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Boarding House Health Promotion Program – A Collaborative Model

Introduction

In February 2001 Katoomba Neighbourhood Centre received funding from Wentworth Area Health to employ a part time [25 hours week] project worker to instigate a health promotion program with residents of licensed boarding houses in the Wentworth Area. Initially this funding was for a period of 6 months. The funding has subsequently been extended for a further year and includes access to a realistic budget for the purchase of health services for residents and staff. The initial six month period has shown that a community based NGO such as the Katoomba Neighbourhood Centre can successfully develop a program traditionally the domain of government departments. In fact the Katoomba Neighbourhood Centre project has shown how NGOs may be ideally placed to provide services that cut across health streams, public and private services, government and non-government agencies. The service has been developed on a comprehensive case management model incorporating direct service provision and brokerage. The framework for health promotion has been based on the five strategies for action outlined in the Ottawa Charter [World Health Organisation, 1986]: developing personal skills; creating supportive environments; strengthening community action; re-orientating health services; and building healthy public policy.

Background

The process of deinstitutionalisation and improvements in medication and treatment has meant that the numbers of people with disabilities, particularly mental illness and intellectual disability incarcerated for long periods in psychiatric hospitals has been steadily declining since the 1950s. The rate of change increased dramatically in the late 1970s and early 1980s following the recommendations of the Richmond Report, 1982. Unfortunately the provision of adequate supported accommodation in the community has not kept pace with the demand. Private for-profit Boarding houses have provided accommodation for large numbers of people with disabilities over the last twenty years. As [Burdekin 1994, p.387] outlines, they changed dramatically from their original purpose – as a temporary form of housing for people visiting the city or as holiday destination guest houses to a “de facto part of the mental health system, housing a large number of the system’s clients.”

The Youth and Community Services Act 1973 requires a premise to be licensed if accommodating two or more handicapped persons who require supervision and social habilitation. The licensing requirements pertain more to the physical structures and basic public health requirements than to aspects of resident care. As Burdekin [1994,p.388] states, “Some boarding houses are run by caring people who make a conscientious attempt to provide a decent ‘home’ for their residents. But the conditions in many are a national disgrace.”

Descriptions of boarding houses given to the Human Rights and Equal Opportunity Commission Inquiry into the Human rights of People with Mental illness [Burdekin, 1994] include:

- The physical conditions are appalling. If they are not the same as institutions, they are actually worse;
- The environment is very bleak. There is sometimes overcrowding, there is poor diet, there is no protection of the persons rights;
- There is very little heating or cooling in boarding houses. Where it does exist it tends to be used quite sparingly;
- The long hallways are dark and pungent with the smell of cats. In the industrial-style communal kitchen, two residents argue over the sink. No one challenges you, and a request to the manager meets a shrug and an averted face;
- It is known that there are malpractices with food, money, forced dependency, overcrowding, theft and clumsiness; and
- This is the worst place I've lived in my life.

The lack of service development for residents of boarding houses with a mental illness and other disabilities has been well documented over the years. The report of the Royal Commission into "Chelmsford Hospital"[Slattery, 1990], and the "Human Rights and Equal Opportunity Commission Inquiry into Human Rights and Mental Illness" [Burdekin Report, 1993] clearly describe this situation. Millard [1997:1] has comprehensively outlined many of the issues for people with disabilities living in boarding houses based on the experience of the Boarding House Project in Central Sydney Area Health Service. As she states "Residents of licensed boarding houses are people with disability who have a history of passivity, poverty and absence of knowledge about their rights. The boarding house industry has in the past and still today been a model of minimum care. This has been further compounded by government and non-government agencies neglect over the years."

In October 1998 the NSW Government announced a \$66m reform program for boarding houses licensed under the Youth and Community Services Act 1973. The stated basis for the reform program was a concern with two broad issues: a concern for residents and a concern for the viability of the industry. The program was planned to encompass the following elements: the offer of relocation of high needs residents to alternative community based supported accommodation; the facilitation of assessments for placement of people who qualify for an aged care facility; the provision of support services to people remaining in boarding houses with a focus on personal care, primary health care and recreation / social habilitation.

At the time of the programs implementation Wentworth Area had approximately 8% of the total number of boarding house residents in NSW [Ageing and Disability Department data, August 1999]. At this time there were 10 licensed boarding houses with a capacity to house 199 residents. The surveys completed by the Ageing and Disability Department in 1998 found that residents in licensed boarding houses had the following primary diagnosis:

- 40% psychiatric;
- 31% intellectual disability;
- 15% alcohol related brain damage;
- 5% aged specific problems;
- 5% psychical illness;
- 3% organic brain syndromes [including dementia];
- 43% of residents were found to have two or more diagnoses; and

- 29% of residents were over the age of 65.

The Katoomba Neighbourhood Centre Boarding House Project should be seen in the context of a slow, somewhat spasmodic development of services for residents of boarding houses in the Wentworth Area. The local Community Mental Health Team has for many years provided a non-discriminatory service to boarding house residents as referred. The service has also instigated specific health promotion projects targeting the boarding house population. The Women in Boarding Houses Project – Wentworth Area Health, 1995 was set up in response to concerns raised in the Burdekin Report [HREOC, 1994] as to the adequacy of physical health care provided for residents of boarding houses. The project was innovative, combining information collection with a service provision aspect. The project found “a lack of consensus among both boarding house managers and mental health case managers regarding responsibility for monitoring and follow-up of a resident’s physical health care needs.” In recognition of this gap in service provision a further project was established, The Boarding House Project, Wentworth Area Mental Health Services, 1996 –1997. This project employed a mental health nurse to focus on improving the general health of boarding house residents by increasing access to a wider range of health and community services. An important aspect of this project was the recognition that this position should incorporate a community development component. The project final report [1997; 15] outlines the service providers who had increased resident’s access to their services:

General practitioners, Home Care, Community Transport, Aged Care Services, Community Options, Blue Mountains food Services, TAFE, Women’s Health Centre, BMDAMH Dental Services, BMDAMH Podiatry Services, Community Physiotherapist, Wentworth Area Sexual Health Services, Volunteer Carers, St Vincent de Paul Society.

This project did provide the impetus for the development of partnerships in care between service providers in different sectors and was successful in improving access and provision of health services to this client group. However a clear issue highlighted by the running of specific time limited projects with no ongoing funding has been the ability of the gains made to be sustained when they have finished. At the end of the Boarding House Project [1996-1997] it was recommended, “that the position of Boarding House Nurse be disbanded, and the unresolved issues relating to inter-agency co-operation be addressed at director and management level”. Unfortunately the optimism expressed in such a proposal, that service providers would pro-actively engage this population or that the population and their carers would actively seek appropriate service would seem to have been unfounded. By 1999 when the Boarding House Reform Program funded by the Ageing and Disability Department was being set up, many of the boarding house residents were again receiving at best poorly co-ordinated and sporadic health care and at worst acute care in response to crises.

Despite an extensive range of private and public health services available in the area, residents of the boarding houses were tending to access only a limited range of services, often as one – off or intermittently with no follow – up. Boarding House managers and staff tended to refer residents to health services when needing acute treatment. They did not often advocate for or were unaware of preventative health interventions or interventions that may have improved resident’s quality of life. For clients with a disability related primarily to mental illness, continuity and comprehensive health care seemed to be directly related to active case management. Whilst some residents did have support from case managers [predominantly those with more acute or severe mental illness] the majority did not.

The “episode of care” model of health service provision with an emphasis on management of symptoms of “illness” rather than a more global view of “disability” can be seen to have failed many residents of boarding houses who constitute one of the most marginalised, passive and disenfranchised populations, least likely to initiate or maintain contact with service providers. A consistent and pro-active co-ordination of health services is needed with the role of “advocacy” playing an important part in this service provision.

Case Study

Ms A.R. a 76 year-old woman, of Croatian origin, divorced with two adult children moved to the Eldon in 1996 following the closure of a boarding house in Eastern Sydney. Ms A.R. has a diagnosis of chronic schizophrenia with an affective component. She has physical health issues that need treatment and monitoring; diabetes, osteoarthritis, low thyroid function and episodes of anaemia. When she arrived at the Eldon Ms A.R. presented as guarded, isolative with severe mood swings and poor self-care. At this time the Boarding House Project worker attempted to engage with Ms A.R., arranging medical assessment from a local GP, psychiatric review, podiatry, dental and optometry appointments. Ms .A.R. refused to attend some of these appointments. The Boarding House Project Worker maintained a close liaison between GP, psychiatrist and boarding house staff. When her project finished, a case manager from the Katoomba Mental Health Team continued to work with Ms A.R. With sustained and pro-active interventions she was able to encourage and support Ms A.R. to have dental, podiatry, women’s health checks and help her settle into a routine at the Eldon. In March 1999 Ms A.R. was discharged from the Katoomba Mental Health Team. The plan was for her local GP and the boarding house managers to monitor her ongoing medical needs. When the Katoomba Neighbourhood Centre Health Promotion project worker began in February 2001, Ms A.R. had not seen a G.P. or mental health professional for over a year and had not been followed-up by the podiatrist. Whilst her mental state has appeared stable and she has not complained of any acute physical health problems, she would be unlikely to instigate any contact with health services unless in severe distress.

The ongoing stigma related to mental illness and ideas related to possible outcomes for people with longstanding and chronic problems may have some impact on service provision. “That’s how they are” or “What can you expect” being common responses from service providers. The closure of a number of boarding houses and the provision of alternative accommodation with better facilities and greater staff input has highlighted the possibilities of considerable change for a number of residents previously considered “chronic” and basically left to their own isolation and constricted routine.

Case Study

Brian X. is a 53 year-old man with a long history of mental illness, schizophrenia. He moved to a boarding house in Blackheath shortly before it closed in December 2000. Mr X. had lived in another boarding house owned by the proprietor in Western Sydney for the previous seven years. He presented as isolative, non-communicative with idiosyncratic mannerisms and little spontaneity. He had been taking high doses of neuroleptic medication for many years as prescribed by a GP with no psychiatric review of his treatment. Mr X. had a significant tremor. On the closure of Calamondah Mr X. was housed in a supported boarding house staffed by Home Care. This establishment has a high staff/resident ratio, regular input from a private psychiatrist and good links with community services including the Active Linking Initiative. In this environment Mr X. has begun to initiate conversation, attend group outings, decrease

his odd mannerisms. His medication has been rationalised and he has had regular psychiatric review.

Concern for the welfare of the residents of boarding houses has been an issue in the Blue Mountains for many years. This coincided with a growing awareness across NSW and the publication of numerous reports and newspaper articles documenting the plight of residents who live in boarding houses. In response to increased awareness in 1998 the Disability Community Worker, Mountains Community Resource Network organised a forum called 'The Boarding House Network'. This was attended by representatives from Community Transport, Blue Mountains Legal Centre, GPs, community workers, mental health case workers and workers from the Department of Community Services. There was some awareness that funding was to be announced by the Ageing and Disability Department and the network wanted 'to position' itself to avail mountain services to seek opportunities for funding: to either increase existing services or create new ones.

During this period collaborative strategies were developed between service providers. For example a health promotion seeding grant was secured between a worker from the Community Mental Health Team and the then Disability Community Worker. The grant enabled those workers and TAFE students to research the feasibility of a supported voluntary visiting service for residents who live in boarding houses. Katoomba Neighbourhood Centre's Voluntary Carers Service began to provide a volunteer worker to The Eldon Guest House in Katoomba to run some recreation activities.

When the Boarding House Reform Program was initially implemented with the establishment of an Area Support Manager and Case Workers, the existing "Boarding House Network" was effectively disbanded by the Ageing and Disability Department citing the government implementation strategy. Consequently the lessons learned from earlier collaborations were not incorporated into these plans. There is no doubt that planning practices with a "top – down" approach often fail to acknowledge the benefits of a community development model.

The Boarding House Reform Program included funding directed at the primary and secondary health needs of residents. This funding was allocated to local health services to administer. In the Wentworth Area the initial funding was poorly managed and the co-ordination of services somewhat sporadic. In fact this has been a problem for the Boarding House Reform Program across NSW. Despite the availability of funds and the offer of immediate access to services such as dental, podiatry and optometry many residents refused or did not keep appointments as arranged. The "brokerage" model of case management [Intagliata, 1982] proved ineffective. It became clear that in order for both primary and secondary health issues to be delivered effectively to boarding house residents there needed to be significant intervention with the boarding house staff, residents and service providers. Staff needed ongoing education, advice and support. Residents needed ongoing assessment, advocacy, support and practical assistance. Service providers needed advice and support on appropriate interventions with boarding house residents. Provision of health services to boarding house residents requires more than merely paying for and organising services. It requires sensitivity to changing needs, an understanding of the culture and routine of the boarding houses, an intimate knowledge and relationship with residents and staff and commitment to increasing the involvement of local services with this client group.

The projects run in the Wentworth Area [1995; 1996 –1997] and the more comprehensive services provided by the Boarding House Project in Central Sydney

Area Health Service [see Millard 1997] highlight some key aspects of providing successful services to improve the health and wellbeing of boarding house residents. An effective model of health service provision would be based on what Intagliata [1982] calls a "Comprehensive Model" of case management. This would include a worker/s to provide: outreach, client assessment, case planning, referral to service providers, advocacy for clients, direct casework, developing natural support systems, reassessment, advocacy for resource development, monitoring quality, public education and crisis intervention. The development of trust and familiarity with a worker would make an enormous difference for the residents and staff of the boarding houses. A project worker would also be able to co-ordinate health initiatives, developing a balanced and equitable program with a focus on areas of priority and providing a bridge between the boarding houses and health providers.

In 1999 Katoomba Neighbourhood Centre was funded to employ a project worker for 10 hours a week to initiate social and recreation activities with residents living at the Eldon Boarding House in Katoomba. Although this project did not have a specific focus on health needs, it provided a useful model of service delivery. A number of the activities undertaken gave a clear idea of how this type of intervention could be further developed by an NGO with a specific health focus. The project worker had worked with individuals [eg. Helping one resident improve areas of personal hygiene; helping another resident consider the benefits of referral to a psychologist for help with anxiety] and also instigated group projects. The worker had been able to gradually involve residents in activities such as a women's morning focussing on emotional and health needs and including the provision of massage [private practitioner working with the project worker]; completion of a mural [private artist working with the project worker – this included activities such as bush walks and discussion groups]; shopping trips to buy fruit and herb teas. It took the worker considerable time to develop even a superficial trust with the residents and develop an understanding of their needs, personalities and abilities. This knowledge and relationship allowed the worker to facilitate activities with outside agencies that may otherwise have been difficult if not impossible.

Katoomba Neighbourhood Centre Boarding House Health Promotion Project – The First Six Months

The initial six month work plan for the Boarding House Health Promotion Project had three clear objectives;

1. To promote health improvements with residents who live in Blackheath and Katoomba;
2. To source other health initiatives and process proposals; and
3. To provide education to boarding house staff and operators on individual client needs.

The following work has been undertaken:

Individuals who do not have case managers have been identified and baseline health tests (full blood count, chest X-ray, blood pressure etc). have been initiated by GPs. The project worker has accompanied each resident to the GP surgery to ensure appropriate communication and that instructions for on-going treatment are understood.

The project worker has identified residents whose care needs have increased due to aged related health problems. Two residents were referred to ACAT and assessed

for aged care facilities. They have subsequently moved to nursing homes in the Blue Mountains. A third resident is awaiting ACAT assessment.

One-off Information sessions and weekly groupwork sessions have been facilitated by the worker. These were jointly run with local private and public health practitioners. They included:

- Women's health group – sessions on gentle exercise; caffeine reduction; 'stress-less'; dance; 'vitamin C for morning tea';
- Reproductive Health;
- Drug and Alcohol information session; and
- Massage.

Residents have been encouraged to attend regular appointments with the dentist, ophthalmologist and podiatrist.

The worker has liaised with the Women's Health Centre whose staff is committed to providing a range of services for women who live in the boarding house. An initiative has been planned to introduce the women to the staff at the Women's Health Centre – the staff have issued an invitation to all women to attend a morning tea. Massage, pap test and discussion around nutrition with the naturopath will be included. Familiarization of the service and individual service providers will increase confidence. Support to use the services will be initially essential but sustaining contact and ongoing support is a real possibility.

A number of staff training days have been arranged and well attended. Sessions have included information and focus groups on epilepsy, diabetes and sexual health. Information on Infection control has been requested, and a half-day session on 'Stress Less and Treat Yourself Well' was planned but staff were unable to attend.

The worker has maintained a close liaison with ADD Case manager, Health and DOCs workers, Homecare and ALI workers on a range of issues. The worker attends bi-monthly case management and ALI planning meetings and attended a full planning day looking at the development of ALI activities in the mountains. Medical equipment for residents' use that they would otherwise have been unable to afford has been purchased. Nebulizer, support stockings, medical alert bracelets and sanitary wear.

One resident has been accompanied to the Women's Health. Centre for a regular massage.

The worker has organized with the University of Western Sydney for two students to undertake a Diversional Therapy placement at the Eldon. The worker will support these final year students as they plan and develop a program with some of the more isolated and amotivated residents.

A Men's Health Initiative was developed and a submission for funding to conduct a Men's health Sports Group submitted to Wentworth Area Health. At this time the submission remains unfunded.

The project has been consulted by the researcher for 'The Community Health Indicators Project' facilitated by WAHAS.

The worker is responsible to ensure that all invoices for services [i.e. dental, podiatry] are forwarded to Wentworth Area Health. The worker has a role in ensuring the equitable distribution of health funds and that priority health needs are addressed.

Outcomes

For many years general practitioners have conducted regular surgeries in the boarding houses. Some general practitioners have been reluctant to see residents of boarding houses in their surgeries, preferring to visit the boarding houses. The operator of the largest boarding house in the mountains has been dissatisfied with the GP service but has felt unable to challenge or change the routine. The fortnightly 'surgery' at the Boarding House was mainly used for the renewal of prescriptions. The operator has felt that the instruction 'give me a list of the patient's symptoms and I will prescribe some medication' has been inadequate and that the GP did not know the resident's name or history when making a diagnosis. If the resident is perceived as sick, ie. has a cold, the resident is advised by the operator 'to go to the doctor's surgery. This does not always occur.

In the past month, the GP who provides a fortnightly surgery has changed. The replacement GP has asked that residents who present with a problem are assisted to attend her surgery rather than be seen at the boarding house. For the first time, treatment plans have been documented and assistance with communication and ongoing treatment identified. There is no doubt that people receive a more thorough and individualised service when they visit general practitioners in their practice. There continues to be a need to advocate for residents rights to choice and the same level of service that other members of the community receive.

At present there are 30 people with no identified case manager from Health or DOCs. Of these, 10 have had baseline health checks and six people have plans for ongoing medical treatment. Residents are beginning to show more awareness about their health problems, although many residents do not wish to consult a doctor.

Some residents are more likely to attend appointments if they have some support. The worker discussed the idea of some basic health tests with an individual and she said 'I don't think so' The worker persisted and the resident agreed "I suppose I could discuss my sore throat, sore ear, dry skin and breathlessness" and then, 'I don't want to go on my own'.

The resident who presently attends the Women's Health Centre for regular massage had done so with the support of the 'Boarding House Nurse' in 1997. She had not been since that worker left. The massage is free, and the staff are flexible about arranging an appointment, but this has to be done by telephone and as the resident does not have access to a telephone, a worker has to arrange the appointment.

Another resident had persistent, open sore, leg ulcers. He had been told by the boarding house manager to 'go to the doctor', however he failed to make appointments, or attend the surgery. The worker was able to assist his regular attendance. She was also able to provide support stockings for his general comfort and improvement of blood circulation. The resident would be unable to pay for these expensive surgical items.

The project has supported personal and social development through the provision of information, education and practical assistance. The introduction of ALI and Homecare workers has also given residents another support network. An increase in

resident's self-reporting health concerns and their willingness to engage in appointments with GP's has been observed.

The manager from the boarding house in Katoomba is on the Health Promotion service committee. The availability of a monthly report to this committee invites discussion about issues. The operator has been encouraged to assist in planning the project work so that initiatives are 'owned' and supported.

A closer working relationship is being developed between boarding house managers and the KNC Health Project Worker. It has been possible to engage the boarding house managers in regular 'strategy' meetings to identify the residents who may require more support. The managers have felt more able to report problems to the worker and ask her to support residents when attending health services. The operators have also expressed an interest in the availability of a training session on 'Infection Control' which the worker has organised with the Health Department.

Important informal networks have been established between the worker and many local service providers. This has resulted in the worker being approached by HACC and health staff to assist them in their contact with individual residents. This has also ensured that the Women's Health Centre is able to provide education and services to a priority group.

Challenges

Whilst the availability of a worker to support the residents health care needs is being seen to be an improvement in care, there are a number of challenges in providing that direct service role.

The residents have individual and complex needs. They also, for the most part, do not wish to take-up services. The residents have traditionally been treated as 'psychiatric' patients, with a concern for their mental health only. The residents have not been engaged in reflection about their physical health needs; one resident outlined his experience of attending the doctor to discuss his inflamed skin, and being asked "Are you angry? Do you still hear voices"?

Many residents' lifestyles are not conducive to good health: smoking, caffeine consumption, lack of exercise, long-term medications for psychiatric symptoms, alcohol abuse, poor diet and dehydration have contributed to poor health. Residents have learned to live with pain, fatigue, nausea, agitation, thirst, palpitations, insomnia and dizziness and they are used to not being heard. It will take time for individuals to gain confidence in their health service, just as it will take time for service providers to gain the confidence to communicate well with the individual.

The Boarding House managers have provided 'total care' for a number of years, without the back-up of support services. They are weary of the rhetoric of the need for change and are consequently suspicious that services will 'meddle', withdraw, or become defunded. They often describe how they have "seen and heard it all before". One of the biggest challenges being that boarding house managers truly believe that they are providing a good service, with adequate levels of care.

One Boarding house manager is on the service committee of the KNC Health Promotion Project, and was a member of the interview panel. This is obviously a positive initiative and assists with communication and feedback. There remain however, communication difficulties that arise from 'different care perspectives'. When the project worker was assaulted by a male resident and reported the incident

to the managers, she was told that the other women residents had mentioned 'incidents'. She was also blamed for encouraging the resident (She always said "hello" to him) and was told "you know nothing; I have almost been thrown down the stairs by a resident". The managers enforced complacency about practice issues is not easily challenged because they remind external service providers that they are in the boarding house "all day, every day...I learn from the floor, not a text book". Whilst Homecare staff are welcoming of their training opportunities, the staff of one boarding house have yet to attend training unless it is seen as a licensing requirement by ADD.

Whilst it has been possible to work across services and gain the support of a range of professionals, there is still more work to do. Despite a number of planning meetings and discussions it has not been possible to engage the community dietician, based at the local hospital to provide a focussed and pro-active service for this client group. Some residents have attended the hospital for individual appointments, however the dietician felt she needed more 'resources' to conduct a food issues group or do individual work at the boarding house.

Men's health issues remain difficult to address. The lack of specific services and the male resident's reluctance to take-up services result in a situation whereby health interventions tend to be acute and symptom related rather than preventative. There is no generalist agency such as Women's Health Centre that may be encouraged to work with the male boarding house residents. This can be seen to relate to a broader community issue as outlined in the NSW Health document "Moving forward in Men's Health"[1999]. There have been some initiatives focusing on the promotion of "mens health" for residents of boarding houses in the Central Sydney [Steve Swan, Paper given to the Mens' Health Conference, 2000]. This remains an area needing further development.

Discussion

The shift of services from government departments such as health to non-government and charitable organisations needs to be monitored and considered with care. The population of people living in boarding houses is one of high needs and complex problems. Highly skilled and experienced staff with adequate back-up and supervision are needed to work effectively with this population. The period of transition from government to non-government service provision opens the possibility for benign neglect while new services get "up-to-speed". The employment of more qualified staff, even at the expense of hours of service provision is in the residents' interests rather than employing less qualified staff.

The KNC Boarding House Project Worker was employed at SACS Award Category 2 Year 4. The project worker employed came with a background of 25 years experience in psychiatric nursing and social work. More recently she had been employed to implement community projects with people who live in Boarding Houses in Central Sydney. Two of these projects involved the collaborations of Ashfield Council, the Central Sydney Boarding House team, St. Vincent de Paul and Inner West Neighbour-Aid. This wealth of experience has proved invaluable and has been one of the reasons the project has been able to "get up to speed" so quickly. Working as an outside agency in the boarding house environment can provide some of the most difficult situations that workers may ever encounter. The culture of these total institutions and the tentative acceptance of their practices by government agencies have created a demoralizing situation for both residents and workers. Regular supervision and a network of support need to be available for the worker who must negotiate an understanding of issues and need for change at every turn. The work is

a process and 'results' may at times seem insignificant. This supervision needs to be available from suitably qualified and experienced practitioners. Direct line managers may not be the best people in all circumstances to provide this role. NGOs need to be prepared to acknowledge that their workers may need external professional supervision. This should be included in project costings.

NGOs in the Blue Mountains have acknowledged the need for professional supervision and in 1999 submitted to the Western Sydney Area Assistance Scheme for funding to develop a supervision unit. As yet this project remains unfunded.

Whilst the shift of services from government to non-government agencies may open the possibility for "benign neglect", it also opens the possibilities for partnerships, real sharing of expertise and knowledge and a greater variety and flexibility of service provision. In order for this to happen, both government and non-government agencies need to actively involve themselves in the development and ongoing running of programs. Partnerships are not merely about an employer/employee or funder/provider split. If government agencies simply provide funding and do not continue to play an active part in services through regular liaison, mentoring or supervision, ongoing education, involvement in management committees etc. the opportunity to develop strong and sustainable partnerships.

Collaboration between Katoomba Neighbourhood Centre, The Ageing and Disability Department and Wentworth Area Health has been consistent throughout the first six months of this project. The Boarding House Reform Program Support Manager and Case Managers [seconded from Health and DOCs] have met regularly with the project worker. There has been a continuing dialogue regarding individual case work and broader service development issues. The Neighbourhood Centre negotiated with the Area Health Service to rent office space in a local Mental Health facility. This has helped to increase informal networks with both staff and consumers. There has been a real commitment from all partners to remain actively involved in the project. However it has been noticeable that when middle management staff from Health and ADD have vacated positions information regarding small projects such as this, has not been a priority to pass on to the new manager.

One of the key elements of the Boarding House Health Project that has been different from earlier projects has been the availability of funds as part of the ADD Boarding House Reform Program to purchase services and health related goods. This has made an enormous difference to the viability and acceptability of the project to staff and residents of the boarding houses. For example the ability to make an immediate appointment with a private dentist rather than waiting weeks or months to be seen at the public dental hospital or to purchase surgical stockings or a nebuliser when needed. There has been some recognition that the population of people living in licensed boarding houses is one of the poorest with little if any disposable income for health related expenses.

Health Services in NSW are currently organised and funded according to "diagnostic" and geographical categories. Services have tended to be provided as specialties according to increasingly strict criteria. This can make it difficult for individuals with multiple needs to effectively co-ordinate and negotiate appropriate care. The Neighbourhood Centre is in a position to work effectively across service boundaries – the bureaucratic barriers such as diagnosis and disability are not an issue. Whether someone has a "mental illness" or "Drug and alcohol problem" or "alcohol related brain damage" is immaterial to service provision. Rather the KNHC worker can work with all residents focusing on their particular health needs.

Another key element of the project is the recognition of the need for flexible, informal but skilled interactions with residents. Being able to sit with the resident in a café after a GP consultation can aid reflection and allay some fears. The worker also spends informal time in social areas at the boarding house discussing lunch, the world news, backache and culture. Creating a space for conversation and shared experience is a necessary piece of work. With a more holistic and social view of health the KNC worker can create the opportunity for future work with residents not yet identified as 'clients'. The current organisation and focus of government health services does not encourage such practice.

Community Health, Disability and aged care are some of the core services of the community sector, but they do not own them. These are community owned issues and community services are well placed to stimulate discussion and action, and enhance community networks. Despite the rhetoric of some Government Departments, NGOs are in fact structured to be more accessible and accountable than most government agencies. Management structures of community-based organisations have voluntary membership, and community member skills and knowledge are utilised on the various project committees. Committee members have ongoing dialogue with workers and other members of the community, they have continual knowledge of the issues for the various projects and thus, awareness of issues is thorough and decision-making is prompt. Financial management is by necessity exact and reporting procedures to funding bodies detailed.

Projects such as the KNC Boarding House Health Promotion Project can help to reduce the stigma and discrimination experienced by people living in boarding houses. The involvement of a broad band of service providers and the assistance to increase the links between residents and community agencies can help break down many barriers.

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. NGOs are well placed to provide people with information. The dissemination of information by an NGO is a deliberate action. Informed people can ask for appropriate responses to community issues.

The accommodation needs of people with significant disability, whatever the underlying cause should be considered a priority in care planning. For many years both state and federal governments have ignored the growing evidence that the care and accommodation needs of these individuals have been neglected. Our view is that the boarding house industry is not viable in its current format – without significant further financial resources being available it is not possible to provide adequate care for people with significant disability in a for profit establishment. Whilst health and community workers are not indifferent to the poor quality of accommodation and facilities that the residents of boarding houses endure they often feel powerless to intervene without adequate alternatives. The Boarding House Reform Program is not part of a co-ordinated wider strategy to improve accommodation options for people living with disability and could be seen as a “stop-gap” solution to sure-up an already discredited system. NGOs have a history of advocacy and political action on behalf of disadvantaged and disenfranchised groups in the community and have been involved in ongoing campaigns for recognition of human rights. Without many of the bureaucratic and organisational restrictions experienced by large government departments, NGOs can effectively combine service provision with community action.

Working with residents in the licensed boarding houses in Wentworth Area has been an enlightening experience for us both. Whilst the general standard of accommodation and care provided for what is one of the most vulnerable groups in our society by private for profit boarding houses remains appalling, working in boarding houses and with residents of boarding houses is not all 'doom and gloom' – far from it. We are constantly amazed at the fortitude, resilience, humour and generosity of many of the residents despite their circumstances. Contact with residents is often humorous, good natured and fun. The possibility for change, for strengths to be recognised and developed and for greater involvement in community life are evident in many residents.

Conclusion

The initial six months of this project have shown that a community based NGO such as the Katoomba Neighbourhood Centre can successfully develop and maintain a health promotion project in partnership with the Area Health Service. The opportunity exists for a far greater mixed economy of health related services between private, government and non-government agencies. NGOs with their community management structures and broad "human rights" based practice are ideally placed to offer flexible and locally sensitive services. However in order for such partnerships to develop in a sustainable manner, professional standards need to be recognised and maintained and funding needs to be realistic and for many projects ongoing.

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