

The Impact of Deinstitutionalisation: Where to From Here?

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Abstract

A literature review was conducted on the process of deinstitutionalisation over the last 50 years with a view to identifying factors relevant to the quality of life for the seriously mentally ill returning to live in the community. Although the studies varied considerably in methodology and the areas covered were broad, clients consistently report an improved quality of life following deinstitutionalisation. However, several salient issues impacting on consumer satisfaction with return to the community emerged, these include: - type of housing and living environment - consumers' perceived quality of life - types of diagnosis or diagnoses - duration of illness - program funding arrangements. The studies indicate that poorly funded deinstitutionalisation has led to an increase in homelessness and general instability while appropriately funded initiatives have led to consumer satisfaction within various aspects of their community life. Suggestions are made concerning the enhancement of consumer satisfaction and quality of life for mental health patients returning to the community after extended inpatient treatment.

Introduction

Change to the delivery of services to seriously mental ill people was preceded by a series of social and medical changes. The depressions in the 1930s as well as the atrocities against minority groups in Hitler's regime caused a focus on human rights culminating in 1948 with the United Nations Declaration of Human Rights (Whitehead, 1993). In the 1950s the introduction of anti psychotic medications reduced the risk of relapse and the need for hospitalization (Davis, 1975; Davis *et al.*, 1980; Kane and Lieberman, 1985). Structural functionalism was also being challenged at this time resulting in institutions and their functions being replaced by social processes and more interest was generated in understanding "why" people behaved the way they do (Whitehead, 1993). To the collectivist and social Fabians it seemed that the state centralization had concentrated too much power in

essentially conservative institutions and professions, which, despite their benevolent intentions, were largely about social control. (Whitehead, 1993: 52).

The civil rights and feminist movements of the 1960s impacted significantly on the social change occurring by focusing on inequities and marginalisation of certain groups. This important era in social reform not only expanded self-interests for those able to speak out but impassioned idealists to advocate on behalf of those who had been ignored or cast out from society. Once disenfranchised, unnoticed and unheard, people with mental illness resumed the long struggle to live in local communities and to face new challenges, hardships and inequities (McAllister and Walsh, 2004: 22-23).

In the 1960s and 1970s these changes were complimented by the growing public awareness about abuse and neglect in institutions (Wolfensberger, 1975), the influence of developing professionalism within services and by growing family advocacy resulting in changes to public policy regarding institutional care (Tyne, 1993). Evolution in the management and rehabilitation of people with severe and chronic mental illness followed (Brown *et al.*, 1966; Lamb and Mackota, 1968; Lieberman *et al.*, 1975; Lieberman *et al.*, 1976; Anthony, 1980; Wing and Morris, 1981; DeRisi and Mueser, 1989; Lamb, 2001; and Lamb and Weingberger, 2001). The concept of normalisation evolved further during the civil rights movement of the 1960s (Emerson, 1993) and in conjunction with social and political, changes in western countries (Whitehead, 1993). In the 1980s normalisation was redefined in Scandinavian countries as:

Making available to all mentally retarded people patterns of life and conditions of everyday living which are as close as possible to the regular circumstances and ways of life of society' (Nirje 1980:33 cited by Emerson in 1993: 2).

This process strongly influenced thinking and service delivery within the disability field (Tyne, 1993). While implementation of the principals of normalisation has varied and attracted criticism, ideologically it has had significant impact on the value system which underpins service delivery (Tyne, 1993). While the early Scandinavian definitions of normalisation indicate how services can reflect basic rights, social policies pertaining to disadvantaged people often reflect society's unconscious but unpleasant beliefs. Wolf Wolfensberger's intent was that citizens with a disability should enjoy the same rights as non-disabled citizens (Emerson, 1993). In the mid 1980s the Australian Bureau of Statistics concluded that:

government policy has increasingly emphasized the need to support older people and people with a disability to live in the community with some degree of independence, receiving help from family, friends, neighbours,

and formal service providers, (government, private, non profit and commercial). (Australian Bureau of Statistics, 2003: 2).

The changes to the Commonwealth Disability Services Act made in 1986 was a move toward changing community attitudes toward people with a disability. The Act stated recognition of the needs and desires of people with a disability and that these needs and desires were similar to the rest of the community. The strategies and reforms that followed focused largely on the individual needs of people with a disability and moved further toward their inclusion in decision-making (Johnson and Leahy, 1999). The Burdekin Report (1993) together with the growing consumer movement of the time highlighted the rights and needs of Australians living with a psychiatric disability. Institutional reform followed. In keeping with policy change in Australia the number of people living in long stay hospital situations or institutions declined from 21,700 in 1981 to 6,100 in 2001 (Australian Bureau of Statistics, 2003). States were funded by the Commonwealth to provide services. Queensland Disability Services moved away from block funding and began its Institutional Reform Program with a focus on individualized funding. In recognition that services available to people with a psychiatric disability were inadequate Project 300 was funded in the 1995/1996 Queensland Health Budget. The budget was moved to Disability Services in Queensland in 1999 when it was recognized that a broader focus was required rather than the medical model offered by Health (Harmon, 2002).

Whitehead (1993) suggests that services offered to disabled people have moved away from a treatment model to an advocacy model. However it appears that both the medical model and the advocacy model coexist and are symbolic of the power struggles that exist in health and welfare services. These struggles were exacerbated by the advent of economic rationalism and the managerialist practices that followed with a strong focus on individual service delivery, duty of care and legal liability issues. The inability to embrace a range of more humanistic models of service provision may in part be responsible for the limited progress that has occurred in the provision of responsive and effective services to this marginalized group. Incongruity exists between the rhetoric which describes a holistic approach to service provision while the models influencing service provision are clearly reductionist. (Ife, 1999). Several decades after the commencement of deinstitutionalisation in Australia, Disability Services Queensland began to recognize the importance of community membership to successful reintegration for people with a psychiatric disability. Project 300 program managers changed their direction in 2001, to include a vision statement in which the gifts and talents of the individual were connected with their aspirations (Harmon, 2002). This change supports the notion that Maslow's hierarchy of needs (Hilgard *et al.*, 1979) is relevant to all human beings and that the progress toward self actualization is not necessarily a hierarchical process.

Reported Outcomes of Deinstitutionalization

The process of deinstitutionalisation has been underway over the past 50 years and Government policies and services have evolved during this time. Studies reflecting the outcome of this initiative have varied from relatively small numbers of individuals who were discharged into the community (e.g., Hobbs *et al.*, 2002 N = 67) to the deinstitutionalisation of entire populations of long-stay mental health patients from regional mental health facilities over several years (Honkonen *et al.*, 1999 N = 3257). Outcome follow-up periods have varied from one to twelve Years with several studies entailing evaluations at specific intervals.

The major focus of nearly all of the deinstitutionalization studies has been to determine whether the discharged mental health patients were happier and had a better quality of life once they were returned to the community. Although there is substantial variance with respect to how the researchers arrived at their conclusions, there is sufficient overlap to identify factors that influence the extent to which consumers are satisfied with their return to the community. They include type of housing and living environment, perceived quality of life, diagnosis, duration of mental illness, and funding arrangements.

As a preliminary note, little has been written about how long-term mental health patients were prepared for the transition from their long-term mental health placement back to the community. Researchers appear to have been invested in base line measures of functioning pre-discharge without considering what skills and coping mechanisms would be required as long-term mental health patients moved into the community.

What evolved was largely reactive planning whereby institutional mental health professional staff provided ongoing support until community mental health services or other avenues of service provision were established. How that process impacted on consumers is unknown. As acute mental health patients continue to be discharged into the community, it would be useful to assess what skills and coping mechanisms are required to assist the transition process and to provide the relevant training as part of the pre-discharge process (Honkonen *et al.*, 2003).

Housing

Some studies have focused on outcomes of homelessness as a function of increased rates of imprisonment of people following deinstitutionalization (Lamb and Weinberger, 2001). Other studies indicate that the countries that ensured the deinstitutionalization process was well funded for individuals with a serious mental illness did not experience a significant increase in homelessness, aggressiveness or imprisonment (Priebe *et al.*, 2002; Leff *et al.*, 1996; Hobbs *et al.*, 2002).

In the USA studies from the 1970s onward began to identify a higher arrest rate of former psychiatric patients and homeless people with a mental illness were over represented in the criminal justice system (Zitrin *et al*, 1976; Sosowskly, 1978). Martell, Rosner and Harmon's 1995 study found that 43 percent of defendants with a mental health condition were homeless at the time they were arrested (Lamb and Weinberger, 2001). Belcher (1988) identified the tendency to decompensate in unstructured environments together with the reduction in follow through with aftercare arrangements including case management and medication compliance as contributors to the likelihood of mentally ill persons being involved in the criminal justice system (Lamb and Weinberger, 2001).

Fakhoury and Priebe (2002) suggest that a significant proportion of deinstitutionalised people with a mental illness in the United States are living in prisons or are homeless. USA studies suggest that 10 percent to 15 percent of people in American state prisons have a major mental illness (Lamb and Weinberger, 2001). The implied result of the American approach to deinstitutionalisation is that it was not adequately funded or supported and many people with a serious mental illness suffered. Australian studies have focused on homelessness of people with a mental illness as a major issue. The closure of institutions and early discharge trends have resulted in a higher rate of homelessness amongst people with a mental illness (Robinson 2003; Reynolds *et al.*, 2002; Northern Residential Mental Health Services Reference Group, 2003). This trend coincides with a reduction in Commonwealth and State Housing funding of 30 percent over the last decade while low cost housing options such as boarding houses have been declining since the 1970s (Green, 2003).

Robinson's (2003) study of 185 homeless people living with a mental illness in Victoria identified 46.5 percent as having been previously admitted to a prison or juvenile detention center. The Australian Bureau of Statistics 2003 report also suggests that deinstitutionalisation may be contributing to an increase in the prison population in Australia. The report however claims that the increase in the prison population of mentally ill people has not risen significantly since deinstitutionalisation. A report completed by the Northern Residential Mental Health Services Reference Group in Victoria in 2003 surveyed 220 people with a mental illness and found that 66 of these were homeless and 81 were in unstable home situations. They concluded:

The impact of institutional closures in Victoria, and the complexity and interactive effects of the changes that have taken place over the past three decades tend to be only recognized as specific crises occur and when the media becomes involved.(Green, 2003: 5).

The Victorian homelessness strategy developed an information paper in 2000. This paper has a definition of "interactive" homelessness that focuses on primary

homelessness (people sleeping in parks, cars, railway carriages etc.), secondary homelessness (people moving frequently between emergency accommodation) and tertiary homelessness (accommodation that is not self contained i.e. people living in single rooms, sharing facilities with no security of tenure (Harris, 2003). The information paper identified 2823 people with two thirds of this group experiencing primary and secondary homelessness (Green, 2003).

Robinson (2003) studied a cohort of 185 to understand interactive homelessness amongst people with a mental illness. Of the participants 18 percent lived in the street, squats or cars (51 percent of these were aged 14-25yrs), 12 percent lived in boarding houses, 40 percent lived in hostels, 23 percent lived independently with support. Sixty three percent were planning to leave their accommodation. The group surveyed reported significant disadvantage in terms of income and employment. The in depth interviews carried out found a high incidence of violence and/or abuse as the reason for people leaving their accommodation. Sixty nine percent of periods of accommodation lasted for 6 months or less and of these 11.5 percent found other accommodation, 10.5 percent were evicted because the tenancy ended or the relationship break down (Robinson, 2003).

Overall participants seemed deeply traumatized and grief stricken and struggled with desperation in a context of self-loathing, shame and fear. Participants felt strongly stigmatized as “failures” as “welfare dependents” as “no-hopers” (Robinson, 2003: 17). On the basis of these research results it is arguable that while Australia has not experienced a significant increase in people with a mental illness being incarcerated since deinstitutionalisation commenced, people with a mental illness are overrepresented amongst the homeless, in jails and in the criminal justice system. Although deinstitutionalisation significantly reduced the need for long-term hospitalization some studies have identified losses such as homelessness, increased risk of incarceration and loss of quality of life. However it seems that in countries where deinstitutionalization has been appropriately funded these risks are significantly reduced (Trieman *et al.*, 1999 and Fakhoury and Priebe, 2002).

Satisfaction with housing type and living environment

When long-term mental health patients were deinstitutionalised there was little documented debate about what type of community residential arrangements would best meet client needs and the clients were rarely consulted about their future living arrangements. Subsequently, various studies have reported a large variety of accommodation arrangements. Forrester-Jones *et al.* (2002) reported that their research cohort of 102 mental health clients were housed in hostels (5), residential nursing homes (41), staffed group homes (15) and supported accommodation (41). Tsemberis *et al.* (2003) examined housing satisfaction for

265 deinstitutionalized mental health clients who were housed in community housing (defined as residential settings comprised of multiple unit dwellings of 8 to 16 units with full time around the clock mental health staffing on site); supportive housing (defined as larger multiple dwelling units with 20 to 40 clients with no on site clinicians providing services during business hours); and supported housing (defined as apartments spread throughout the community with low concentrations of program units in any one building and no on-site mental health care services). Hobbs *et al.*, (2002) reported on housing satisfaction of 47 long-term mental health patients returned to the community and housed in one of three community houses or in a cluster apartment block. Each facility provided 24-hour on-site mental health services. Trieman *et al.*, (1999) stated that their research cohort of 670 long-stay mental health patients were discharged into group homes with around the clock mental health staffing (525 patients); unstaffed group homes (46 patients); independent flats (72 patients); or returned to the care of their families (27 patients).

In terms of housing satisfaction Forrester-Jones *et al.*, (2002) reported only on the consumers' comments on their quality of life. Tsemberis *et al.*, (2003) found that clients in supported housing (the least restrictive option) were significantly more satisfied with their type of housing and the amount of choice in housing options and the privacy afforded them within this type of accommodation. Supportive housing clients (the middle option) were more satisfied with their housing choice than the community residents (the most restrictive housing option). However, the supportive housing clients were the least satisfied with their safety. The community residence clients were most satisfied with their safety but least satisfied with their privacy. Tsemberis and his colleagues concluded that individuals with psychiatric disabilities should be afforded the least restrictive housing options possible.

Hobbs *et al.*, (2002) reported that after six years in the community approximately half of their 47 research subjects had evolved into less restrictive and more independent living arrangements (2 to 3 person living units with externally provided limited professional mental health care) and were much happier with this arrangement as compared to the more crowded group homes with 24 hour on-site service provision. Trieman *et al.*, (1999) reported that five years after discharge nearly 60 percent of their research cohort of 670 people were still in their original discharge accommodation and satisfied with this arrangement however they did not differentiate housing satisfaction by type of accommodation.

Srebnik *et al.*, (1995) have concluded that housing choice options correlate significantly with housing satisfaction, housing stability and psychological well being. While this may be true, the deinstitutionalisation research while being able to describe the types of community housing available for long-term mental health patients on discharge has not been conclusive in linking the type of housing with quality of life improvements. What appears to be emerging is data that suggests

that housing needs are multidimensional and may evolve over time as suggested by Hobbs and her colleagues.

Quality of life

Throughout the deinstitutionalisation research there is a uniform finding that long-term mental health clients returned to the community report a significantly better quality of life than those remaining in institutions as measured by various instruments. Examples include the Lehman Quality of Life Profile (Tremberis *et al.*, 2003); the Lancashire Quality of Life Profile (Priebe *et al.*, 2002), the Global Assessment Scale (Honkonen *et al.*, 2003), the Social Behavior Schedule (Leff, Trieman and Gooch, 1996) and consumer driven open-ended quality of life questions (Forrester-Jones *et al.*, 2002). However, most researchers do not differentiate the quality of life from the type of accommodation and living environment. Tsemberis *et al.*, (2003) took into account housing types in relation to consumer satisfaction and, by implication, quality of life. As earlier indicated, he and his colleagues found that mental health patients in supported housing with the least restrictive arrangements (dispersed within the community with no on-site mental health staff) had the best quality of life.

Forrester-Jones and her colleagues used a client generated open-ended qualitative measure and found that deinstitutionalized mental health patients most frequently reported the positive aspects of discharge as being the alternative living environment, the social milieu (living with other clients but having their own bedroom) and independence. Negative aspects of discharge were largely within the context of the social milieu and focused on bullying, the social regime, the physical aspects of accommodation and personal feelings of loneliness and boredom. However, Forrester-Jones and her colleagues did not differentiate responses from the four types of accommodation utilized (residential nursing home, hostel, staffed group home and supported accommodation).

Trieman *et al.*, (1999) also demonstrated significant quality of life improvement but did not differentiate the results for the four different types of accommodation. Comparing quality of life response with accommodation type could potentially yield significant new information. It would be useful for future researchers to address this information gap. Forrester-Jones and her colleagues did break new ground by asking their 102 research participants about their future aspirations. This appears to be one of the first attempts at allowing discharged mental health patients to think beyond their immediate survival needs and advise of medium to long-term goals that assist in planning future case management initiatives that relate to the consumer's stated intentions and potential for greater quality of life improvements.

Although not directly examining quality of life issues Harvey *et al.*, (2000) have made a useful contribution by conceptualizing deinstitutionalisation as a five

by five matrix. Their survey of all relevant stakeholders in the mental health field in a Northern Queensland Mental Health District yielded a consensus view of key issues that influence the quality of life over the course of life of an individual with a serious mental health issue residing in the community. The key issues co-morbidity, information, self-competence, co-ordination and flexibility occur in the context of the beginnings of the illness process, the long term needs becoming clearer, coping with instability as needs evolve, finding stability and ongoing evaluation.

The current deinstitutionalisation research appears to be developing commonalties in the processes that evolve when mental health patients are discharged into the community and effect their quality of life. They include heavy resource dependency in the early stages of discharge, (Hobbs *et al.*, 2002 and Trieman *et al.*, 1999), short-term improvement in symptomology followed by a period of regression or instability as long term needs emerge (Pescosolido *et al.*, 1999 and Leff *et al.*, 1994), and then recovered stability and ongoing maintenance (Pescosolido *et al.*, 1999 and Leff *et al.*, 1996). Fitting future mental health research into the model proffered by Harvey and her colleagues could aid in the development of a comprehensive holistic approach to the management of community mental health clients with a focus on ensuring an optimal quality of life.

Diagnosis and symptoms

As previously indicated co-morbidity has been identified as a key factor in successful transition from institution into the community (Harvey *et al.*, 2000 and Fakhoury and Priebe, 2002). Individuals with two or more illnesses experience considerably greater difficulty in living within the community. Another factor that appears to be salient is the type of mental health disorder and the duration of the mental illness.

In their study of discharged and non-discharged psychiatric patients Priebe *et al.*, (2002) found that very significant differences emerged between the cohorts (65 non-discharged and 65 discharged patients). The discharged group was approximately ten years younger and spent 10.5 years less in mental health institutions. The discharged group was significantly less likely to have a diagnosis of schizophrenia and an overall lower degree of psychopathology. When followed-up 18 months later the discharged group indicated a higher quality of life and fewer needs than those who remained in hospital. Honkonen *et al.*, (1999) found in their three-year follow-up study of 1,517 patients discharged from psychiatric institutions in Finland that patients with a longer duration of illness were significantly more socially impaired than patients with a shorter duration of illness. They also found that long-term schizophrenia patients engaged in fewer social contacts and became more socially withdrawn. Trieman *et al.*, (1999)

reported that adults diagnosed with schizophrenia were more vulnerable to hospital readmission. Contrary to most other studies (eg. Leff *et al.*, 1996; Priebe *et al.*, 2002 and Hobbs *et al.*, 2000), Honkonen and his colleagues reported that their research cohorts displayed an increase in psychotic symptomology and daily neuroleptic doses at the end of the follow-up period. The predominant finding has been that there is no change in psychopathology or that there is less psychopathology post-discharge and medication is either maintained at the same level or reduced.

Psychosocial functioning

Generally speaking there is an improvement in psychosocial functioning for long-term mental health clients discharged into the community (Honkonen *et al.*, 2003; Leff *et al.*, 1996 and Priebe *et al.*, 2002). The nature of the improvement appears to be non-linear with researchers reporting initial positive improvement, a period of slight decline during the first year after discharge and then gradual improvement in psycho-social functioning to the point where there is significantly more effective psycho-social functioning from discharge to the end of the follow-up period. Pescosolido, Wright and Lutfey (1999) found that clients' hopes (e.g. independence, working, improved finances) decreased while their worries (e.g. fear of crime, mental health treatment, living arrangements) increased post-discharge with the greatest period of vulnerability being at the end of the first year in the community before rebounding somewhat.

Leff and colleagues (1994) reported that anxiety was a problem for 10 percent of their patients at baseline, 22 percent at the one-year follow-up and 12 percent at the five-year follow-up suggesting that the transition to the community causes considerable stress but the patients adjust over time. Leff *et al.*, (1996) also note a significant increase in community skills (budgeting, use of public transport, use of social services) and domestic skills (shopping, cooking, laundry and household chores). Leff and his colleagues also found a significant increase in autonomy from seven percent enjoying autonomy at discharge, 18 percent at the one-year follow-up and 36 percent at the five-year follow-up. In terms of social contacts, the size of patient social networks appears to be stable throughout post-discharge follow-ups. However, Leff *et al.*, (1996) and Pescosolido *et al.*, (1999) found that the nature of the contacts within patients' social networks evolved as the follow-up period expanded. There was significantly less contact with relatives after discharge but a significant increase occurred in the number of people considered to be friends or professional supports.

Readmission

Several deinstitutionalisation studies reported figures on re-admissions after initial discharge. Trieman *et al.*, (1999) reported that 10 percent of 531 patients assessed at a five-year follow-up had been readmitted to a mental health facility for a further long-term placement. One third of the cohort (210 clients) was readmitted on at least one occasion during the course of the Trieman study. Hobbs *et al.*, (2000) indicated that 37 percent of their cohort of 47 patients required readmission on at least one occasion. Seven of these patients required long-term readmission during the follow-up period. Over one third of Pescosolido and colleagues' (1999) research cohort was assessed as being too unwell to be discharged into the community and were transferred to other long-stay mental health facilities. Priebe *et al.*, (2002) found that nearly 30 percent of the 65 long-term mental health patients discharged into the community were re-admitted. However, all of these patients had returned to the community before their one-year follow-up assessment.

Two factors appear to influence whether the readmission is long-term or short-term. The first is co-morbidity and the second is that the more recently discharged patients are consistently manifesting a more severe and persistent mental illness (Fakhoury and Priebe, 2002 and Lamb, 2001). The readmission rates highlight two realities. Some long-term hospital based mental health services will continue to be required for those individuals who are unable to cope with community living. The second is that the majority of readmitted clients will again be discharged back into the community highlighting the need for close liaison between hospital based and community based mental health workers and investigation of clients needs upon discharge back into the community.

Funding

While various countries have pursued deinstitutionalisation in different ways, the literature strongly suggests that the process must be adequately funded. Leff, Trieman and Gooch (1996) report that when two major psychiatric hospitals were closed to facilitate the discharge of long-term mental health patients, the entire budget of each hospital was transferred into community mental health services. Hobbs and her colleagues (2002) also indicated that the community mental health services that their patients were discharged to were equally well funded. Both research groups indicated that their clients were well serviced and manifested very small amounts of homelessness, aggression or imprisonment. Properly planned and resourced deinstitutionalization not only maintains people with prolonged mental illness outside of hospital, it also enhances their quality of life (Newton *et al.*, Lapsley and Tribe, 2000 : 484).

In Australia deinstitutionalisation was initially well funded, particularly by Project 300 and other funding allocations. This level of funding is no longer available. While the funding package now appears the preferred way of funding in disability, applying for a package is very competitive with only the most extreme situations being funded. Block funding allocated to NGO's is becoming rarer. More recently in Queensland the "Boarding House Project" Funding has been established. It provides low volume services to adults with a disability residing in accredited boarding houses. This funding appears to be acceptance of tertiary homelessness (living in boarding or rooming houses with no security of tenure) (Harris, 2003). The reduction in all types of funding has occurred at a time when the most disabled and vulnerable people are left in institutions waiting for reintegration. This has occurred despite the significant savings incurred as a result of deinstitutionalization (Johnson and Leahy, 1999). As previously indicated this process, similar to that used in America results in further marginalization and suffering for those individuals with a serious mental illness.

Conclusion

The majority of deinstitutionalisation studies have concluded that there has been a positive outcome for clients at reduced costs. The positive impact of deinstitutionalisation has been that long term mental health clients that returned to the community reported significantly better quality of life than those remaining in institutions. While it is acknowledged that the transition from institution to the community often causes considerable stress and readmissions are common, mental health clients have, in most cases adjusted well over time.

The research is not clear regarding the circumstances required to optimize quality of life. In part these circumstances appear related to housing type and flexibility around housing as time passes. Housing needs for people with mental illness is an area requiring more knowledge and attention. The needs of this group are multidimensional and may evolve over time. Consequently flexibility is necessary on the part of funding and service provision. Adults diagnosed with a dual diagnosis or schizophrenia, particularly long term sufferers, are more vulnerable to hospital readmission and require significantly more resources and flexibility to meet their housing and support needs. The studies however focused little beyond the client's immediate service needs and did not differentiate between quality of life and type of accommodation and living environment. Further research comparing quality of life and accommodation type has the potential to yield significant new information. It is also important to identify these studies as having focused on past reintegration programs that were in the main, well funded. Present funding is at a comparatively reduced level and this is of particular concern as often the more vulnerable clients have remained in institutional care and are still waiting to return to the community. Studies have

also identified that the time immediately following return to the community is when highest dependency exists. Hence intensive resources are needed at the beginning of reintegration and are able to be reduced as life conditions improve. Stress and relapse around the end of the first year can be expected and needs to be anticipated. Hospital readmission may be required. Higher level resources are also required for people diagnosed with schizophrenia and dual diagnosis. These groups require more frequent follow up in the community. It is essential to recognize that reintegration is an ongoing process, it is not linear and it has not been completed. Deinstitutionalisation continues to require attention from researchers as well as ongoing flexibility from funding bodies and service providers.

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