychiatry*, 11: 446-451. Republished on line as part of papers for the Senate Enquiry into Mental Health (2005) http://www.aph.gov.au/Senate/committee/mentalhealth_ctte/submissions/sub108_att_ach3.pdf Accessed 11th October 2008.

Rosenheck, RA, Resnick, SG & Morrissey, JP (2003) 'Closing service system gaps for homeless clients with a dual diagnosis: Integrated teams and interagency cooperation' *The Journal of Mental Health Policy and Economics*, vol. 6, pp. 77–87.

Sansom M (2008) Callan Park lobbyists turn up the heat *Glebe and Inner City News* (NSW Cumberland, Australia) Edition 28th February 2008.

Shine J and Young A (2008) Review of Health and Medical Research in South Australia, http://www.health.sa.gov.au/DesktopModules/SSSA_Documents/LinkClick.aspx?tabid=46&table=SSSA_Documents&field=ItemID&id=644&link=H%3A%5CWeb+Pages%5Cuploads%5CSHINE%5CShine-Young-Report.pdf Accessed 20th October 2008.

Social Inclusion Board (2007) Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012, South Australian Social Inclusion Board. http://www.socialinclusion.sa.gov.au/files/Stepping_Up-_mental_health_action_plan.pdf Accessed 18th October 2008.

South West London and St George's Mental Health NHS Trust (2008) Background to Springfield Garden Village, <http://www.swlstg-tr.nhs.uk/future/background.asp> Accessed 18th October 2008.

Standing Committee on Social Issues 2004, *Report on the Inebriates Act 1912*, NSW Legislative Council, accessed 19th October 2008., <<http://www.parliament.nsw.gov.au/prod/PARLMENT/Committee.nsf/0/2578557B574B0450CA256F000000123B>>.

Teeson, M, Hodder, T & Buhrich, N (2003) 'Alcohol and other drug use disorders among homeless people in Australia, *Substance Use & Misuse*, vol. 38, nos. 3–6, pp. 463–474.

Teeson M, Hodder T , & Buhrich (2004) Psychiatric disorders in homeless men and women in inner Sydney, *Australian and New Zealand Journal of Psychiatry*, 38:162–168.

Trounson A (2008) Building programs buried by stock market collapse, *The Australian* Edition 1st October 2008.

Tsemberis, S, Gulcur, L & Nakae, M 2004, 'Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis', *American Journal of Public Health*, vol. 94, pp. 651–656.

Warner R and Mandiberg J (2006) An update on affirmative businesses or social firms for people with mental illness, *Psychiatric Services*, 10:1488-1492.