THE SOCIAL DETERMINANTS OF HEALTH AND PSYCHOLOGICAL WELLBEING: IMPROVING THE MENTAL HEALTH OF ALL THROUGH BROAD BASED POLICY AND INTERSECTORAL ACTION

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SUMMARY

This thesis seeks to better understand how Health and non-Health policy can enact strategy that improves population mental health. The main aim of this research is to examine and identify policy from selected state sectors for evidence of strategy and action on the social determinants of mental health and the conditions in which people grow, live, work and age. An extensive evidence base exists on the need to address the social determinants of health to progress population health and mental health, however the literature indicates that this knowledge is not well utilised in current policy and practice. In examining policy for constructions of mental health that enable the promotion of mental health, this thesis seeks to identify exemplary policies that promote mental health and prevent mental illness. The findings contribute to the research that examines how policy can progress population mental health, at a time when the need for individualised treatment and clinical services are consistently emphasised, given the rising incidence of mental illness and the privileging of the biomedical model.

There is considerable research that articulates the importance of mental health promotion as a matter of concern for both Health and non-Health sectors. However, a specific focus on mental health and the role of the built and natural environments in promoting population mental health is viewed as a gap in the literature. This research seeks therefore to add to the literature, by focusing on the sectors which hold responsibility for the environments in which we live, in addition to the Health sector, which holds responsibility for population health.

The research articulated three questions relating to the thesis aim: the extent to which mental health is considered in policy, the construction and representation of mental health in policy and the enablers and barriers to the implementation of policy that promotes mental health and psychological wellbeing.

A qualitative methodology was used, and the following methods employed: a document review pertaining to 27 policies, interviews with 33 policy actors and academics, and two nested case studies in which further examination of the exemplar policies in practice was completed. My focus throughout the analysis was to uncover the underlying meanings related to mental health and the implications for agenda setting and the development and implementation of policy strategy.

The findings revealed that a policy from both non-Health sectors that had the potential to enable population mental health. The identified exemplars are: the *Healthy Parks, Healthy People* strategy from the Natural environment sector and the *30-year Plan* from the Built environment sector. Both policies demonstrated an explicit concern for mental health and acceptance of a level of accountability for health outcomes. The findings indicated that enabling factors were: a focus on wellbeing and intersectoral collaboration, and disabling factors: lack of outcome measurement relative to a social view of health and the prioritisation of economic outcomes.

A Health sector policy was unable to be identified as an exemplar, where the predominant focus on mental illness, individual treatment and clinical services, precluded adequate focus on mental health and psychological wellbeing.

The implications of these findings include the need for the authorisation of mental health promotion approaches within the Health sector and for both authorisation and endorsement of the Public Health Partnerships approach, which the research identified as integral to the development of healthy public policy and practice that benefits mental health. Both non-health sectors have demonstrated their capacity and willingness to apply a health lens to policy, and it is needed for this lens to be extended to other policies, if we are to govern for health. The need for an elevation of the social view of health in relation to both mental health and mental illness is vital and remains outstanding.

DECLARATION

I certify that this thesis:

1. Does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and
2. To the best of my knowledge and belief, does not contain any material previously published or written by another person except where due reference is made in the text.

ACKNOWLEDGEMENTS

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Another family member that guided me at times was my father. He was a father with a strong sense of justice, a strong work ethic and a commitment to lifelong learning. As with so much parenting, it is what we do that our children notice, and to be at this completion point of the thesis has much to do with that guidance.

I remember saying to my supervisors early in the process that supervising a PhD student must be a process of delayed gratification. I have become persuaded that there is in fact a dearth of gratitude more generally for academics, having seen the demands upon them increase over the time of my research, in response to the efficiency and outcome demands that academics and universities are increasingly facing in Australia. I would like to express my deep gratitude to my supervisors, Professor Fran Baum, Dr. Toni Delany-Crowe and Dr. Matt Fisher, and for a short time, Dr. Angela Lawless, who afforded me their constancy, their knowledge and their support. I found in my supervisors and at Southgate generally, a group of highly knowledgeable, esteemed and committed people with shared goals and views regarding a social view of health; goals and views that I also shared. In various ways they have taught, supervised and supported my learning with attention, care and respect. I had much to learn about public health and am very grateful for having been given this opportunity to extend my learning.

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I would also like to thank my research participants and acknowledge their interest and participation in my research. Their time, thoughts and insights are central to the creation of this thesis. I felt privileged to be given that time and was much informed by their knowledge. Witnessing their energy and commitment to improving population health and wellbeing in whatever way their diverse roles afforded them, was in fact, cathartic for a somewhat unsettled clinical psychologist.

Finally, my research was also made possible by the award of a privately funded scholarship through Flinders University, which enabled me to step out of my employment and attendant work responsibilities and fully embrace a period of study. I would like to acknowledge the person/s who made that possible and the systems of governance, including those employed in Flinders administration, scholarships and graduate research teams, that support that process.

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CHAPTER 1 INTRODUCTION

1.1 Research Context

The incidence of mental illness continues to rise both internationally and nationally as does the associated burden of disease, affecting individuals, families and communities. It is associated with a significant emotional, social and financial cost and as such has recently triggered two Commission inquiries at a state and national level in Australia. The *Victorian Royal Commission into Mental Health* (Victoria State Government, 2019) concerns the need for mental health system improvements to better meet service demand, to improve service access and to review models of care. It is hoped that the Commission will improve outcomes for those with mental illness. The Australian Government's Productivity Commission inquiry, the *Social and Economic Benefits of Improving Mental Health* (Productivity Commission, 2019) however, is a broader inquiry, seeking to contribute to improved population mental health and in this respect has strong links to my thesis.

The Productivity Commission seeks to *examine the effect of mental health on people's ability to participate in and prosper in the community and workplace*, and how that impacts our economy and productivity. In this inquiry the concern lies not with mental illness but mental health and how different government sectors, employers, community organisations and professional groups (justice, housing, welfare services, employment, education and health) can contribute to improved mental health for all people. My research is likewise concerned with population mental health and the contribution of different sectors.

I approached this research following many years working in the Public Healthcare system in several roles but primarily as a Clinical Psychologist. I have worked with many children, young adults and their families. I have been privileged to witness the significant emotional and developmental shifts in trajectories for children, when parents and families have the support they need to access their own resources and resiliencies. My practice and subsequent research have taught me that a focus on individual circumstance and capacity is not sufficient to create change - a broader approach is required. This involves considering the social, economic and physical environments in which people live, work and age and in which children grow; the social determinants of health and mental health. I sought to understand why is it so difficult for health systems to adopt and sustain practice that supports mental health promotion and that acknowledges the links between mental health and social inequalities given the depth of evidence that suggests such practice to be most effective (Barry, 2007; Commission on Social Determinants of Health [CSDH], 2008; Friedli, 2009; Allen, Balfour, Bell & Marmot, 2014; WHO, 2014b & Patel et al. 2018).

Drawing on my clinical background, I set the research context with a case scenario of a child and his family, who I worked with in a community health centre in Adelaide. This scenario provides insight into the motivations driving my research.

Steve was one of three boys under the age of five who had been brought in for assessment and therapy by his mother. He had recently been referred by his local doctor who had requested a formal psychological assessment. Steve's language use was significantly delayed i.e. single words at three years and his ability to attend was minimal. Steve's behaviour was a constant challenge which his mother, Karen, was both stressed and concerned about. However, Steve had very well developed physical and sensorimotor based skills, demonstrated beautifully as he burst into the room, immediately looking past myself as the therapist to the contents of the room and commenced pulling out toys, throwing toys, pulling at locked cupboard doors and climbing the desk. Steve did not provide me or Karen with eye contact or engage in shared play.

Karen watched her son and confided her exhaustion, and a growing sense of desperation, anger and resignation.
She spoke of her sense of feeling overwhelmed as a single parent with no social or extended family support and living in a small and inadequate courtyard house in a new outer suburban area.

Sitting away from the toys Karen punctuated her story with protests of 'No's' and 'Stop that's', all with little effect while we discussed her constant worry about Steve, about the possibility of developmental delay, attention deficit disorder, conduct disorder and/or autism; all possible diagnoses that had been raised with her. Karen spoke of her deep fear and embarrassment at how he is in the world, her worry about what would happen to him if he does have a disability, about her growing self-doubt in herself as a parent and her own sadness and feelings of helplessness. Will he be able to go to 'normal' school? Will he have friends? Essentially, who will care for, connect with and support my child, when it is so hard even for myself as his Mum? The emotional pain she spoke of was raw and intense and conveyed some of her own trauma. A person who had an abusive childhood she was adamant that this history would not be repeated but was feeling overwhelmed, isolated and incapacitated by the parenting needs of Steve and aware of the impact this was having on the whole family and indeed herself.

Our next session started outside with a little bucket and a spade. Outside the offices was a little 'wirra', an outside space with dirt paths, native grasses and small bushes, while overhead the she-oaks and eucalyptus provided shade as you wandered seeing the occasional skink dart into a log and hearing the birds. Steve, his Mum and I headed out to the wirra. We walked through the area together, Karen with the bucket, Steve with the spade. Steve picked up sticks, leaves, flowers and pine-cones. He dug holes, made campfires and watched the sparrows in the birdbath and all the time he was continually bringing and showing found objects to his Mum before entrusting them to her and placing them in her bucket. He constantly looked up at her and spoke the occasional word. We did not pursue this activity for a long time so as not to tax everyone's resources but in the time we had, Steve's Mum was able to relax, and see her child, rather than his behaviour. She was able to notice what he was noticing, comment on what he was showing her and show her genuine interest and joy at what he found in his little discoveries. This activity in the wirra was a shared play experience for both Steve and his Mum; it had meaning and fun; it supported emotional regulation, attention and connection; and gave a sense of shared joy. For Karen, it gave hope.

We worked together for many more sessions but this second family session, set in the 'wirra' was a turning point for Steve and his Mum.

Two additional actions I took supported that turning point. The first was to advocate for access to alternative housing options and while that was still not ideal, the house had more internal space and a backyard, and proximity to shops and parks. The second was to support engagement with other community and education-based supports where the family started to slowly connect with others and develop a sense of community.

Steve's development improved and he continued to make up ground in relation to his attention, speech and communication. No diagnosis of autism, attentional deficit disorder, developmental delay or conduct disorder was made.

The opportunity to work with families at times of need has been profoundly rewarding. However, the case of Steve demonstrates two key points: the significance of attending to the situational and contextual factors surrounding a clinical presentation and the role of the 'setting' (both the natural and physical environments in this case) in enabling health and mental health. Inadequate housing, lack of transport, difficulty in accessing shops, lack of accessible greenspace and lack of social support were all highly significant factors affecting Steve and his family, and Steve, in a sense, was the mouthpiece for the impact of these negative realities for all the family. Clearly, there are also individual differences and previous intergenerational traumas that were current, however, the negative realities experienced by the family effectively constituted the preconditions of poor health and poor mental health. These negative realities, that is, inadequate housing, poor access to transport or greenspace, lack of social and educational supports, are all key social determinants and are fundamental to both health and mental health. As a therapist, however, I have very limited ability to affect structural change. The Australian Psychological Society (APS) identifies that one of the roles for a psychologist is to help facilitate organisational or social change, but the current scope of practice in the South Australian Health care system (SA Health), doesn't endorse practice that progresses the structural and policy change needed to facilitate social change. This has not always been the case as evidenced by SA Health's Noarlunga *Healthy Cities* initiative, which previously demonstrated achievements in community safety and social sustainability benefitting the health of all (Baum, Jolley, Hicks, Saint & Parker, 2006).

Over three decades of working as a clinician in the Public Health sector, there are three experiential learnings that have been firmly 'cemented in' me by those many work years. These three key learnings drove my shift from the role of senior clinical health professional to public health research student.

The first learning is that: mental health operates in a social context and social disadvantage impacts mental health negatively. Where a family is struggling with limited resources whether that be financial or social or related to educational, occupational, sociocultural and/or environmental challenges, there is an increased risk of the development of mental illness for all family members, including children.

The second learning is that: disadvantage is intergenerational. Disadvantage is experienced on physical, social and emotional levels by individuals and families, mediated by familial relationships. The inequities that are experienced as a child often continue to have life impacts well into adulthood.

The third learning is that: disadvantage means a lack of access to the resources that support health and mental health and a lack of access can constitute an antecedent of mental illness. This is not a problem that can be addressed at the client, clinician or service level. It is essentially a socio-political problem, often interpreted as an individual deficit that individuals will 'cope' with and/or 'overcome', as illustrated in this quote from Bauman (2007), "Although the risks and contradictions of life go on being as socially produced as ever, the duty and necessity of coping with them has been delegated to our individual selves" (p.14).

Despite these experiential learnings, I have witnessed systems and services within SA Health increasingly swing away from developing and funding supportive socio-cultural approaches working in the community to address the underlying causes of health or mental health issues (Baum, Freeman et al. 2016; Littlejohns, Baum, Lawless & Freeman, 2019). Simultaneously, I have witnessed an increasing tendency to individualise mental health problems and an over- reliance on pathologizing. My concern that the social and economic conditions in which people live, are unconsidered and unaddressed within the Health system, has grown in this time, and recent structural changes associated with SA Health and the *Transforming Health* initiative[1] have reinforced that concern (Anaf et al. 2014; Littlejohns, 2016).

Stepping into a University Institute, assuming the role of a public health student and shifting away from my clinical persona has been challenging but also reaffirming. As a public health student, I found confirmation that the social determinants of health do indeed matter, and they strongly influence mental health.

The research that I have undertaken therefore explores the following themes.

- The role of the social determinants of health in both individual and population mental health
- The individualisation of mental illness in contemporary Australian society

[1] SA Health implemented the Transforming Health initiative in 2014 as a response to the Federal budget cuts in 2014-2015. Health system and service reform, focussed on the development of hospital infrastructure, consolidation of specialist services and the delivery of quality clinical practice (SA Health, 2018)

- The contribution of government departments in health, the natural environment and the built environment in creating conditions of living that engender mental health and psychological wellbeing.

1.2 Research Focus

The evidence on the social determinants of health stresses that health outcomes are most significantly influenced by social, economic and political factors, rather than genetics, individual behaviour and health care. As such it is the policies and practices in a wide range of sectors, such as planning, transport, trade, agriculture, employment, education and the environment that contribute to the development of conditions that either enable or prevent health (Marmot, Friel, Bell, Houweling & Taylor, 2008; Marmot & Bell, 2012).

The actions of all government sectors then impact not only on how healthy people are but how mentally healthy people are. This research will analyse in detail the policies from selected South Australian (SA) Government sectors to identify what policies best support mental health by attending to those aspects of the social determinants of health related to the work of the sector. The policies of three sectors of the SA government will be critically examined: the Health, Natural Environment and Built Environment sectors.

Case study exemplars of mental health promotion in South Australia from each policy sector will be drawn from the identified policy and assessed in terms of their potential to promote health and mental health.

The ongoing and increasing demand for mental illness treatment and services has forced the realisation that treatment models alone are unable to meet existing need and further, that they are inadequate as the central approach to improve population mental health. There is an outstanding need to develop and commit to alternative models and collaborative practices that promote population mental health and psychological wellbeing, in addition to addressing the incidence of mental illness in Australia. An extract from an introductory letter to the National Review of Mental Health Services and Programmes [National Review] completed by the National Mental Health Commission (2014) by Professor Alan Fels and CEO David Butt, who co-authored the review, provided validation of the need for a systemic paradigm shift to improve the mental health of Australians:

> *The work of the review has found there is an extraordinary high degree of consensus as to the direction needed to create a system which promotes good mental health and wellbeing...Practical steps now need to be taken…while there is significant expenditure on mental health, it is not necessarily being spent on the right things – those services which prevent illness, keep people well, support recovery and enable people to lead contributing lives...The recommendations of the Review have implications for a number of portfolios which go beyond health* (Sweet, 2015).

Recognition of the need for all sectors to contribute towards health and mental health is one of the consistent messages of the *National Review* (2014) which is a document I refer to throughout the thesis as it provided the most recent significant and comprehensive review of mental health programmes and services in Australia from a whole-of-system and whole-of-government perspective. The *Closing the Gap in a Generation* report from the CSDH (2008) I also refer to throughout the thesis as it provided a body of evidence that strongly linked health and health inequity to the conditions in which people grow, live, work and age and the social and structural factors that produce those conditions. Both documents are central to my research focus. More recent literature concerning the same subject matter has also been utilised in the research (Marmot et al. 2010; Marmot, Allen, Bell, Bloomer & Goldblatt, 2012; Marmot & Allen, 2014)

The *CSDH Conceptual Framework* was produced in the *Closing the Gap in a Generation* report and detailed below. It draws attention to the impact of not only the socioeconomic but the political context, on other structural determinants and intermediary determinants on health outcomes. That is, the structural drivers (governance, policy and cultural and societal values) are mediated through the intermediary factors (socioeconomic position including class, gender, and ethnicity, education, occupation and income) which in turn determine living, working and social conditions, behaviours and biological factors. Importantly, in directing attention to the role of governance, policy and culture and societal values, the political context is highlighted as playing a significant role in determining the distribution of health and health inequity, which relates to my research given its examination of policy.

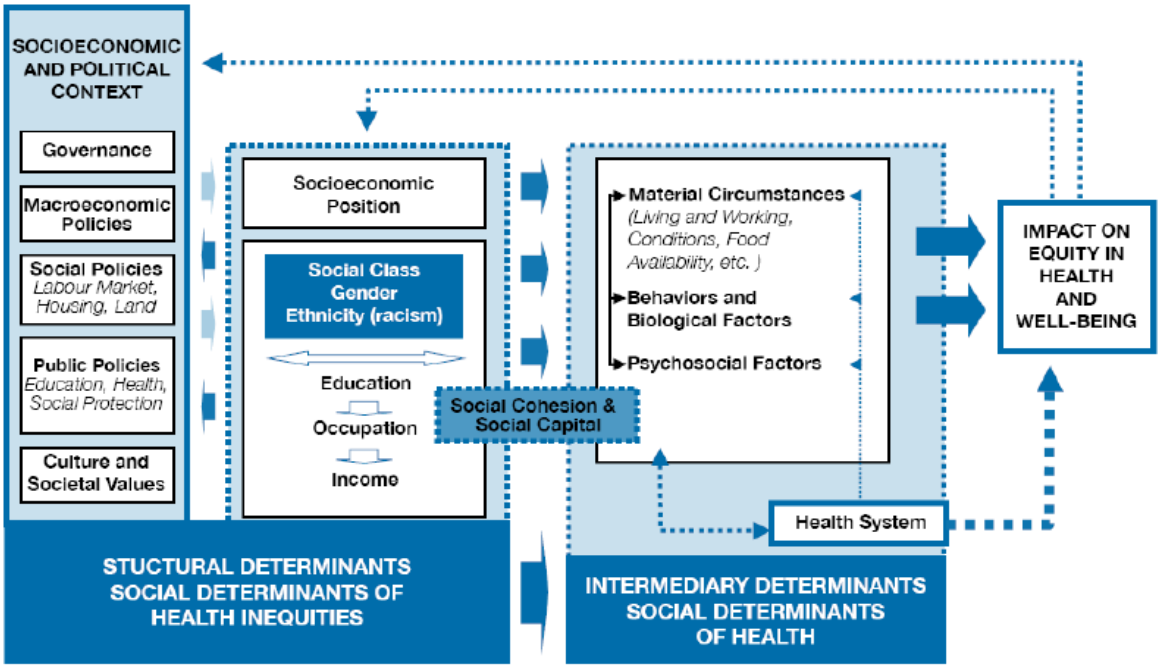

Figure 1.1 CSDH Conceptual framework (Solar and Irwin, 2010)

This framework developed by the Commission is underpinned by a significant volume of evidence as to the need to address the social determinants of health and health inequity, as stated:

> Globally it is now understood better than at any moment in history how social factors affect health and health equity. While information is always partial and the need for better evidence remains, we have the knowledge to guide effective action (CSDH, 2008, p.43).

The CSDH review highlighted the systemic differences in health outcomes for those from different social groups and where there are differences that are structurally determined, this constitutes inequity. To address the inequities which affect health and mental health outcomes, action is needed by the whole of government to address the social determinants of health across the lifespan and in wider economic and social spheres (Marmot et al. 2012).

Specific to this research, is the understanding that mental illness is inequitably distributed, with those struggling with social and economic disadvantage bearing a disproportionate burden (Friedli, 2009; Patel et al. 2010; Allen, Balfour et al. 2014). Reference to the social determinants of health and health equity is therefore central to the research, given that attention to both promotes population mental health and psychological wellbeing (Hosman, Jane-Llopis & Saxena, 2004; Hermann, Saxena & Moodie, 2004; Allen, Balfour et al. 2014) as is the understanding that there is no health without mental health (Prince et al. 2007; Sturgeon, 2007).

In the Health sector, my research will identify policy that enables a focus on the promotion of mental health as opposed to the diagnosis of or treatment for illness for it is by maintaining and strengthening mental health, that the incidence of mental illness is reduced.

In the Natural and Built Environment sectors my research will identify policy that has the potential to promote mental health even where that policy does not focus specifically on mental health, but rather other sector goals. It is understood that policy in these sectors may positively impact health and equity indirectly as well as directly.

At the completion of the research, it is intended that the findings offer what Professor Alan Fels discussed as practical steps that can be taken to improve population mental health. Whereas Fels discusses these steps as essential to arresting the incidence of mental illness and promoting mental health, this research is primarily focussed on the steps that can be taken to promote mental health. The need to address pathology is well understood. A recent grant of $125 million Australian dollars to the *Medical Research Future Fund* made in the last national budget (Government of Australia, 2018) providing 10 years of funding for research and supports for those with mental illness, attests to that. The need to address the underlying social causes of that pathology, the social and economic difficulties that contribute to the acute, chronic and toxic stress that in turn affects physical and mental health (Brunner & Marmot, 2009; Fisher & Baum, 2010; Corburn, 2015) is not so well understood. This research seeks to contribute to this literature base, highlight the value of mental health promotion and enable the mental health of all; *the well, the unwell, the in between*.

1.3 Research questions

The themes I have outlined will be explored through the following research questions:

1. To what extent is mental health and psychological wellbeing considered within the policy of the three sectors (the Health, Natural Environment and the Built Environment sectors) and how do the policy framings construct responsibility for mental health and psychological wellbeing?
2. How is mental health and psychological wellbeing represented in those sectors?
3. What enables and disables the best exemplars of policy and policy implementation and how can these findings inform policy and practice concerning mental health and psychological wellbeing?

1.4 Terminology

Before outlining the thesis structure, I will explain the terms which are used frequently in the relevant literature and which I use in discussing the research. The following terms are defined in this section: health, healthy public policy, Health in All Policies (HiAP), health policy, health and mental health promotion, the biomedical model of health, public/population health, the social determinants of health, Aboriginal and Torres Strait Islander health, mental health, mental illness, wellbeing,

community wellbeing and terms relevant to the natural and built environments: public open space and greenspace.

I have utilised the WHO's definition of ***health*** as "*complete physical, mental and social well-being not just the absence of disease*" (WHO, 1948, p. 1) in this research. This is a long standing and respected definition of health, an aspirational and expansive definition which has important conceptual value in progressing health as a broader phenomenon rather than merely an absence of illness and offers "*a vision of health beyond that suggested by the biomedical model*" (Baum, 2015, p.5), the dominant model in modern western medicine. Labonte (2016) considers that the 'vision' of health portrayed in the WHO's definition faces increasing levels of resistance from a range of agencies focussed predominately on individual illness and the biomedical model, including: government agencies, health care providers and commercial (medical technology and pharmaceutical) businesses.

Building ***healthy public policy***, is the first of five goals listed in the Ottawa Charter for Health Promotion. Developing healthy public policy 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*" (World Health Organisation, 1986, p.2). The term is frequently used in conjunction with ***Health in all Policies,*** which is a worldwide approach to promote healthy public policy, a way of working across government to support all sectors to consider the impact of policy and practice on health outcomes (WHO, 2014a).

The World Health Organisation (WHO) defines ***health policy*** as policy that refers to decisions, plans, and actions undertaken to achieve specific health care goals within a society. Importantly, the WHO identifies that health policy relates to more than the use of clinical systems to provide care and treatment but also to the "*organizations, people and actions whose primary intent is to promote, restore, or maintain health*" (WHO, 2007, p. 2) This statement identifies the use of health policy to support both health care and ***health promotion***. Health promotion strategies outlined in the Ottawa Charter (WHO, 1986) include: Building healthy public policy; Creating supportive environments; Reorientating health services; Strengthening community action; and Developing personal skills. Given these understandings, health systems need to be concerned with more than the delivery of health care services (Hancock, 1999; Baum, 2015) and it is this conceptualisation that is used in the examination of policy.

Mental health promotion and prevention can be defined separately but given both are concerned with reducing mental disorders, the crossover or similarities are considerable (Hosman, Jane-Llopis & Saxena, 2004; Herman, Saxena & Moodie, 2004). For the purposes of this research I use the term ***mental health promotion*** as inclusive of both promotion and prevention, in accordance with the above documents.

*The **biomedical model of health*** refers to the assumptions that disease and illness are the result of pathology, can be removed or attenuated through the application of medicine, and that a return to health will result (Wade and Halligan, 2004). It is a model that aligns with the mind/body dichotomy, applied to both mental and physical health. A biomedical view of mental health has been driven in part by (so far) flawed assumptions about being able to identify distinct neurobiological markers of specific forms of mental illness (Rose, 2016). The separation of mental health from social context and the overextension of diagnosis (Raven and Parry, 2012; Frances, 2013; Rose, 2016) is consistent with an individually based biomedical approach to health in general and has served to alienate mental health from the ***Public Health/Population approach*** which aims to create healthy environments in order to improve the health and mental health of the population (Sturgeon, 2007; Hancock, 2018).

A broader understanding of health and mental health that is inclusive of the impact of social, cultural, environmental and economic factors on mental health and psychological wellbeing is utilised in the thesis and explored through the methodology applied, thus what is good for health is assumed to be good for mental health given the intimate connections between body and mind. The ***social view of health*** or a ***social determinants of health*** view recognises the conditions in which people live and the broader social, cultural, environmental and economic factors shaping those conditions as causally contributing to both health and mental health outcomes for individuals and populations (CSDH, 2008). The Commission defined the social determinants of health as "*structural determinants and conditions of daily life*" (p.1), identifying their unfair distribution within and between populations as responsible for poor health outcomes and health inequities.

Policy that relates to the health of **Aboriginal and Torres Strait Islanders,** the traditional owners of Australia, is also considered in this thesis and in relation to this I refer to the Aboriginal definition of health from the National Aboriginal Health Strategy Working Party (1989). It is viewed as a holistic definition (Lutschini, 2005) and draws on the WHO definition of health which I provided earlier. Further, it defines health as intertwined with goals of justice and self-determination for the Indigenous people of Australia (Boddington & Raisanen, 2009).

> *Aboriginal health means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their Community. It is a whole of life view and includes the cyclical concept of life-death-life.*

> *Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, dignity, community, self-esteem and justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.*

The WHO definition of ***mental health*** directs a focus towards wellbeing as opposed to illness and it is this understanding that is utilised in the thesis. The definition references the benefits to mental health of being in a productive work role and contributing socially to a community, both which reinforce the importance of social interactions and relationships to mental health, a key theme in the research.

> *Mental health/Wellbeing is defined as a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community (WHO, 2014b).*

The term ***mental illness*** reflects a deficit model and is defined in the central South Australian government policy concerning mental health, the *SA Mental Health and Wellbeing Policy* (2010-2015) as *a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities* (Appendix A).

Two challenges to the use of the term **mental health** have been considered in the structuring of the thesis: 1. The conflation of mental health with mental illness and 2. The conflation and substitution of the terms' health, mental health and wellbeing.

With regards to the first challenge, the term mental health is consistently conflated with mental illness resulting in confusion about what it is to be mentally healthy (Barry & Jenkins, 2007). The persistent use of this conflation may indicate an awareness of the stigma associated with the term mental illness. However, it fails to address the underlying structural and individual stigma and discrimination associated with mental illness (Link, Yang, Phelan & Collins, 2004). Putman (2008) confirms the presence of negative attitudes towards those with mental illness in Australia and appraisals of those with mental illness that focus on deficits in the person. In a culture where such appraisals are prevalent it is to be expected that open reference to mental illness in the community is guarded.

Conflation of mental health and mental illness was common in the academic and grey literature used in this research. To avoid this conflation, the terms mental illness and mental health, are both used meaningfully and deliberately in my thesis and where the meaning is implied or ambiguous, I articulate this explicitly. Additionally, I pair the term *mental health* (read health) with the term *psychological wellbeing* to support the association with 'positive mental health', itself a term that has come into use because of the conflation of mental health and mental illness.

With regards to the second challenge, it is considered in this thesis that mental health is a part of health and health a component of wellbeing, all are central constructs used in the thesis. Additionally, a holistic approach to health is adopted in the research where physical health and mental health are viewed as interrelated (Prince et al. 2007).

In recent years **Wellbeing** has become a widely utilised concept, interpreted differently across different areas of research and practice (Jayawickreme, Forgeard & Seligman, 2012). As a concept it is utilised in many of the policies examined in this thesis as a broad term, embodying physical, mental and community health. As such, both psychological wellbeing and community wellbeing are considered concepts in the research. Psychological wellbeing is associated with the work of Ryff (1989) and Keyes (2002) and more recently Seligman (2011), who identified five individual components in his theory of Wellbeing (PERMA): Positive emotion, Engagement, Relationships, Meaning & Accomplishment. ***Community wellbeing*** recognises that the components of wellbeing extend beyond the individual and are enabled by access to economic, social, cultural and environmental resources, which collectively enable the health of individuals and communities, as illustrated in the following diagram which used in the City of Norwood, Payneham & St. Peters Community Plan (2017). The council applies a quadruple bottom line (QBL) approach, as opposed to a triple bottom line approach in incorporating economic prosperity, environmental sustainability, social equity and cultural vitality as important to community wellbeing.

Figure 1.2 QBL Community Wellbeing model (City of Norwood, Payneham & St. Peters, 2017)

Lastly, the ***Built environment,*** includes the streets, neighbourhoods and cities in which people live and therefore could feature housing, services and amenities, town squares, parks, public open space and urban greenspace. The built environment is inclusive of both structural and physical elements and the social processes that these elements support (Hancock, 2000; Corburn, 2015).

Public Open space is a common term utilised in the literature which refers to public spaces within the urban environment that are accessible to the community for recreational sporting, play and social needs (Koohsari et al. 2016). The ***Natural environment*** includes a range of environmental spaces: public open space, playgrounds, local parks, playing fields and reserves, larger national, recreational and conservation parks and oceans and wilderness. The term ***greenspace*** is used in the thesis as a composite term for these environmental spaces, and the elements and nature that are found there i.e. plants, animals, soil water and air (Maller et al. 2006, p.46).

1.5 Thesis Structure

My thesis is structured into 7 chapters.

The next chapter, Chapter 2, presents the literature relevant to the research questions that have guided the research, drawing on information from key academic and government resources.

Chapter 3 presents the theoretical framework underlying the research design, explains the use of qualitative methodology and describes the methods of data collection employed during the research.

Chapter 4 – 6 present the Research findings. Chapter 4 presents the data from the Health sector, Chapter 5, the Natural Environment sector and Chapter 6, the Built Environment sector. Each findings chapter utilises the same structure: first, the analysis of the selected policies identified as pertinent to the research is presented; second, the interviews from key policy actors are examined; and third, analysis of both documents and interviews pertinent to the nested case study is provided.

Chapter 7 presents the Discussion and Conclusion, linking the findings to the research questions and the literature. It contains acknowledgement of current achievements in relation to state based mental health promotion, provides policy and practice implications to further develop and strengthen mental health promotion and outlines the overall contribution made by this research.

CHAPTER 2 LITERATURE REVIEW

In this chapter I position my research within the relevant bodies of literature. I examine relevant academic and grey literature to explain the following:

- The rationale for investigating mental health promotion given the increasing incidence, prevalence and burden of disease associated with mental illness
- Current approaches in Australia to addressing mental illness which currently serve to:
    1. focus health sectors primarily on treatment, rather than promotion and prevention and
    2. distance other sectors from active roles in enabling universal mental health and psychological wellbeing
- The associations between mental health inequity and the social determinants of health and mental health
- How the natural and built environments contribute to mental health and psychological wellbeing

2.1 Literature search strategy

At the beginning of my doctoral studies I consulted the Flinders University subject librarian to discuss my research and ensure the development of a research strategy was both comprehensive but specific to my subject matter. I was advised to review literature from the following databases: CINAHL, Psych INFO, Medline, Scopus and Web of Science. I also reviewed literature from the World Health Organisation (WHO), with a specific focus on the literature concerning mental health. Relevant grey literature and policy from the Australian federal and state governments was also reviewed, as were reports from Australian non-government organisations and research institutes. My initial search terms were social determinants of health, mental health, population health and environment and these terms supported the development of my research proposal. I specifically defined two fields relevant to mental health to ensure the literature I was obtaining was relevant to mental health as opposed to mental illness, as explained below. I have included the initial search results which illustrate the predominant use of the term mental health for what is fact, mental illness.

#	Mental health/Lived experience of mental health/mental illness/mental disorders (adjustment disorders, anxiety, dissociative disorders, delusions, schizophrenia, impulse control disorders, attention deficit and disruptive behaviour disorders, mood disorders, depression, personality disorders, somatoform disorders, psychoses, self- harm, suicide)	735803
#	Mental health/Psychological wellbeing/Resilience (happiness, eudaemonic wellbeing, positive emotion, flourish)	111628

Table 2.1 Search Strategy

I cross-referenced those results with policy and health promotion and identified two environment fields, built environment and natural environment to enable further refinement as I progressed my research. I also set up alerts through Scopus to ensure I remained aware of further research and in addition to this formal research strategy, I reviewed the references of the articles I read, which was an effective process allowing my understanding of which authors and journals were producing and publishing research that was relevant to my research subject matter. In addition, I followed up on suggestions made by my supervisors and as my research progressed, research participants.

2.2 The incidence and prevalence of mental illness: providing a rationale for a focus on mental health

In this section I consider the incidence and prevalence of mental illness across a global, national and local level and draw attention to arguments made that support an increased focus not only on treatment of mental illness but on attending to the conditions that enable mental health. Globally, the *WHO Mental Health Action Plan 2013-2020* (2013) proposes a range of strategies to meet the differing needs in low, middle and high-income countries. For those in low and middle-income countries, the *Action Plan* lists poverty, low education, social exclusion, gender disadvantage, conflict and disasters as the major social determinants of mental disorders; reports that mental disorders account for 11.1% of the burden of disease; and highlights the scarcity of treatment and resources. For high income countries, the *WHO Action Plan* highlights that despite improved access to treatment and resources there is a growing incidence and concurrence of mental disorders; reports that mental illness, neurological, and substance disorders, collectively accounted for 13% of the burden of disease in 2004, specifically highlighting the rising incidence of depression. The significance of depression was also highlighted in the recent *WHO Global Burden of Disease Study* (Institute for Health Metrics and Evaluation, 2018) with depression reported to be one of the top five contributors to disability. Murray and Lopez (1996) estimated that by 2020 depression would account for 20% of the burden of disease.

The results disseminated by the *WHO Global Burden of Disease Study* have been questioned regarding the underestimation of the global burden of mental illness by disaggregating a range of psychiatric, psychological and neurological conditions which Patel et al. (2018) suggest fails to represent the magnitude of mental illness as a problem. The authors highlight depression, dementia and alcohol and drug use as significant contributors to burden of disease, as did Hermann et al. in 2005. They clearly state that the global burden of disease attributable to mental disorders has increased and continues to increase in all countries. They emphasise the growth of mental illness in the context of major demographic, environmental, and socio-political transitions and further, that despite the incidence and prevalence of mental illness, government investment in promotion, prevention or treatment across the globe, remains small, representing a collective failure to acknowledge or respond to the mental illness crisis.

From a national perspective, the Australian Institute of Health and Welfare (2019) using aggregated data list mental and substance use disorders to also be the second largest contributor (24%) of the non-fatal burden of disease, behind musculoskeletal conditions (25%). They additionally reported that the lowest socioeconomic group experienced a total burden of disease 1.5 times as high as the highest group, highlighting the correlation between the disadvantage and the development of mental health illness. The data indicates the presence of a social gradient in mental health outcomes where the lower on the social ladder the worse one's mental health is (Marmot & Wilkinson, 2011) although all people are affected by relative socioeconomic status. This mental health inequity was also found to be present for younger Australians with growing rates of mental health issues for younger people reported i.e. in 2014-2015, 15.4% of 18-24 olds suffered high to very high psychological distress, previously reported at 11.8% in 2011 and 33% of young Aboriginal and Torres Strait Islanders estimated to have a mental health condition (Australian Research Alliance for Children and Youth, 2018). Additionally, suicide rates for younger Indigenous Australians were reported to be three times that of non-Indigenous Australians at a rate of 39.2% per 100,000 population in 2016, up from 33.0 in 2007.

Further national statistics have been taken from the *National Review* (2014). The review documents the incidence of mental health issues in the population, reporting that each year 3.5 million of Australians experience mental illness, predominately depression and/or anxiety, that is, 20% of the adult population. Further, each year, 600,000-young people between the ages of 4-17 also present with mental health issues (1 child in every 7). The following graphic highlights a snapshot of the extent of documented mental illness in the population in 2014.

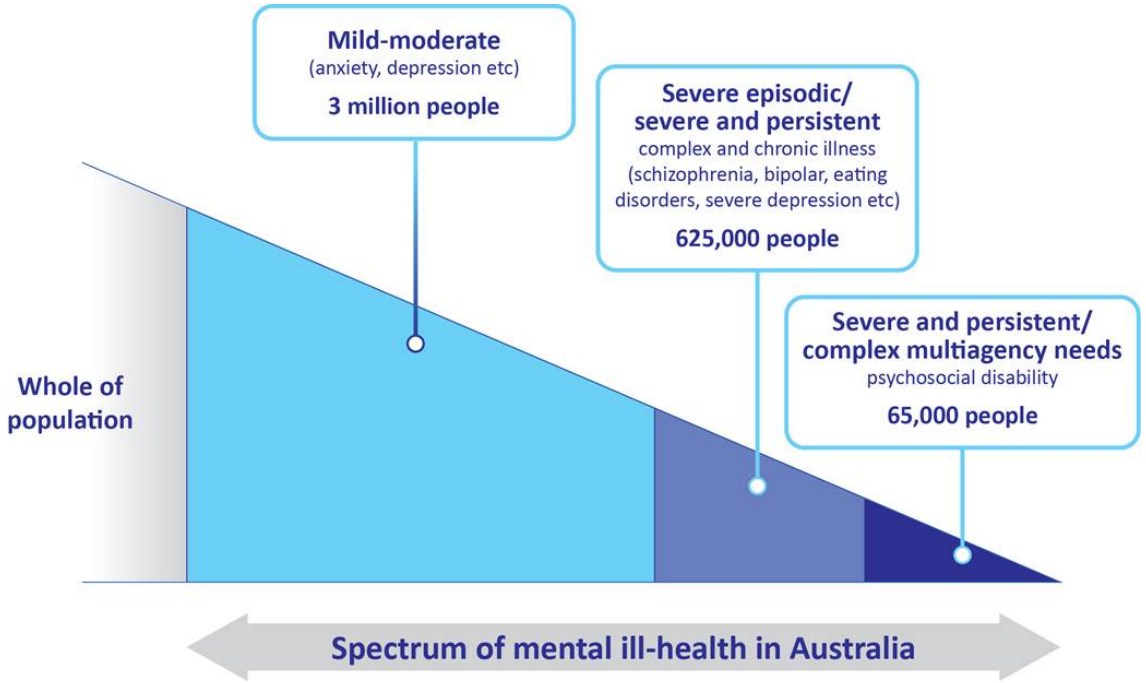

Figure 2.1 Spectrum of mental ill-health in Australia (National Review, 2014, p.8)

Confirmatory evidence is offered by *Beyond Blue*, *Mind* and *SANE*, key Non-Government Organisations (NGO's) working in the mental health arena. They report that mental health issues are at 'epidemic' levels. From their websites: *Beyond Blue* report that 1 in 5 adult Australians have depression and 1 in 4 have anxiety (Beyond Blue 2019); and *SANE* and *Mind*, report that 1 in 5 adult Australians have a mental health issue each year (SANE Australia 2019; Mind Australia 2015). As discussed later, this evidence is also confirmatory of the dominant presentation of perspectives based on the diagnostic biomedical model within the mental health (read illness) field.

The *National Review* (2014) also reported on national suicide rates, that is, 11 deaths per 100,000, stating that suicide is the leading cause of death in people aged 15-44, with Indigenous Australians, those living in rural areas and men overrepresented in suicide statistics. This is consistent with the WHO report of the global suicide rate in a similar time period: 11.4 deaths per 100,000, in 2012 (WHO, 2013). The *National Review* emphasises the disturbingly high suicide rate for Indigenous Australians, that is, 22 deaths per 100,000, far exceeding current national and global figures. In relation to Australia, Larson, Gillies, Howard & Coffin (2007) draw attention to the high rates of suicide and persistent mental health inequities as consistent with experiences of racism. Hatcher, Crawford & Coupe (2016) highlight the links between suicide, mental illness and the ongoing intergenerational impact of grief and loss, secondary to colonisation. High suicide rates have also been found in Canadian and New Zealand Indigenous populations (Hatcher et al. 2016). The unequal differences in the above health statistics across ethnicity, demonstrate mental health inequities, which are largely attributable to racism, dispossession and dislocation i.e. social and structural factors that are highly significant drivers of health and mental health.

Where inequalities are unfair and considered avoidable and where action could be taken to address these inequalities, mental health inequities are produced (Marmot & Allen, 2014).

From a local South Australian perspective, current data reveal the following:

- The percentage of the population experiencing high or very high levels of psychological distress, is currently reported at 11.9% (SA Health Performance Council, 2017), as measured by the Kessler Questionnaire (K10). [Both high and very high levels of distress are equivalent with a diagnosis of major depression, Kessler at al. (2002)]. Data additionally indicates that those with lower socioeconomic status have higher levels of psychological distress.
- Over a 10-year time period (1998-2008), a study specific to South Australia found a significant increase in the prevalence of major depression from 6.8% to 10.3% (Goldney, Eckert, Hawthorne & Taylor, 2010).
- The University of Adelaide (Population Health and Outcome studies, 2013) indicated consistently high levels of psychological distress (also indicated by the K10) which were also maintained over a 10-year period (2003-2013). They reported 9.1% of the adult population had high or very high levels of psychological distress and further that those in the lowest socioeconomic group had higher levels of psychological distress.

In relation to the first point, an example of the social gradient in relation to psychological distress and mental illness has been drawn from recent survey statistics from the population of South Australia (SA Government Health Performance Council, 2017). Social gradient refers to a *pattern of health outcomes* related to differences in measures of socioeconomic status (SES) and in the following graph the lowest socioeconomic status (SES) quintile, reports a psychological distress percentage of 17.1% and the highest SES quintile, 9.5% and although the linearity is imperfect in this instance, the pattern is apparent.

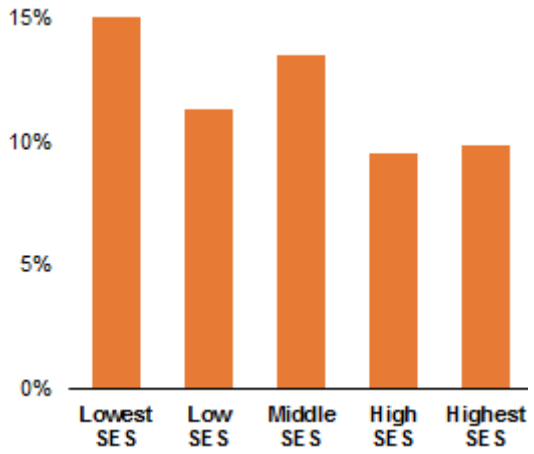

Figure 2.2 Psychological distress in South Australia by SES (SA Health Performance Council, 2017)

Thus, the increasing incidence and prevalence of mental illness are evident on a global, national and state level. What is not represented in these statistics is the human impact of mental illness, a stigmatised illness that disrupts relationships, education and occupations, ends lives prematurely and impacts not only individuals but families and communities (Frances, 2013). Patel et al. (2018) reflect that the, "*Collective failure to respond to this global health crisis results in monumental loss of human capabilities and avoidable suffering*" (p. 1553).

This thesis takes the starting point that the magnitude of the problem demands a population-based model to support and address the underlying causes of increasing psychological distress and mental illness, in addition to current biomedical approaches. Further, it will be argued that there is a need to shift the focus from primarily addressing mental illness to additionally promoting mental health as is recommended in the *WHO Mental Health Action Plan* (2013-2020). In building this argument, I initially review current approaches to mental illness in Australia.

2.3 Current approaches to address mental illness

2.3.1 Focus on Individual Treatment rather than Promotion and Prevention

Current responses to the increasing incidence of mental illness in Australia, are strongly reflective of an individual illness focus utilising a dominant medical and pharmacological treatment paradigm. A reported 87.5% of the national mental health budget is allocated to individual treatment, which includes 20% allocated to hospital inpatient care (National Review, 2014, p.9).

Further confirmation of the dominance of individual treatment in mental health is highlighted in the following examples which reflect concerns about the individual treatment model across political, commercial, community and service delivery arenas.

- The *Senate Select Committee on Mental Health* (2006) reported evidence showing that the bulk of mental health care resources are allocated to acute clinical care and the treatment of mental illness through hospital-based services, finding that funding was not reflective of the burden of disease and that current approaches would do little to address inequity and decrease unmet need.
- *Medibank Private* (2013) acknowledged that while Australian governments had made significant policy commitments and funding improvements to improve access to individual mental health treatment since the early 1990's, outcomes were suboptimal, and that mental health system reform is required.
- *Mental Health Services of Australia* (2018) reported a significant increase in the proportion of Australians accessing individual treatment options for mental health disorders, from 5.7% in 2008-9 to 10.2% in 2017-18.

- Stephenson, Karanges and McGregor (2013) reported a dramatic escalation of the use of psychotropic medication in Australia over the time period 2000-2011: 58.2% increase in the dispensing of psychotropic medication and 95.3% increase in antidepressant medication.

The current dominance of the individual treatment paradigm in relation to mental illness has been shaped by a range of past and present political, social and cultural factors. The following authors elaborate on these factors and their influence on health systems, policies and practices in developed economies.

- Busfield (2000) wrote of the rising ascendency and valuing of medicine and the life 'biological' sciences in understanding and treating health including mental health. She reflected that as medicine and biological sciences have progressed, the social sciences have been backgrounded and that the contribution of sociology and anthropology to understanding individual or population mental health outcomes has been devalued.
- More recently, Lupton (2012) and Rose (2016) reflected on a similar theme, proposing that the exponentially increased knowledge base in neuroscience, neuroplasticity and epigenetics, has resulted in a devaluing of the environmental and social factors influencing mental health and wellbeing. Both suggest there is an increasing dependence on medical science and technology to provide answers to social as well as medical problems.
- Healy (2004) wrote of the medicalisation of social problems, highlighting the dominant conceptualisation of depression as a biochemical disorder and the associated pharmaceutical solutions which are promoted within a neoliberal market economy.
- Stavropoulos (2008) theorised that Australian culture, being strongly characterised by an increasing focus on individualism, materialism and rationalism, has increased psychological stress in relation to the need to achieve, acquire and cope. She emphasises that this stress is predominantly addressed through individual treatment that is focussed on amending individual cognitions, not on addressing the predisposing social conditions.
- Harvey (2007) and Baum (2015) both theorise about the links between political systems and health, linking neoliberalism, individualism and the expectation for individuals to assume a greater personal responsibility for their wellbeing. Baum (2015) writes of the growing inequities inherent in key neoliberal processes: deregulation, globalisation and corporatisation. She indicates that as inequalities and inequities increase through a neoliberal approach, the health and mental health of individuals and populations is negatively impacted.

Commenting on the current focus on individual mental health treatment, Hickie, Rosenberg & Davenport (2011) and Jorm & Reavley (2012) have iterated increasing concern for a number of years with the overinvestment and reliance on treatment modalities and failure to shift the focus to population mental health for a number of years.

They refer to the overinvestment of funds directed towards individualised treatment options such as the *Better Access to Psychiatrists, Psychologists and General Practitioners* scheme, which has enabled Australians to access free or affordable individual treatment. However, Hickie, Rosenberg et al. (2011) suggest that the directing of funds towards individualised treatment has had the unintended consequence of decreasing the focus on mental health promotion and prevention, against evidence to the contrary (Hosman et al. 2004; Hermann et al. 2005; Barry & Jenkins, 2007; Barry 2009; Allen, Balfour et al. 2014). The scheme has also been questioned for its efficacy and equity outcomes which has failed to deliver options and outcomes for those in rural and remote areas and for those with more complex social issues (Meadows & Bobevski, 2011; Allen & Jackson, 2011). Recently Jorm (2018) has reiterated that the scheme "*has not had a detectable effect on the prevalence of very high psychological distress or the suicide rate or on the mental health of the Australian population*" (p.1058).

Allen & Jackson (2011) state, "…*if it is not effective, then the programme represents misspent funds and an enormous opportunity cost, in the sense that the money could be spent on other programmes that might be much more influential in improving the mental health of Australians*" (p.696). This comment aligns with the key message from the *National Review (2014)* which stressed the need to "*rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community support, stable housing and participation in employment, education and training*" (p.7).

The *National Review* (2014) highlighted the need to progress a "*proactive, strategically aligned system that shifts the centre of gravity of funding away from the acute, crises end, towards prevention, early intervention and community services which reduce the onset of illness, complications and crises*" (p.13). In presenting a plan for achieving this paradigm shift, the *National Review (2014)* emphasised the need for a system change to address the current predicament by engaging other sectors to 'enable contributing lives' (defined by the Commission as engaged in both the economy and the community) by supporting education, employment and meaningful relationships, as illustrated below.

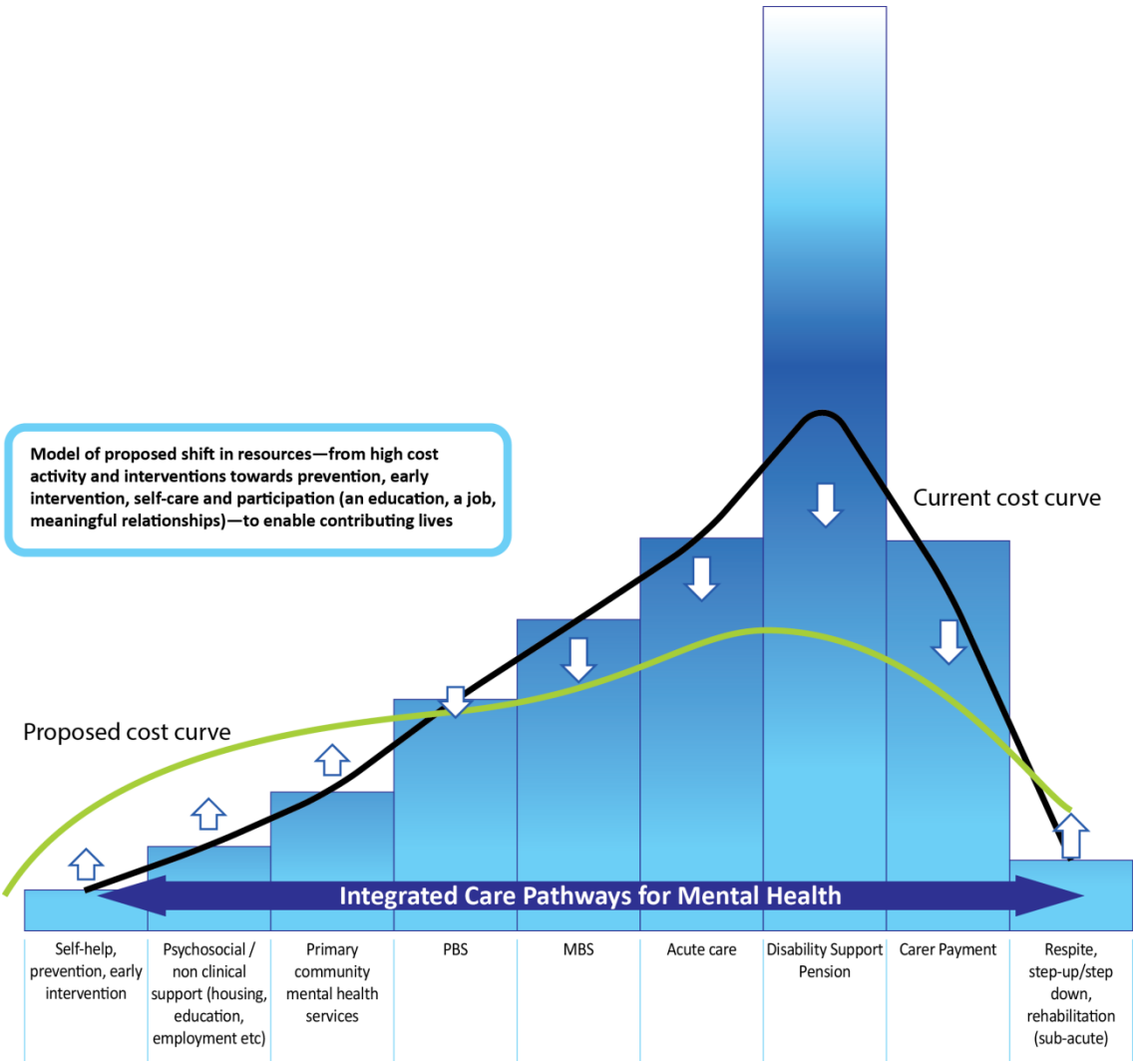

Figure 2.3 Model of proposed resource shift (National Review, 2014, p.15)

Despite this, the *Fifth National Mental Health and Suicide Prevention Plan (2017-2022)* fails to acknowledge and articulate plans for prevention or promotion strategies. Strategies largely concern treatment modalities and service delivery plans for those with mental illness, failing to prioritise promotion, prevention or early intervention strategies (Government of Australia, 2017). The plan has been criticised by key mental health agencies, the *Black Dog Institute* (2017) who state that the plan is silent on prevention and *Orygen Youth Mental Health* (2017) who state "*The Fifth Plan still remains heavily health system orientated, with governance arrangements centred on health and mental health ministers. As a result, it doesn't connect to the other systems central to an individual's wellbeing such as housing, education and employment. This is despite the articulation early in the document of the importance of these systems in mental health and wellbeing outcomes*" (p.5). Thus, even when the need to involve other sectors and address broader social and structural issues is raised, it fails to eventuate, as is consistent with lifestyle drift in which the social and economic determinants are undermined by individual practices (Popay, Whitehead & Hunter, 2010; Baum & Fisher, 2014).

In summary, downstream approaches to provide mental health care and treatment are needed but not in lieu of upstream approaches to address the systemic and structural causes of disadvantage and social injustice that predispose individuals towards mental illness and impact mental health and psychological wellbeing (Sturgeon, 2007; Patel 2015; Wahlbeck, 2015). To do this, population mental health approaches that work across all sectors are required. "As many determinants of health and particularly mental health, largely lie outside the health sector, addressing promotion requires an understanding and commitment from stakeholders from many constituencies" (Sturgeon, 2007, p.39).

2.3.2 Distancing other sectors from active roles in promoting mental health and psychological wellbeing through universal approaches

In this section I discuss the literature that evidences the need for mental health promotion that is comprehensive, intersectoral and collaborative to progress both population and individual health. The literature also confirms the need for health sector involvement to advocate for and guide the development of effective policies, programmes and services in other policy sectors to benefit population mental health.

Barry's (2001) model of mental health promotion is detailed below (Figure 2.4). This model extended the Mzarek & Haggerty (1994) model, which highlighted the need for a spectrum of approaches to support, treat, maintain and strengthen mental health, by identifying the need for promotion, prevention, early intervention and treatment as necessary health-based approaches. Barry extended the model outside of Health, integrating the need to work at an intersectoral and community level and adopting an 'upstream approach' by including *Supportive Environments*, one of the strategies of the Ottawa Charter for Health Promotion (1986). The charter advocates for action to be directed towards improving health and health equity, which it does through five defined strategies which focus on policy, community and intersectoral collaboration: *Creating supportive environments*; *Building healthy public policy; Strengthening community action; Developing personal skills;* and *Reorientating health services.* It remains central to health promotion today (Hancock, 2011).

By linking mental health promotion to both ends of the spectrum i.e. universal prevention and after care rehabilitation Barry progresses the idea that mental health promotion is relevant to all, despite current mental health status.

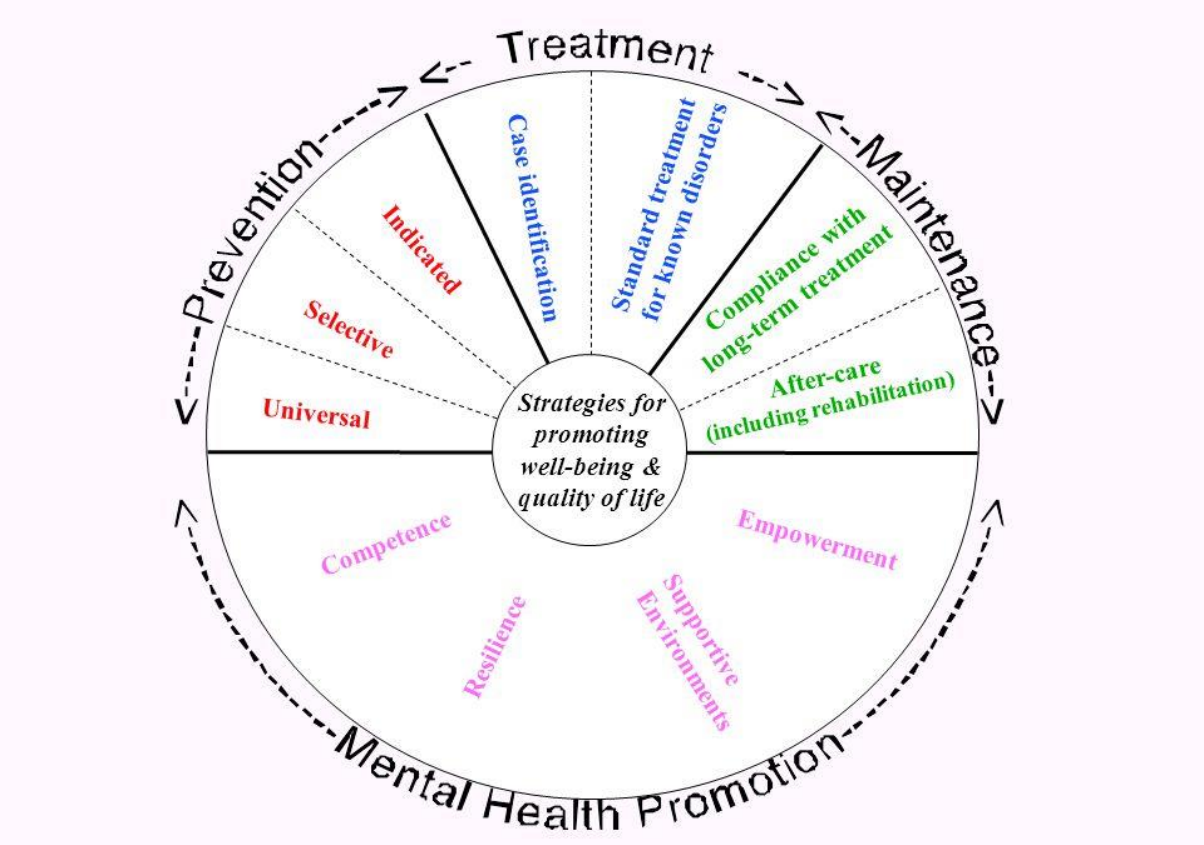

Figure 2.4 Model of Mental Health Promotion (Barry, 2001)

The inclusion of 'supportive environments' and 'empowerment' in the model are significant, as they highlight the necessity for change in the social and environmental conditions, to enable mental health.

Supportive environments are universal approaches, in that they support the mental health of all as highlighted by Jane-Llopis et al. (2005), who stress the importance of identifying and cultivating the preconditions of mental health to enable both individual and community wellbeing. They articulate the need for a *Healthy settings* approach, such as *Healthy Cities* but also *Healthy Schools* and *Healthy Workplaces* highlighted by Allen et al. (2014). *Healthy settings* is an approach to health promotion, originally proposed in 1980 and *Healthy cities* is the best-known example of the *Healthy settings* approach. Detailed by Hancock and Duhl (1986) *Healthy cities* involves the development of holistic and multi-disciplinary methods specific to site, which integrate action across sectors to support health in urban settings. More recently, the need for urban planning which prioritises environmental health and sustainability has been reinforced (Hancock, Capon, Dooris & Patrick, 2017). Cole et al. (2017) however, have stressed the difficulty in achieving social equity and environmental justice through *Healthy Cities*, given the strength of current market orientated economies suggesting that intersectoral health initiatives need to be politically supported to achieve reductions in health inequities.

Healthy schools highlight the role of education as a partner in supporting the mental health of children. Access to schools provides good education, healthy social networks and broader connections in community, potentially delivering the greatest benefits to mental health and wellbeing across the lifespan (Friedli, 2009; Allen et al. (2014); WHO, 2014b). *Healthy Workplaces* highlights the need for decent work, decent work conditions and an equal, fair and living wage, which is a universal approach that has relevance across the lifespan (WHO, 2014b). Trennery, Franklin & Paradies (2012) make the point that a healthy workplace is also culturally safe.

Applying both universal (settings focussed) and targeted strategies (population focussed) to reduce the potential for the development of mental health issues at key transition points across the lifespan is recognised as a major mental health promotion strategy, that is at: conception, pregnancy, infancy, early childhood, adolescence, ageing and at other times of difficulty, such as unemployment or family change. (Barry, 2007; WHO, 2014b; Allen et al. 2014). Both approaches require systemic practice which prioritises intersectoral and collaborative approaches, bringing together sectors, such as health, transport, education, housing, welfare and urban planning to advance health and mental health outcomes. However, as discussed in the previous section, the predominant focus on individual treatment fails to progress these approaches which have the potential to address the disadvantage and social determinants that underlie the burden of mental disorders and the social and structural factors that engender mental health inequity. As I do in this thesis, other Australian researchers have questioned current approaches to addressing population mental health (Sebastian, Mendoza & Russell, 2012; Jorm, 2018) and along with Herman (2001) and Parham (2007) have strongly advocated for mental health to be addressed within a public health and population framework.

Central to population approaches is the understanding that to prevent illness, including mental illness, attention needs to be paid to the 'causes of incidence' (Rose, 2001). That is, by applying universal prevention-based activities to the social and structural 'causes of incidence', the health status of the population is improved. Recognition of the need to view mental disorders as population health problems and not as an individual-brain disease that requires clinical treatment is progressed by a number of researchers (van Os, 2015; Gureje, 2015) and Wahlbeck (2015) stresses the time is nigh to enact the evidence that relates to population based mental health interventions. These researchers all stress the need for public mental health approaches that shift the focus from an individual to a population level, an action that would additionally do much to reduce the stigma and discrimination associated with diagnosis.

Wahlbeck (2015) and Hancock (2018) both claim that mental health issues have been neglected in public health agendas, arguing that given the social determinants of health and mental health largely lie in non-Health policy domains, universal approaches such as *Health in all Policies* or *Healthy Cities* are required, as well as targeted approaches that address mental health inequalities.

Modification of the natural and built environments as a key strategy to improve population health and mental health outcomes, is highly considered by Hancock (2000) and Corburn (2009; 2013) as is discussed later in this section.

The discussion of current Australian approaches in relation to mental health, in 2.3, indicates a significant failure to adopt a population or public mental health approach and it would appear that little has changed since Parham (2007) reflected on Australian policy and practice in mental health 12 years ago. She highlighted the need to shift mental health policy towards a population and public health framework, stating, "…*treatment interventions alone can't significantly reduce the burden of mental illness… prevention and promotion approaches are important in order to achieve this*" (p.173). Parham warned of the need for Federal leadership and governance to support public mental health policy and practice, given the dominance and embedded nature of the medical model in current national and state health systems. As the evidence in Chapter 4 will demonstrate, this has failed to occur.

In relation to federal leadership and governance in health, Hurley, Baum, Johns and Labonte (2010) report that Australian health policy is more focused on addressing individual health and less focussed on community and population-based factors. In relation to the South Australian health context, Littlejohns (2016) reported an absence of health promotion building blocks, including leadership and governance, disabling health promotion; and Anaf et al. (2014) reported an overt focus on policy and funding for practice that prioritises individual behaviour change, as is consistent with the phenomena of lifestyle drift (Popay, Whitehead & Hunter, 2010).

An example of lifestyle drift in relation to mental health is seen in the following poster which provides evidence of practice that ensues when policy in mental health focuses on illness as opposed to health and the individual as opposed to the population. The poster was disseminated nationally by *Mental Health Australia*, in October 2014, for Mental Health week. It provides an example of an individualised approach to mental health promotion and the increasing demand for individual responsibility in terms of health.

Figure 2.5 Mental Health Week Poster (Mental Health Australia, 2014)

Baum & Dwyer (2014) question whether the present system embedded in a free market economy, can adequately serve to promote population health and equity or contain health costs, indicating the broader concern with impact of our current socioeconomic and political frameworks (Labonte, 2016). In relation to these broader concerns, Baum states, "no public health student can afford to ignore the powerful impact that political or economic arrangements have on the health of populations" (2015, p.145) and I address that here. Neoliberal approaches are characterised by the dominance of the free market economy, reduced regulation and an elevation of economic priorities over social and environmental imperatives (Harvey, 2007), which is highly problematic to public health/mental health (Labonte & Stuckler, 2016). Baum states, "Public health is an essential element of nation building that is threatened by undue emphasis on economic considerations (2015, p.134). Specifically, the ability to achieve public health aims, such as improving population health and wellbeing and reducing health inequity, is significantly compromised by a neoliberal approach which links wellbeing to the economic imperative (Labonte & Stuckler, 2016). Failure to employ progressive taxation or other re-distributive policy approaches, concentrates wealth, creating social inequalities and contributing to health inequities (Harvey, 2007) a situation contrary to the second overarching recommendation of the Commission on Social Determinants of Health (2008) - *Tackle the inequitable distribution of power, money and resources*. Relative to this, the Commission called for "*health equity to become a marker of good government performance*" (CSDH, 2008, p.11).

However, in 2014, Friel reported the social structural determinants of health remained unaddressed and there was *no fair go for health* at the moment.

In conclusion, this section has presented information on the rising levels of mental illness globally, nationally and locally; research that details and questions the current approaches to addressing mental illness; and failure to practice a broader set of approaches to address population mental health. Despite the National Mental Health Commission (2014) stressing the need for action to redistribute resources across acute care, prevention and promotion and work collaboratively across sectors to address the social determinants of mental health, the current National Mental Health plan – 2017-2022, has been widely criticised for its failure to respond and has been found lacking. To progress this argument further, I now discuss the literature relevant to the social determinants of health and health equity, specifically drawing attention to the relationship between access to the social determinants of health and improved mental health.

2.4 Mental Health Inequity and the Social Determinants of Health

In this section I review the literature relevant to mental health inequities and the social determinants of health and mental health. This is consistent with the understanding that health and mental health are enabled when people have access to the social determinants of health, that is access to adequate housing, healthy food, safe communities, education, employment and financial security, social supports and public transport (Wilkinson and Marmot, 2003). It is also enabled when people have access to healthcare (Whitehead, 1991) which is itself, a social determinant of health but as the following graphed estimates display, the percentage of influence that the social determinants have on health outcomes exceeds healthcare. The following estimates have been put forward by several researchers and although these estimates vary, all serve to demonstrate the profundity of the influence.

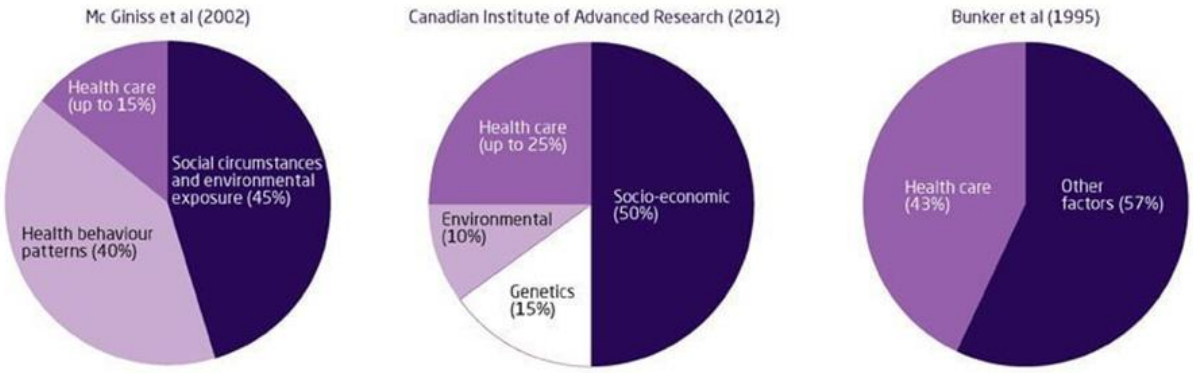

Figure 2.6 Estimates of factors influencing health outcomes (McGinnis, 2005; Canadian Institute of Advanced Research, 2001; Bunker et al., 1995)

Marmot and Allen (2014) stress that too often "*health is only equated with health care*" (p.513), reflecting the previous discussion regarding the current dominance of individual treatment options. This is despite the depth of evidence developed by the CSDH (2008) and presented in the *Closing the Gap in a Generation* report and further evidence relative to the need to address the social determinants of health and health equities (Whitehead, 1991; Solar & Irwin 2010; Whitehead & Dahlgren, 2006; Marmot et al. 2008). To address these issues, three overarching goals were articulated by the CSDH (2008): 1. Improve daily living conditions; 2. Tackle the unequal distribution of resources; and 3. Measure and document outcomes, which all require the involvement and collaboration of a wide range of sectors. The *Closing the Gap* report, indicated that to achieve these goals, "Action on the social determinants of health must involve the whole of government, civil society, local communities, business and international agencies. Policies and programmes must embrace all sectors of society, not just the health sector" (Marmot et al. 2008, p.1661). Such action must support social and community participation enabling people to have a level of control over their lives.

The Dahlgren and Whitehead Rainbow model (1991) below, provides a visual display of how health is impacted by the work associated with a range of sectors, not only health care services. It is the first of two socioecological models that I use to highlight how individual health and mental health is impacted by a range of wider economic, social and environmental factors.

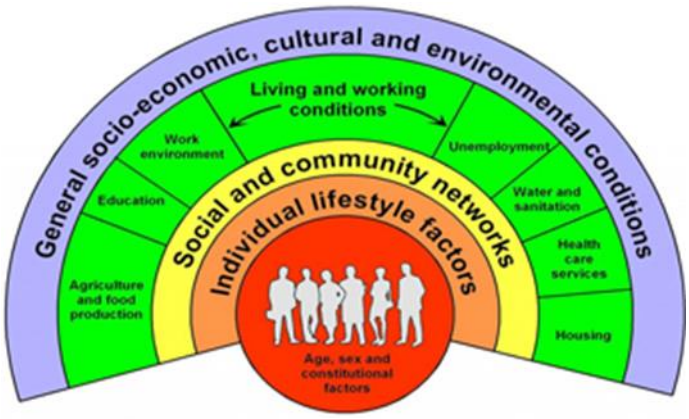

Figure 2.7 The Rainbow model of health (Dahlgren and Whitehead, 1991)

As indicated in the *CSDH Framework*, however, it is the structural determinants and conditions of daily life that enable access to the social determinants of health which in turn support health and health equity outcomes. *Health inequalities* relate to any difference in health status between population groups, health *inequities* are those health inequalities understood to arise from avoidable differences in socioeconomic or cultural conditions and are therefore deemed to be unfair or unjust (Whitehead, 1991). Given this definition I regard systemic inequalities in mental health related to socioeconomic status as a form of health inequity.

The *Closing the Gap* report identified the social injustice produced by the unequal distribution of resources that enable health, stressing the need for political and social action to address these difficulties. However, since this time the need remains outstanding and the imperative to reduce health inequities continues to be reiterated (Wilkinson and Pickett, 2011; Popay, Whitehead & Hunter, 2010; Friel, 2014) as does the imperative to reduce mental health inequities (Whitehead, 1991; Friedli, 2009; Allen et al. 2014; WHO, 2014b).

The outstanding need to invest in structural and systemic actions to address the incidence and prevalence of mental illness, reduce mental health inequities and enable population mental health and psychological wellbeing is a common theme in the literature (Barry, 2007; WHO, 2014b, Patel, 2015). The ethical dimension associated with investing in structural and systemic change is highlighted by Hermann et al. (2004) who state, "*A climate that respects and protects basic civil, political, economic, social, and cultural rights is fundamental to the promotion of mental health*" (p. 11).

Following that theme, Friedli (2009) recommended five principles to progress population mental health including social and structural recommendations: reducing the policy barriers to social contact; enabling intersectoral partnerships with health; supporting fair and healthy workplaces and conditions; fostering the social, economic and cultural conditions that enable families to prosper; and providing education that supports children emotionally and developmentally.

Friedli (2009) also makes the point that improving population health is important given the reciprocity between individual and population health and that in attending to the social determinants of health, both community and individual mental health are improved. Reflecting the *National Review's* (2014) resolve to 'enable contributing lives', she stresses that mentally well people are more able to participate in, and support community and reciprocally, that healthy community will foster individual mental health and psychological wellbeing.

Further principles and actions are clearly articulated in the *Social determinants of mental health* (WHO, 2014b) and stress the need to:

- Invest in whole-of-government policies which will improve mental health
- Take action to reduce the steepness of the social gradient with both universal and targeted approaches
- Support intersectoral action across multiple sectors
- Implement life-course and early intervention approaches
- Take into account the relationship between mental and physical health
- Consider Health Inequity Assessments (HIA) to ensure policies and strategies will not harm mental health
- Support country wide strategies to address key problems such as poverty, discrimination and violence and implement these locally
- Commit to long term and sustained policies that focus on reducing inequalities

The WHO has long recognised and disseminated the urgent need to address *health inequity*, which was reinforced in the *Alma Ata Declaration on Primary Health Care* (WHO, 1978), the *Ottawa Charter* (WHO, 1986), the Health in all Policies (Stahl, Wismar, Ollila, Lahtinen & Leppo, 2006) prior to the CSDH (2008). In relation to *mental health inequity*, the *Mental Health, Resilience and Inequalities* report (Friedli, 2009) and the *WHO Mental Health Action Plan* (2013-2020) reiterate the need to address mental health inequity to reduce mental disorders and promote mental health.

The CSDH (2008) report stressed that addressing health inequities is not only indicated by a raft of evidence but is an ethical imperative. "*The unequal distribution of health damaging experiences is not in any sense a natural phenomenon, but it is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements and bad politics"* (CSDH, 2008, p.1). The ethical imperative to address the intergenerational transmission of disadvantage is acknowledged in the title of the CSDH report, *Closing the Gap in a Generation* and Friel (2014) highlights the continuing inaction to address the social and structural determinants of health in Australia. She stresses the urgent need to address health inequities at the political and economic level through policy action to regulate the economy, redistribute income and provide citizen rights, integral to improved population health.

The significant difficulty in translating the *Closing the Gap* recommendations into policy (Braveman & Gottlieb, 2014; Baum & Fisher, 2011) and the need for research to identify the factors that enable or disable this translation is highlighted as a literature gap.

The social gradient in mental health was discussed previously in relation to levels of psychological distress for South Australians in 2.2, that is, whereby those at a lower level of socioeconomic status have somewhat worse mental health outcomes on average than those at a higher level. This form of mental health inequity effectively tells us how sensitive health is to socioeconomic factors and adds to the necessity and the impetus to address the social determinants of health to improve health outcomes universally (Marmot & Wilkinson, 2011). Friedli (2009) concurs, confirming the commonly occurring social gradient in mental health within many countries and the outstanding need for policies and programmes to support improved population mental health. Further, she emphasises that socioeconomic position is experienced on a societal level and that the person's perception of their positioning in the social hierarchy can impact identity, lower self-esteem and induce shame, negatively impacting psychological wellbeing and social inclusion and consequently impacting access to the social support so important to mental health.

There is a large literature base showing the association between mental illness, low socioeconomic status and disadvantage (Fisher & Baum, 2010; Taylor et al. 2012; Campion, Bhugra, Bailey & Marmot, 2013). However, given that the research focus is neither about mental illness nor disadvantaged groups but universal mental health (read health) it is only briefly mentioned. Literature, that conversely seeks to highlight the mental health gains associated with access to the social determinants of health has been less available and again I highlight this gap in the literature.

Mental health inequity in Australia

Wilkinson and Pickett (2011) stress that as societies become less equal, they experience greater health and social consequences and the *Australian Council of Social Services* [*ACOSS*], 2018 reports this to be true for Australia. Their Annual Report (2018) states that health inequities have become further entrenched as income and wealth inequalities widen, which leads to a "*fraying of the bonds of social cohesion and trust*" (p.14), potentially creating the pre-conditions for the development of psychological distress with predictable health, social and community impacts.

Mental health inequity issues are significant for all, however for Aboriginal and Torres Strait Islanders they are highly significant, given the extreme incidence of suicide and mental illness discussed previously. Baum & Dwyer (2014) highlight that maximising health outcomes for Australia's First Peoples is of utmost importance.

In the similarly named document to the CSDH (2008) report, the *Closing the Gap* (2008) initiative in Australia, has been implemented to address the health inequalities and inequities for Aboriginal people. However, progress has been limited and reports on the progress inertia (Australian Human Rights Commission, 2017) have been referenced back to funding cuts, failure to address the social determinants of health and lack of political voice, yet Indigenous Australians were recently denied a request for an Indigenous voice in parliament following the release of the Statement from the Heart document produced at an Aboriginal and Torres Strait Islander Referendum Convention held in 2017. This inaction was defined as 'indefensible' by Gordon (2017), is contrary to CSDH (2008) recommendations and inconsistent with policy that promotes the respect, rights and justice necessary to mental health (Herrman et al. 2004; Friedli, 2009). This political inaction highlights the ongoing failure to develop structural and systemic approaches to progress Indigenous health and mental health, although as will be discussed in the Discussion chapter, the Natural Environment nested case study provides some potential for effective policy action in this respect. Current federal inaction also highlights the outstanding need to address the ongoing impact of colonisation, lack of self-determination, and racism and discrimination of indigenous peoples, all highly implicated as causal factors in the development of mental illness (Larson et al. 2007).

With this knowledge, I now proceed to examine the literature relevant to the two non-Health sectors, the Natural Environment and Built Environment, in relation to their potential to develop policy and programmes and engage in intersectoral approaches that have the potential to contribute to population mental health and psychological wellbeing.

2.5 Mental health and the natural and built environments

2.5.1 Introduction

In the following section, I discuss mental health and the natural environment, followed by mental health and the built environment. I have reviewed the literature in this same section given their relatedness, which is also conveyed in the following socioecological model.

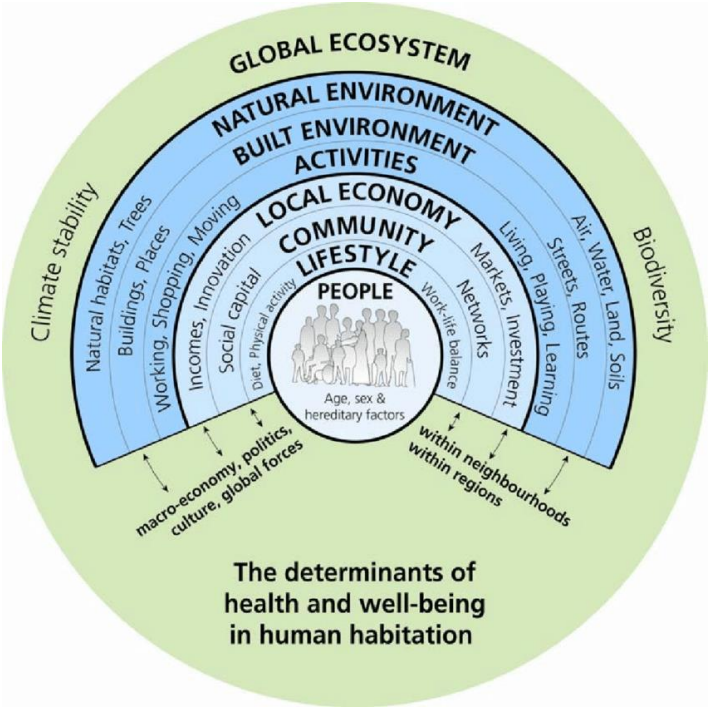

Figure 2.8 Settlement Health Map (Barton & Grant, 2006)

The Barton and Grant model (2006) utilised in the *WHO Healthy Cities* initiative, further develops the Dahlgren and Whitehead (1991) model with specific emphasis on the significance of the built and natural environments to health and mental health, making it directly pertinent to the two non-Health sectors being examined in my research.

As will be discussed, the literature identifies that the planning and building safe, connected and pro-social urban areas that integrate greenspace and contact with nature is integral to mental health and psychological wellbeing. There are specific factors that enable mental health in each the natural and built environments but in our increasingly urbanised world, the development of living spaces and places in which both are integrated is needed. For this reason, I introduce this section by briefly discussing urbanisation, which is changing the way we regard and relate to each other and the environment. I then take the position that it is by focusing on the relationships between people and place (*sense of place*) and people and people within that place (*sense of community*) that mental health is enabled.

Urbanisation

Statistics confirm that globally more people now live in urban areas and it is expected that by 2050, 70% of the global population will live in urban areas (WHO, 2010). Further, it is understood that planning for urban areas to support higher population densities is important to maximise available resources, minimise land use and protect the environment.

Leading public health researchers, Hartig, Mitchell, de Vries and Frumkin (2014), also highlight the significant and ongoing post-industrial changes in urban living in the developed world, citing the developments initially in mechanisation, and now in technology that have introduced significant change into how the majority of people live and work, impacting health and wellbeing, including mental health.

Urbanisation has resulted in people becoming distanced from the natural world, introducing significant change to how people live, being increasingly surrounded by more buildings and people and less nature. The natural world is additionally becoming degraded and polluted through the overuse of resources and climate change and McMichael, Friel, Nyong and Corvalan (2008) stressed over a decade ago, that climate change, environment degradation and loss of biodiversity, threaten not only the integrity of the environment but human health, and further that the resulting health risks will particularly affect the vulnerable and poorly resourced.

Urbanisation has also led to people living increasingly sedentary and isolated lives. Working in buildings and offices and traveling by car, results in reduced contact with the natural environment, reduced social connection and reduced opportunity for physical activity; effectively the preconditions for obesity, cardiovascular disease and depression. Barton (2016) highlights the connection between these increasing public health concerns and the built environment, stating, "…*in many ways we are building unhealthy conditions into the human habitat*" (p.6). In relation to mental health, he emphasises the need for urban environments to be built to enable social connection, community participation and cohesion but also to 'build in' access to greenspace.

Sense of place and sense of community

I introduce the psychosocial concepts of *sense of place* and *sense of community*, as these are important concepts which support a shift from the consideration of the person, to consideration of the relationships between *people & place* and *people & people.* The importance of these relationships was acknowledged by Thompson & Kent (2014) in their *Places Framework* which encourages an increased focus on how built and environmental features in a neighbourhood, shape the *person-place* and *person-community* relationship and in so doing support a focus on health and mental health as situated, relational and contextual concepts (Atkinson, 2013). *Sense of place* and *sense of community* are important relational concepts for mental health, for a sense of belonging to a physical place and/or a community can potentially protect and strengthen mental health (Francis, 2010; Francis, Wood, Knuiman & Giles-Corti, 2012). Corburn (2013) also discusses place and community, as relational concepts emphasising the need to understand these concepts as dynamic, in that they are constantly "*made and remade, enabled and stymied, valued or discounted by institutions and people"* (p.22).

Sense of place is a general concept used in the literature to describe the relationship between a place or space and a person (Jorgensen & Steadman, 2001). It is viewed as an umbrella term which includes *place attachment*, defined as positive emotional connection to certain landscapes or locations (Devine-Wright, 2013); *place identity*, defined as how physical and symbolic features of places are embodied in an individual's sense of identity (Devine-Wright, 2013); and *place dependence,* which refers to functional features of a place that facilitate certain activities and emotional connections (Brown and Raymond, 2007). Literature relating to the concept is minimal in public health according to Frumkin (2003) although interestingly the literature references 'displacement', that is the loss of a *sense of place* and its relationship to the development of mental illness, associated with the experiences of residents forced to leave their homes because of gentrification, refugees and migrants, Fly in - Fly out workers and international students. More recently the literature includes, solastalgia, which is a form of psychological distress caused by environmental change, most commonly ecosystem change brought about by the destruction of the ecosystem and/or climate change (Albrecht et al. 2007). Such change is disorienting and disruptive to our sense of place. Frumkin (2003) argued that *sense of place* is an important public health concept, stressing the need for further research and I identify this as a significant gap in the literature.

Sense of community is most frequently referenced in the literature as "a feeling that members have of belonging, a feeling that members matter to each other and to the group, and a shared faith that members needs will be met through their commitment to be together (McMillan and Chavis 1986, p. 9). Research detailing the positive links between *sense of community* and mental health is highlighted in the following publications: Ellaway and Macintyre (2001) who found that neighbourhoods characterised by social cohesion, that is, a *sense of community* were associated with better self-reported health and mental health; Kawachi and Berkman (2001) who reported that *sense of community* and participation is associated with fewer mental health problems and Francis et al. (2012), who reported that a strong *sense of community* is associated with improved wellbeing, increased feelings of safety and security, participation in community affairs and civic responsibility.

2.5.2 Mental health and the Natural Environment

Overview

In this section the literature relevant to the ability of the natural environment to promote mental health and wellbeing is examined. de Vries, van Dillen, Groenewegen & Spreeuwenberg (2013) identified three aspects to the health benefits of contact with nature: psychological, physical and social. Benefits are both discrete and inter-related and this section discusses the research specific to the discrete psychological benefits of contact with nature and then the interaction of psychological and physical benefits.

There are social aspects to contact with nature in urban settings, such as community gardens and I discuss these in the Built environment section, given these benefits are associated not only with natural environments but with public open space. I finish with a review of the literature relevant to equitable access to contact with nature.

Historically, the initial focus in the literature on mental health and the natural environment was on *psychological and attentional restoration* which continues to be a strong theme in the literature, however the knowledge base has expanded as related psychological constructs, such as *emotional regulation* (Korpela, Hartig, Kaiser & Fuhrer, 2001) and *mindfulnes*s (Wolsko & Lindberg, 2013) have developed. These three constructs and their relationship to the natural environment are discussed.

Psychological and Attentional Restoration

Research on the psychological benefits of contact with nature, has consistently accumulated over four decades (Kaplan & Kaplan, 1989; Ulrich et al. 1991; Grahn & Stigsdotter, 2003; Berto, 2005; Neilson & Hansen, 2007; Sugiyama, Leslie, Giles-Corti & Owen, 2008; Townsend & Weerasuriya, 2015; Schutte & Malouff, 2018). Long-time researchers in the field, Kaplan & Kaplan (1989) argued that the natural environment assists in psychological restoration by supporting recovery from mental fatigue, emphasising that sustaining attention is psychologically demanding given the need to inhibit alternative stimuli, thoughts or impulses. They proposed the Attention Restoration Theory (ART) in 1989, which outlines four components that constitute the restorative process:

1. Having time away from one's usual routines;
2. Being affectively engaged in an aspect of the natural environment;
3. Being immersed to the point of wanting to explore the environment; and
4. Having some level of personal comprehension and interpretation of the environment.

They present these processes, as mediators of the relationship between contact with nature and the level of psychological restoration that is enabled - processes that also enable the development of a *sense of place*.

Research has revealed that psychological restoration and stress reduction is enabled by wilderness areas, forests, reserves and parks (Ulrich et al. 1991; Kaplan, 1995). It is also enabled by urban or streetscape greenery and a window view of nature, whether that be from home or workplace (Tennessen & Cimprich, 1995, Kaplan, 2001; Hartig, Evans, Jammer, Davis & Garling, 2003). Additionally, greater benefit was noted to be associated with greener settings (Beil & Hanes, 2013) and specifically the presence of trees (Taylor, Wheeler, White, Economou & Osborne, 2015).

Ulrich (1979) proposed the Stress Reduction Theory suggesting that natural environments promote psychological restoration, as they have done throughout human evolution, because natural environments do not require higher levels of processing information.

This theory is closely related to Wilson's biophilia theory (1984) which hypothesises that people have an innate tendency to seek connection with nature. It is this connection that is hypothesised to have been disrupted by increased urbanisation which has served to distance of people from their natural environment. In relation to this, McMichael et al. (2008) stated, there is an urgent need for societies to recognise the intrinsic value of the environment, given its relationship to progressing development that preserves the natural environment and reducing environment degradation related to climate change. Naess (1973) discussed how the appreciation of nature supports not only ecological behaviour but diversity, symbiosis and egalitarianism, important notions that support the positioning of people as 'a part of nature', not, 'ruling over nature'.

Psychological restoration has been found to be linked to both quantity and quality of greenspace. The area size, attractiveness, the percentage covered by grass, the presence of water, the number of trees and bushes and the visibility of green elements from a viewing point, have all been found to be associated with psychological restoration (Giles-Corti et al. 2005; Nordh, Hartig, Hagerhall & Fry, 2009 & Largo-Wright, 2011). In relation to quality in an Australian setting, Francis et al. (2012) specifically highlighted the importance of trees, walking paths, shade, water features, lawn, birdlife, lighting (microfeatures) and access to sporting facilities and playgrounds positioned away from surrounding roads (macrofeatures). Payne (2013) expands our understanding of quality from an element based concept to an experiential concept, making the point that a number of these components are experienced through different sensory pathways, identifying that the restoration experience is multisensorial, i.e. the sound of birds and water, the scents of leaves and flowers, the feel of the wind, and not the sight, sound or smell of traffic.

Further, the quality of greenspace, specifically, public open space, has been highlighted by Francis (2010) as possibly more important than quantity.

Emotional Regulation

The concept of nature and experiences of nature as supporting the regulation of emotion has been specifically progressed by Korpela & Hartig (1996), Korpela et al. (2001) and Hartig et al. (2003). Korpela et al. (2001) proposed an 'environmental self-regulation hypothesis', additionally proposing that places we feel connected to and appreciate, are more likely to support emotional regulation and psychological restoration. Further research has reinforced the importance of the situated and relational aspect of the environment to psychological restoration (Korpela, Ylen, Tyrainen & Silvennoinen, 2010) as is expressed in the following statement: "...*place identity, place attachment and restorative experiences can be viewed as nested and reciprocally influential within self-regulation*" (Korpela et al., 2001, p. 573). That is, emotional regulation is enabled by contact with the environment but is further enabled where a *sense of place* is established.

This understanding mirrors Kaplan and Kaplan's ART, which hypothesises that the level of psychological restoration is supported by 'affective engagement' with the environment and is also reflective of Wilson's biophilia hypothesis (1984).

Mindfulness

Within the field of psychology, the links between emotional regulation and mindfulness are viewed as inter-related; mindfulness practice is viewed as enabling emotion regulation and neural integration (Kabat-Zinn, 2003; Siegel, 2011), a path to mind, body and relational wellbeing. This link has been extended to environmental psychology, where mindfulness practice is seen to enable emotional regulation through contact with nature. Schutte & Malouff (2018) found a two-way relationship between contact with nature and the traits associated with mindfulness (being calm and quietly attentive), aligning with Wolsko & Lindberg (2013) who state "…*the same cognitive and emotional experiences appear to be cultivated by both mindfulness practice and by restorative time spent in the natural world, including a deep fascination with one's present experience, relief from egocentric preoccupations and connection with phenomena outside of one's independent self*" (p.89). Again, this description of the benefits of contact with nature aligns Kaplan and Kaplan's ART, that is, 'immersion in the environment'. It was access to this experience, that in part, enabled the initial progress discussed in the clinical case scenario outlined in Chapter 1.

The practice of mindfulness in the natural environment is also seen to have benefits for both psychological and environmental health by strengthening 'self-nature' interconnectedness (Unsworth, Palicki & Lustig, 2016). The interconnectedness between self and nature, that develops over time, enables a *sense of place* that is viewed as benefitting not only the person but nature, by invoking behaviour that is ecologically informed (Hartig, Kaiser & Strumse, 2007). This could be conceived as behaviour that additionally supports eudaemonic wellbeing, that is, wellbeing related to contributing to the greater good and acting in accordance with values, again, integral to mental health and psychological wellbeing (Ryff & Singer, 2008).

The importance of relationship to nature and its significance to both human and environmental health, is central to many Indigenous peoples worldwide, including Aboriginal culture (Ungunmerr Baumann, 2002). The sense of 'mindfulness' (my interpretation) expressed by Daly River elder, Miriam-Rose Ungunmerr Baumann (2002) from Northern Territory, Australia, is evolved from the experience of 'being' in nature, as opposed to 'using' nature or 'doing' in nature, to support health and wellbeing, as is expressed in the following statement.

> *What I want to talk about is another special quality of my people. I believe it is the most important. It is our most unique gift. It is perhaps the greatest gift we can give to our fellow Australians. In our language this quality is called dadirri. It is inner, deep listening and quiet, still awareness.*

> *Dadirri recognises the deep spring that is inside us. We call on it and it calls to us. This is the gift that Australia is thirsting for. It is something like what you call "contemplation". When I experience dadirri, I am made whole again. I can sit on the riverbank or walk through the trees; even if someone close to me has passed away, I can find my peace in this silent awareness. There is no need of words. A big part of dadirri is listening.*

Frumkin et al. (2017) highlight that although much evidence regarding the psychological benefits of contact with nature is available, much remains unknown. They suggest there is a need for a robust research agenda to progress the link between nature contact and mental health, outlining seven domains of research that need to be prioritised, including research on the biomedical mechanisms activated by contact with nature. They hope that this research agenda will enable further accumulation of evidence that necessitates recognition of contact with nature as a significant public mental health strategy (Maller et al. 2006; Pretty et al. 2007; Lewis & Townsend, 2015). A strategy is needed that will support both individuals and the population to achieve better health (Hartig, Kaiser & Strumse, 2007) and that will enable a greater appreciation and recognition of the value of nature to health and mental health (Trombley, Chalupka & Anderko, 2017).

Psychological, social and physical benefits of contact with nature

Having discussed the discrete psychological benefits of contact with the natural environment, I now briefly discuss the research that links psychological, social and physical benefits. There is an interactive and accumulative nature to these benefits and research confirms the links between physical activity, restorative experiences and social interaction in a natural setting although examination of the mediators of health benefits has revealed inconsistent results (Korpela, Borodulin, Neuvonen, Paronen & Tyrvainen, 2014), as was confirmed by Frumkin et al (2017). However, where contact with nature is enabled in an urban environment, that is, in everyday settings there is increased opportunity for social interaction (Maller, Henderson-Wilson & Townsend, 2009; Kaczynski & Glover, 2012) which supports both social and mental health. Where contact with nature involves recreation and physical activity there is increased opportunity for psychological and physical benefits (Pretty, Peacock, Sellens & Griffin, 2005; Hansman, Hug & Seeland, 2007; Barton, Hine & Pretty, 2009; Barton & Pretty, 2010; Wolch, Bryne & Newell, 2014).

Further, research has indicated that contact with nature is associated with general wellbeing benefits (Kuo & Sullivan, 2001; Howell, Dopko, Passmore & Buro, 2011; Capaldi, Passmore, Nisbet, Zelenski & Dopko, 2015) and can be helpful as a part of a remedial or rehabilitative approach for those with mental illness (Maller et al. 2006).

However, McLeod, Pryor & Meade (2004) found that most research examining the links between the contact with nature and health, was focussed on physical health and Jackson, Dannenberg & Frumkin (2013) report little has changed a decade later (Passmore and Howell, 2014; Marselle, Irvine and Warber, 2014) and I identify this is another literature gap. The physical benefits associated with walking in nature specifically has been highly researched, in part, a response to the need to address the incidence of obesity, cardiovascular disease and diabetes in developed countries (Neilson & Hansen, 2007; Blair & Morris, 2009; Muller-Riemenschneider et al. 2013).

Essential to supporting psychological, social and physical benefits of contact with nature for all (Maller et al. 2006) is access to quality greenspace, and in urban environments, quality public open space (Francis, 2010) which I discuss further in the Built Environment section. To support the psychological and physical benefits of contact with nature for all, policy and practice is needed to support: the proximity of greenspace in the neighbourhood; a safe and cohesive neighbourhood; and the equal distribution of quality greenspace. I now discuss these factors.

Equitable access to the health benefits of contact with nature

Proximity

In relation to proximity, Grahn & Stigsdotter (2003) identified the need to consider proximity of the greenspace setting to work and/or home given that closer parks are more likely to be used, even when better quality natural environment settings offering greater restorative experiences may not be much further away. Barton (2016) indicates that to maximise the use of local parks and greenspace, they should be between 400-600m from the place of residence and that major natural greenspace should be 2-3kms. More recently, the need to attend to the immediate residential environs has been further highlighted by De Vries et al. (2013) who associate psychological wellbeing and reduced stress with the number of trees or viewable greenery in residential streets. Additionally, the benefits of street trees are not only relative to immediate mental health but to long-term mental health because of reduced urban heat effect, increased biodiversity and climate change mitigation (Salmond et al. 2016). These findings demonstrate that urban greenery and streetscapes, in addition to what is historically thought of as greenspace (i.e. forests, reserves and parks) are equally important to health and mental health (Van Dillen, De Vries, Groenewegen & Spreeuwenberg, 2012).

Neighbourhood safety and contact with nature

This topic is discussed further in the following section on the Built Environment, but I make the following points at this stage of the literature review. In relation to neighbourhood safety and cohesion, De Vries et al. (2013) discuss the emerging role of both stress and social cohesion as significant mediators impacting the ability to achieve physical or psychological benefit from contact with nature. They identify that where people are experiencing significant and ongoing stress, whether that be community or individually based, that is, where chronic and toxic stress exists (Fisher & Baum, 2010; Corburn, 2015), the ability to benefit from contact with nature is diminished, a view also consistent with Kaplan and Kaplan (1989). De Vries et al. (2013) assert that neighbourhood characteristics such as social disorder, crime and fear of crime, disrupt and inhibit social cohesion which mediates the use of greenspace or public open space reducing potential physical and psychological benefits (Feldman, Warr, Tacticos & Kelaher, 2009; Jennings, Larson & Yun, 2016). Clearly, in this situation the ability to develop a positive *sense of place* and *sense of community* is significantly impacted, providing further evidence of the imperative to address those structural and social factors in play in the community that are impacting population health and mental health (Rose, 1989; 2001).

Feldman et al. (2009) stress the inequity associated with the compounding and cumulative effects of individual households living with disadvantage, in neighbourhoods which are likewise disadvantaged and have less quality greenspace or public open space. They point out that where neighbourhood safety and cohesion is an issue, people are more likely to experience higher levels of anxiety and insecurity and higher levels of chronic disease and yet also have reduced access to quality greenspace, constituting a double disadvantage. Further emphasis on this point is made by Jennings et al. (2016) who identify the widening health gaps between socio-economic groups, advocating for research to "*illuminate more specific mechanisms for enhancing the social determinants of health via urban green spaces*" (p.8).

Further, Wood, Hooper, Foster & Bull (2017) stress that positive mental health outcomes are associated with neighbourhoods that have a range of accessible and attractive parks with quality features that support contact with nature, recreation and/or sport options however, such parks are less likely in disadvantaged area (Mitchell and Popham, 2007; 2008). Mitchell and Popham reported that disadvantaged areas were less likely to have access to quality greenspace which impacts frequency of use and opportunity to benefit, constituting both a health inequality and inequity. Confirmation of this issue as an Australian concern was provided by Astell-Burt, Mavoa, Badland & Giles-Corti (2014) who found an inequitable distribution of greenspace in all Australian capital cities.

They identified that those areas with a higher percentage of low-income households had substantially less greenspace, citing Adelaide to be the least equitable, with approximately 20% of public open space in the most affluent areas and 12% in the least affluent.

Population-based approaches which promote contact with the natural environment have been recognised as powerful and effective public health strategies (Maller et al. 2006; Townsend, Henderson-Wilson, Warner & Weiss, 2015) however this has not been fully recognised in public health policy (Lewis & Townsend, 2015; Barton & Rogerson, 2017; Frumkin et al. 2017). To this point, Lewis and Townsend (2015) stress the need for intersectoral action to enable a range of strategies to address the physical, social and geographical factors to ensure quality natural environments are available to all. They state, "*The oft-cited Ottawa Charter for Health Promotion emphasises human–environment inextricability; however public health discourse and response has not fully engaged with this recognition*" (p. 244).

In conclusion, this section has presented research concerning the link between the natural environment and mental health and psychological wellbeing, the interaction between psychological wellbeing, physical activity in the natural environment and the opportunities that equitable access to the natural environment offers population mental health. I now review the literature relevant to the ability of the Built Environment to do the same.

2.5.3 Mental Health and the Built Environment

Overview

The association between public health and the built environment has a significant history. Much has been achieved through the development of infrastructure that separates water and sanitation, significantly improving physical health outcomes for the developed world. However, this history is predominately physically based. The 'new public health', concerns social issues, including the incidence of chronic and mental health concerns, that have arisen in parallel with globalisation and urbanisation (Baum, 2015).

The need for research into the impact of the built environment on mental health, was initially identified by David Halpern in the 1980's. His work identified how the built environment influences health directly: through exposure to noise, traffic and pollution, exposure to the effects of weather, heat, wind and rain and the lack of exposure to sun and light, and indirectly: housing quality, fear of crime, social isolation, and sense of control over one's environment. Halpern (1995) progressed the understanding that while people inhabit a physical place, the form, composition and quality of that 'place' and the social interactions that occur in that 'place' i.e. the built environment, is a significant determinant of health and mental health which Sainsbury, Harris & Wise (2011) highlight continues to be unappreciated.

Key authors in the area of healthy urban planning include Hancock, 1993; Corburn (2009; 2013; 2015); Kent, Thompson & Jalaludin (2011); Francis et al. (2012); Barton, Thompson, Burgess & Grant (2015) and Giles-Corti et al. (2016). Collectively they report that health and mental health is supported by safe, pro-social built environments that support active living through the integration of higher density, mixed use areas with accessible amenities and services, public transport and quality greenspace. Placement of these elements proximally to each other in areas that support local economic activity and employment options is additionally important. In prioritising these aspects of development, opportunities for social interaction and physical activity are enabled, both of which promote mental health and psychological wellbeing (Corcoran and Marshall, 2016). By increasing the opportunity to live a local life, opportunity to develop a *sense of community* and *sense of place* are enhanced.

In this section the literature relevant to the ability of the built environment to promote mental health and wellbeing is examined. There is a specific focus on how neighbourhoods can be designed to both connect people and enable walkability, which are considered the two key processes that support mental health. Like Halpern before him, Evans (2003) also highlights the direct and indirect impacts of the built environment on mental health, stressing the need for planning and policy to maximise built environment elements that support the social connection which is central to mental health (Kawachi & Berkman, 2001; Kelly et al. 2012). Evans (2003) also highlights the significance of living in a place where you have a level of control over your environment, aligning with the principles of the CSDH (2008) and *Healthy Cities* (WHO, 2014a) recommendations. I finish this section reviewing the role of the built environment in enabling community safety and social cohesion given the significance of these social issues to population mental health.

Connecting people

Social interaction connects and strengthens communities, enabling health (Kent, Thompson & Jalaludin, 2011) and the physical elements and dimensions of the neighbourhood, such as the size, shape and configuration of different built environment elements and the integration of greenspace, can contribute to bringing people together or contribute towards keeping them apart (Giles-Corti et al. 2016; Barton, 2016). Neighbourhood configuration additionally concerns street patterns and connectivity, as major roads and overpasses can disconnect communities, whereas interlocking roads can connect. Barton (2016) stresses the need for neighbourhood design to support pedestrians and cyclists, a principle, embodied in the SA Government sponsored document, *Streets for People* which is further discussed in Chapter 6. In designing neighbourhoods and streets to be people friendly, walking and social interaction is enabled (Barton et al. 2015) and health and mental health is promoted. Further, car use is reduced, a central goal in the SA Government's *30 year-plan*, also discussed further in Chapter 6.

Where neighbourhoods are developed to enable access to quality natural environments, public open space and green streetscapes (Sugiyama et al. 2008; Van Dillen, 2012; De Vries et al. 2013) mental health is promoted.

Well positioned, safe and pleasant town squares, shops, train stations and parks, are examples of the larger physical built forms that are both amenities and serve as social opportunity structures (Baum & Palmer, 2002) which enable social interaction and connection. Additionally, where key neighbourhood amenities are proximal to each other and within walking distance of residences, walkability is enhanced, supporting physical activity and enabling mental health through increased local social interaction and engagement with nature. In walkable neighbourhoods, people are more likely to know their neighbours, trust others and be socially engaged (Lund, 2002); and social capital is more likely to develop (Rogers, Halstead, Gardner & Carlson, 2010). Additionally, Evans (2003) identifies how over time the incidental social interactions that occur in walkable neighbourhoods can become strengthened, supporting social connection and a stronger *sense of community*. Challenges to walkability include the presence of commercial precincts (which frequently market unhealthy food options) as opposed to street frontages (Wood, Frank & Giles-Corti, 2010) and low-density areas or hills (Saelens, Sallis & Frank ,2003).

Conversely, where neighbourhoods are characterised by social and economic deprivation, exposure to pollutants, experiences of discrimination or violence and degraded greenspace, walking and social interaction is significantly less likely (Warr, Feldman, Tacticos & Kelaher, 2009; Corburn, 2013). Further on this section I discuss degraded and impoverished environments, social incivilities and community safety in more depth, but at this point I make the point that these more complex and interrelated issues offer significant challenges to urban planners and public health officials in their aim to improve population health and mental health. Corburn (2013) supports us to take a systemic view and understand the necessity of engaging with the complexity of the underlying economic, social and environmental issues and the multiplicity of urban based factors and their historical and complex interrelationships. He discusses the need to pursue urban health justice through healthy city planning. Such planning requires resistance to being reductionist [considering more than single level health factors]; determinist [considering all constructions of health]; positivist [considering the relationship between science and historical context]; and elitist [not prioritising expert opinion over community knowledge] (Corburn, 2013, p.7).

Walkability

As designing neighbourhoods to support physical exercise, social connection and mental health, requires a focus on walkability, this is a central concept in urban design. Kent & Thompson (2011) stress that walkability, is enabled in public spaces through the provision of paths and bikeways which are integrative of greenspace.

Density is also a key determinant in achieving walkable neighbourhoods. Medium or high-density living will be more likely to support viable public transport options and local facilities (Barton, 2016) and the proximity and accessibility of these facilities will support walking, with benefits for physical and mental health (Giles-Corti et al. 2016). Density is dependent to some extent on site and context but where medium density is possible, walkability is enabled, car use is reduced and physical, psychological and social health is improved (Barton et al. 2015). Built environment elements that support walkability additionally include footpath width, street attractiveness, reduced traffic amount and speed and public transport accessibility (Barton, 2016). Planning that considers these urban macro-factors is essentially healthy public policy, given it relates to actions that improve physical and psychological health.

Microfeatures in neighbourhoods such as water fountains, seats, outside exercise equipment and public art all have the potential to encourage walking, enhance social interaction and support mental health (Baum & Palmer, 2002). Ottoni, Sims-Gould, Winters, Heijnen & McKay (2016) and Anderson & Baldwin (2017) encourage planners to look at how these smaller elements, the microfeatures of a built environment serve to support social connection, a *sense of community* and a *sense of place* enhancing mental health. Examples of the impact of microfeatures functioning as socially supportive tools are provided by the above authors. In a study that focuses on the older populations' use of benches, the insightful placement of well-designed (comfortable) benches was found to be related to the likelihood and length of social interaction (Ottoni et al. 2016). Additionally, Anderson & Baldwin (2017) identify murals, public art installations, picnic shelters, insect hotels, or grouped seats for viewing sports, as potential focal points which provide a reason for walking and socialising in public spaces.

Well planned microfeatures offer opportunities to 'observe, linger and mingle' and have the potential to raise spirits, support social ties, sustain *a sense of community*, build tolerance and acceptance and provide relief from daily routines (Cattell, Dines, Gesler & Curtis, 2008). Cattell et al. (2008) and Baldwin (2015) emphasise the psychological and sociological impact of 'healthy built environments', stressing that by focussing on the relationship between people and place, health is enabled for individuals and communities. Like Corburn (2013), they stress the need for a relational view of people and place to progress health, a focus that has reciprocal and cumulative benefits for the population and the individual.

In discussing both the macro-features and microfeatures of urban design and how they link, I have sought to emphasise how physical neighbourhood aspects have potential to support psychological wellbeing, through both social connection and walkability. In relation to this, Chapter 6 will detail the physical built environment elements that characterise a residential re-development in Adelaide and their potential to promote health and mental health. Importantly, the development of denser, multiple use neighbourhoods with access to public transport, amenities and greenspace is also important to progress environmental sustainability (e.g. see Chp 6, p.).

Hancock (2000) discusses the need for an ecological approach to support environmental sustainability which is a prerequisite for human health and more recently the urgency of this has been articulated by Hes and Du Pleiss (2014), with Hes (2016) stressing that sustainability solutions need to extend beyond technological to social.

Built environment, community safety and mental health

Pfeiffer and Cloutier (2016) suggest that the strongest contribution that planners can make to enabling mentally healthy and happy environments, is to plan areas that are characterised by 1. Access to open natural and greenspace; 2. Design features that allow for social interaction; and 3. Design features that ensure personal security. The literature indicates that it is the third point that will mediate the use of greenspace or social interaction (Warr, Feldman et al. 2009; Kelly, Breadon, Davis, Hunter, Mares, Mullerworth & Weidmann, 2012). Thus, where community safety is maximised, the likelihood of residents engaging in active transport and community based social and/or recreational activities, such as, walking, cycling or joint exercise groups in parks, using the local playground, meeting others in public places or joining the community garden is increased and a *sense of community* is enhanced. Kelly, Breadon et al. (2012) stress the need for planners and developers in Australia to prioritise development that is focused on 'building in' elements to support a sense of community safety, necessary to address in part, the rising incidence of social isolation, loneliness and mental illness.

Pfeiffer and Cloutier (2016) indicate that action that best supports community safety will come from collaborative planning, community participation, identifying action and ensuring sustainability. They stress that it is joint action from the Built Environment sector in collaboration with other key sectors, local councils and community that is essential to support the physical and social elements of the built environment that enable the community safety.

Three key factors have been associated in the literature as threats to community safety and therefore as significant barriers to population mental health: 1. Degraded built environments and social incivilities (Stafford, Chandola & Marmot, 2007; Ziersch, Baum, MacDougall & Putland, 2005; Corburn, 2009) 2. Impoverished neighbourhoods and perceived community safety issues (Warr, Tacticos, Kelaher & Klein, 2007; Taylor et al. 2012; Browne-Yung, Ziersch & Baum, 2016) and 3. Neighbourhood-based exclusion related to racism or discrimination (Corburn, 2009). To discuss how these issues can be addressed in the built environment, I have taken examples from the literature where planning policy and/or practice is progressing social sustainability.

Degraded and impoverished built environments, social incivilities and community health

Degraded built environments include derelict buildings, neglected properties, graffiti and dirty streets and social incivilities include those behaviours that contravene widely held norms of proper and orderly conduct, such as public drinking, evident drug use, vandalism and conflict. The presence of both in the built environment will deter social interaction in the neighbourhood (Putnam 1995) with negative impact for health. Further degradation or removal of remaining infrastructure in such areas has been noted in the literature (Wilson & Kelling, 1982; Ellaway & Macintyre, 2001) essentially creating a negative feedback loop, in which further degradation and incivility is likely, resulting in further neighbourhood dissatisfaction (Warr et al. 2009). In degraded or deprived communities, individuals may choose to drive and not to walk or when walking but to move through the area quickly; behaviours that reduce the opportunity for physical activity or social interaction, resulting in increased loneliness and poorer health (Kearns, Whitley, Tannahill & Ellaway, 2015). The development of a positive *sense of place* and/or *sense of community* is clearly curtailed in such neighbourhoods.

Neighbourhood-based issues require community or population-based approaches that acknowledge and addresses the health inequities at a population level to overcome the socioeconomic disadvantage that underlies the impact on health and mental health (Corburn, 2013). Two examples of how social action taken at a community and political level in the built environment can contribute to improved population mental health are discussed below, both utilising a Health Impact Assessment to enable social and political based change, an approach also considered in Australia (Harris & Spickett, 2011; Delany et al. 2014).

Anderson and Baldwin (2017) report on a study in which a community in Arizona, USA which collectively developed an agenda to take action to remediate degraded neighbourhood elements, including broken basketball courts, unsafe play equipment, poor lighting, dumped refuse and a lack of trees which were identified as impacting social cohesion, sense of belonging and community pride. Using a Health Impact Assessment (HIA)[2] process to facilitate a joint community and civic participation approach (local government housing, community groups and local residents) physical neighbourhood improvements were discussed and actioned at the community level, which was later reflected in improvements in resident's mental health and *sense of community*.

Likewise, Corburn & Bhatia (2007) report on the political use of HIA processes in San Francisco, USA which were utilised to increase recognition and acknowledgement of the health impacts associated with inner city development and redevelopment. Use of a HIA process enabled the health and

[2] A Health Impact Assessment is a process which acknowledges the social, economic and environmental determinants of health by assessing the impacts of policies, plans and projects in an area on population health (Anderson and Baldwin, 2017)

mental health impacts associated with a possible residential displacement to be highlighted. The process enabled the visibility of affordability concerns and potential social disconnection to be better recognised and addressed. Both examples exemplified working in partnership and the different ways a HIA process can be used to achieve better health outcomes, about which Corburn & Bhatia (2007) state, " *While there is no one size fits all approach to human health analyses that can respond to all these issues, experiments with HIA, no matter how piecemeal or comprehensive, are important for building political support, knowledge base and process design alternatives for linking environmental planning and public health*" (p.337.) Both these approaches attempt to put health at the heart of urban decision making and in so doing reduce health inequalities (Barton, 2017, Hancock, 2018).

Built environments and cultural safety

Lastly, I consider cultural safety in the urban environment which can include the following discriminations: racism, age, disability and gender/sexual identity. I specifically highlight the high level of racism experienced by Indigenous Australians in urban areas given the significance of suicide and mental health discussed (Cunningham & Paradies, 2012). Cultural safety is enhanced when local neighbourhoods are inclusive of the needs of different population cohorts. Areas that are characterised by macro or microfeatures that reference Indigenous history or use Indigenous plantings, paths that allow the passage of a wheelchair, playgrounds that have age appropriate play equipment, buildings that have ramps, planning regulations that support the building of different places of worship or safe, gender neutral public restrooms are examples of how the built environment can contribute to cultural safety. Such features have the potential to reflect the community's valuing of cultural diversity and an equal valuing of all past and present cultural and social history will support cultural safety and health equity. In relation to this Eckenwiler states "…places are created, sustained, transformed, or neglected in ways that foster or perpetuate inequities, including health inequities…" (2018, p.562).

Referencing colonising practices in Australia, Jackson, Porter & Johnson (2016) state that the planning policies in Australia in past and present are inconsistent with the culture of traditional peoples or with the recognition of the traditional owners of the land. Amery and Williams (2002) make the point that one of the strategies that can be used to enable Indigenous histories to come to the fore, is to rename local topographies. They consider the 'renaming to reclaim' strategy a small but progressive tool in decolonising space and place in Australia, and that the 'renaming to reclaim' strategy demonstrates a valuing of the relationships Indigenous people have to country, key to a *sense of place and community* and mental health and psychological wellbeing for Indigenous peoples.

Jackson et al. (2016) however, stress that a more profound change in Australian planning practice is urgently needed, whereby genuine consideration of Indigenous rights and interests in relation to land is addressed. Further, as Kingsley, Townsend, Phillips & Aldous (2009) suggest increasing the opportunity to connect to and care for Country may offer a means of improving the poor mental health of Indigenous Australian peoples.

In summary, this section has presented a review of the literature that links both the natural and built environments to mental health and psychological wellbeing. I have explained how contact with the natural and built environments supports psychological, physical and social health, the importance of both physical elements and social contexts within the built environment and the centrality of community safety to engage in either natural or built environments. I finished the section highlighting the importance of community participation and joint processes and partnerships to the development of healthy urban environments that can produce better mental health outcomes for all.

2.6 Summary

In this chapter I have discussed the four areas of literature that inform my research. I commenced by discussing the significant and increasing incidence of mental illness, a trend that is present globally, nationally and locally. I also outlined the social gradient in relation to psychological distress and mental illness and the associated inequity. The second section discussed the current treatment approaches, explored on a national and state level. Approaches were seen to predominantly privilege biomedical solutions, despite calls for upstream approaches that shift towards prevention and promotion. The need for the application of a social lens to mental health issues and the need to facilitate collaboration across sectors were highlighted. The opportunities in the literature to address the current predicament were discussed in the third section and the need for approaches to address mental health inequities and support population mental health both within the health sector and within the government were highlighted. The final section identified how the natural and built environment sectors, as examples of sectors other than health could potentially promote population mental health. In working through the relevant literature, I also identified three gaps where the literature relevant to my research is limited.

1. The need to better understand the enablers and barriers to policy and practice that progresses action on the social determinants of mental health (Embrett & Randall, 2014).
2. The need to better recognise the significance of the impact of the built and natural environments on health outcomes (Sainsbury, Harris & Wise, 2011).
3. The need for more research on how the built environment impacts mental health (Jackson, Dannenberg & Frumkin, 2013).

Consistent with the need to understand the enablers and barriers to policy and practice that promotes population health and mental health better, I seek to examine current policy in the selected sectors to identify exemplars of mental health promotion. All health issues are indicators of structural and social issues (Marmot et al. 2008) and as such, require social and political solutions involving all government sectors and policy makers. Given that policy is the main instrument that governments can use in order to govern for health (Baum, 2019) it follows that an examination of policy would illuminate where mental health is being acknowledged and promoted. A policy process that sets a health agenda, develops strategy and achieves implementation, makes a definitive statement about what the government values, as implementation involves the use of funding and resources (Colebatch, 1998). This is despite the complexities that surround this process including broader government and political influences, policy entrepreneurs both inside and outside of government, advocacy or lobby groups and the ability of sectors (structures, processes and resources) to respond (Kingdon, 2011).

The solutions that are proposed by policy however have much to do with how a problem is framed and what presuppositions and assumptions underlie the representation of the problem (Bacchi, 2009; 2012). Therefore, to identify where policy is enabling mental health, as opposed to managing mental illness and how policy is enabling a governing for health agenda, I have adopted Bacchi's *What the problem represented to be* approach to examine policy. In the following chapter I further outline the methodology and method used to enable this examination.

CHAPTER 3 RESEARCH DESIGN

Overview

I concluded the previous chapter by highlighting the importance of further policy analysis research to explain how mental well-being is currently addressed in policy, and to stimulate policy improvement. In this chapter I explain the methodological design of the research that I have undertaken to examine these issues. I commence this chapter with an outline of the philosophical underpinnings of the research prior to outlining my methodology, the research design and methods I applied. I conclude the chapter with a reflection on the ethical dimensions of this research.

Crotty (1998) considers it unnecessary to discuss ontology separately as this is interwoven with other aspects of research design. Crotty states: "Ontological issues and epistemological issues tend to emerge together …. to talk of the construction of meaning is to talk of the construction of meaningful reality" (p.11). As such, Crotty (1998) identifies four elements that need to be explicated in research: epistemology, theoretical perspectives, methodology and methods. I have structured this chapter according to these four elements. I start with the epistemological and theoretical perspectives, which can be viewed as the overarching philosophical foundations for research (Creswell, 2003).

3.1 Epistemology and Theoretical Perspective

This thesis employs a critical social constructionist epistemology.

Epistemology provides a philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that such knowledge is both adequate and legitimate (Maynard, 1994, p.10). "It is a way of understanding and explaining how we know what we know" (Crotty, 1998, p.3) and provides a conceptual basis for explaining which theories of knowledge are applied in research (Creswell, 2003).

My research was guided by social constructionism, that is, an epistemological position which posits that there is more than one truth or one reality. Further, it argues that knowledge is constructed through social processes, produced and reproduced through the interaction of our social, cultural and political contexts and that knowledge can never be wholly objective or value-free (Creswell, 2003; Crotty,1998). Such a view reflects a relativist ontological perspective, a view not shared by those who adopt a positivist position, where knowledge is seen as absolute and is derived from and requires scientific verification (Crotty, 1998).

Burr (2003) articulates a social constructionist view further: “Our accepted ways of seeing the world are not a product of objective observation of the world, but of the social processes and interactions in which people are constantly engaged with each other” (p.5). Although these social processes and interactions occur individually as well as collectively, Berger and Luckman (1966; 1991) argue that while people create personal meaning, it is collective meaning created through social processes that sustains or institutionalises knowledge and meaning. In my research, the aim is to understand and articulate those social processes and institutionalised knowledges, supported by the use of a constructionist framework, which allows such structures of knowledge to be interrogated. The socially constructed meanings of health and mental health and their relationship to the current policies and practices are central to this research.

Two of the disciplines contributing to the constructed meanings of health and mental health throughout history have been psychology and sociology. In reference to psychology, Gergen (1973) argues that the 20th century has seen the unhelpful separation of these disciplines. He argues that the discipline of psychology must be anchored in cultural and social history stating that, “Political, economic, and institutional factors are all necessary inputs to understanding in an integrated way. A concentration on psychology alone provides a distorted understanding of our present condition” (Gergen, 1973, p.319). Burr concurs saying, “all knowledge, including psychological knowledge, is historically and culturally specific and that we must therefore extend our enquiries beyond the individual into the social, political and economic realms for a proper understanding of the evolution of present-day psychology” (2003, p.13). However, present day psychology continues to demonstrate a strong shift towards individual paradigms (Oishi & Graham, 2010) and away from social psychology, which holds that the individual should be understood within their social context. In reference to sociology, Rose (2016) comments on a similar shift, where disciplines concerned with societies, communities and populations, and so strongly linked to public health, have been overridden by an increased focus on neuroscience, shifting the focus from the collective to the individual. The effect of this is a decontextualisation of understandings about what supports mental health and what contributes to mental illness.

Despite these current paradigmatic shifts, human ‘nature’ is a product of the societal and economic structure that we are born into (Fromm, 1942) and “whatever personal qualities we may display, they are a function of the particular cultural, historical and relational circumstances in which we are located” (Burr, 2003, p.35). My approach in this research is directly informed by these understandings. My research approach is shaped by the view that health and mental health are impacted by factors in the social realm and that social policy as an expression of dominant discourse, strongly influences the overarching economic and political structures that dictate health outcomes. This outlook is consistent with Burr’s understanding of social constructionism.

As such, my research is intended to re-contextualise understandings of mental health; focussing on the social, and specifically on government policy as an expression of social values and as a powerful force in constructing and reinforcing social structures.

Burr's interpretation of social constructionism emphasises four key assumptions: that knowledge is historically and culturally specific; that knowledge is sustained by social processes; that a critical stance must be applied to illuminate and interrogate *taken for granted* knowledge; and that knowledge and social action are intimately connected (2003). For Burr, a social constructionist approach enables the collection of data to understand particular knowledge systems and an examination of how knowledges are produced via "critical reflection on the relationship between knowledge, power and the possibilities for social change", (2003, p.18). This view has been challenged by a number of theorists (such as Hammersley, 1992; Murphy, Dingwall, Greatbatch, Parker & Watson, 1998) who contend that social constructionist research reveals and acknowledges a number of different views of reality with no view having precedence over another, and thus lacks the framework to change things because there is nothing against which to judge the findings. Patton (2002) however, offers a helpful way to bridge social constructionism and critical inquiry, highlighting that from the differing views of reality, there will be dominant views which align with those who exercise power and that analysis of such views can provide opportunity for critical reflection, debate and the potential for change.

Crotty (1998) identifies critical inquiry as a form of research that seeks to both understand and question prevailing values and knowledge systems in the pursuit of greater social justice, a perspective consistent with Burr's interpretation of social constructionism. Additionally, Baum (2008) endorses a critical theoretical perspective as appropriate for undertaking research which supports aspirations for social change and for improving public health and in this instance, population mental health.

In relation to my research, social constructionism provides a framework for understanding and examining how mental health promotion is constructed and interpreted in policy and by policy actors. Using a critical approach then offers opportunities to reveal and discuss the dominant representations, assumptions and framings concerning mental health found in policy and from policy actors and explore alternatives.

Further argument for the application of a critical social constructionist approach to research concerning mental health, comes from Foucault. Foucault (1972) introduced the concept of the 'medical gaze,' arguing that the medical gaze has enabled the development of privileged knowledges and practices including the diagnostic classification systems that dominate mental health practices. Additionally, the medical gaze comes to influence the way people see themselves or as illustrated in the clinical scenario, the way a mother saw her child.

These classification systems provide the apparatus, that is, the 'professionally and legally endorsed approaches' that enable the classification of people as mentally ill, that is, deviant from the socially accepted norm. Foucault argues that these constructions legitimise the imposition of control and power over certain individuals and/or subpopulations resulting in actions to correct or to heal individuals, not to change the social structure that enables and perpetuates illness. If policy (as a powerful form of social discourse) focuses on individuals and on individual deviance from the norm this further legitimises an individualistic policy response, denying the political, cultural and social structures in society that impact health. My thesis intends to consider whether and how policy constructs mental health and illness and to examine what government actions are prioritised on the basis of these constructions. It is achieved through the application of social constructionism and critical theory which uncovers the hidden and often *taken for granted* values that underpin policy and examines the effects of these within the population. This approach aligns with Foucault, whose theories have inspired the analytical approach utilised in the thesis, Bacchi's (2012) *What's the problem represented to be?* (hereinafter referred to as *WPR*) Foucault stresses that knowledge concerning wellness or illness in relation to mental health, sits in alignment with power and agency, which further suggests the benefit of a critical lens, given it illuminates the relationship between power and culture (Giroux, 1983).

3.2. Qualitative methodology

Consistent with the philosophical foundations that shape my critical social constructionist approach, I have chosen to adopt a qualitative research methodology.

Creswell (2003) offers the following definition of qualitative research:

> Qualitative research begins with assumptions and the used of interpretive/theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to a social and human problem. To study this problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a natural setting sensitive to the people and places under study, and data analysis that is both inductive and deductive and establishes patterns and themes. The final report or presentation includes the voices of participants, the reflexivity of the researcher, a complex description and interpretation of the problem, and its contribution to the literature or a call for change (p.44).

That is, a qualitative approach emphasises information and meanings gathered from multiple sources, which serves to reveal our socially constructed and differing realities. In critically examining the institutional and social practices and processes associated with these constructions and realities

we progress our understanding of complex social phenomena and potentially our opportunities for change.

Driven by critical constructionism I am concerned with the what, how and why explanations, identified by Patton (2002) as hallmark questions in qualitative research. The methodological approach that I have outlined so far allows me to question how mental health is represented in policy, why this representation has come about, how dominant representations of problems and solutions influence policy and what social impacts this creates. Patton (2002) discusses the data that such questions yield, as *thick descriptors* of complex social processes, that is, data that describes intentions, meanings, history and context. Denzin (2001) makes the point that without *thick descriptors*, *thick interpretation* is not possible, and that qualitative methodology allows the complexity of the phenomena being examined to be embraced as opposed to reduced or managed, as is consistent with a realist or experimental approach.

In adopting this approach, I have selected methods that provide opportunities to examine and deconstruct social policy, to illuminate and understand the meanings that are applied to mental health. I have employed the methods of document analysis and in-depth qualitative interviewing and I discuss these further in this section on Research methods. I have also adopted a case study approach within the thesis to focus my investigation.

3.2.1 Case Studies

A case study offers the opportunity to study in depth, complex phenomena in a specific context and at a specific point in time. Luck, Jackson & Usher (2006) described a case study as "a detailed, intensive study of a particular contextual and bounded phenomena that is undertaken in real life situations" (p.104). This is also consistent with Yin who offered the following definition: "A case study is an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (2009, p. 18).

Yin (2003) emphasises that case study methodology fits well with the study of complex social phenomena, and the *what, how and why questions* that are fundamental to a critical constructionist approach. It is understood that a case study can be either qualitative or quantitative but in relation to my research, with the emphasis on the *what, how and why* questions of both written policy and policy action, and the need to achieve thick description of social processes, a qualitative case study approach provides the best fit.

The use of case study methodology in my research enabled an in-depth analysis of policy relevant to mental health in three sectors of state government. The three case studies examined included the

development and implementation of policy relevant to mental health in the South Australian (SA) Health sector, Natural Environment and Built Environment sectors.

Following the analysis of relevant policy from each of the three case study sectors, it was intended that one instance of policy implementation would be selected from each to examine its potential to enable population mental health. As I will explain in the findings chapters (Chapters 4-6), however, it was only possible to select exemplars from two of the policy sectors, as a relevant exemplar could not be identified in the Health sector. To study the exemplars of policy implementation in the natural environment and built environment sectors I adopt a nested case study approach. This approach is summarised in Figure 3.1 below.

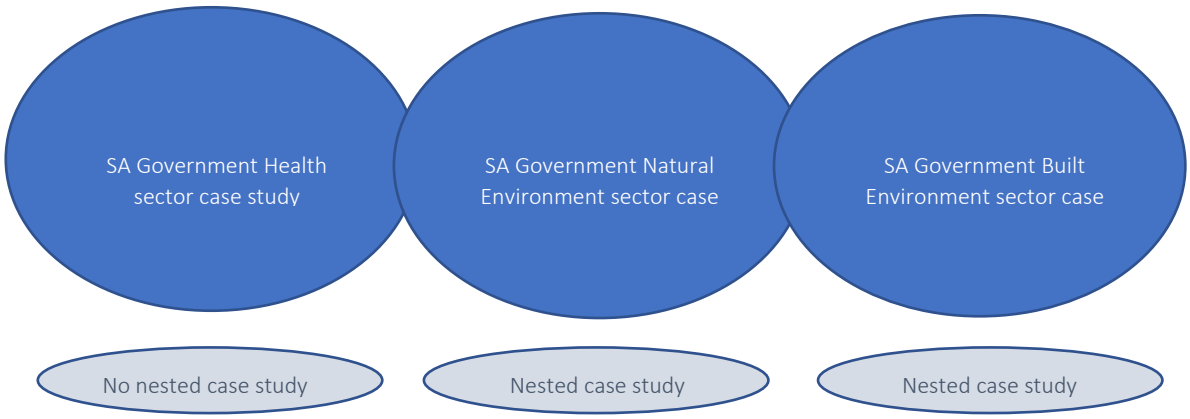

Figure 3.1 Research design - Sector case studies with nested case studies in two sectors

The rationale for the selection of the three case study sectors is based on the socioecological models of determinants of health discussed in Chapter 2, the Dahlgren and Whitehead (1991) and Barton and Grant (2005) models. These models show that health is an outcome of both internal and external factors, emphasising the economic, social and environmental layers of influence that determine health outcomes, including mental health outcomes. The selection of the sectors recognises the role of the natural and built environments as determinants of health and mental health and the Health sector as the sector concerned with health services. Additionally, setting the research in the state of South Australia which has a strong history of health promotion (Littlejohns, 2016) is thought to constitute an application of purposeful sampling. Patton (2002) states, "Purposeful sampling focuses on selecting information-rich cases whose study will illuminate the questions under study" (p.273).

It is acknowledged however that Australia is a federal system with national departments and sectors that to some extent align with the selected state sectors and exert influence over policy, however my research was specific to South Australia. This is partially related to time and resource constraints but is also related to the association of this research with the broader *SA Health in All Policies (HiAP)*

project that was active at the time. The focus of the three state sectors i.e. the three case studies are outlined below.

Health sector

The Health sector in SA equates to the South Australian *Department of Health and Ageing (SA Health).* SA Health's key objective is to lead and deliver a comprehensive and sustainable health system that ensures healthier, longer and better lives for all South Australians. The department is committed to delivering a health system that produces positive health outcomes by focussing on health promotion, illness prevention and early intervention (Department for Health and Ageing Annual Report 2014-2015, p.6).

Natural Environment sector

The Natural Environment sector equates to the SA *Department of Environment, Water and Natural Resources (DEWNR)*. DEWNR leads the management of South Australia's natural resources to protect our environment and support healthy and productive natural resources which sustain our health and wellbeing" (Department for the Environment, Water and Natural Resources Annual Report 2014-2015, p.7).

Built Environment sector

The Built Environment sector comprises three departments/agencies*: South Australian Department of Planning, Transport and Infrastructure (DPTI)*; *Renewal SA* and *Housing SA*. Collectively these departments develop and implement policy that concerns the development of urban infrastructure, including transport systems, the redevelopment of housing and urban areas and the maintenance of state housing. Specifically, the *DPTI* works as part of the SA community to deliver effective planning policy, efficient transport and social and economic infrastructure (Department of Planning, Transport & Infrastructure Annual Report 2014-2015, p.7). *Renewal SA* is leading the urban renewal of Adelaide on behalf of the Government of SA. Renewal SA's role is to attract more people to live, work, visit and invest in SA. Our role is to unlock the potential of existing urban areas, through partnership and consultation with community, industry and all levels of government which will enhance SA's economic and social prosperity (Renewal SA Annual Report, 2014-2015, p.5). *Housing SA* undertakes service delivery functions on behalf of the SA Housing Trust which facilitates a range of housing options for South Australians…such as the delivery of private rental assistance, tenancy management and the maintenance of public housing properties (Housing SA Annual Report, 2014-2015, p.9).

3.3 Research methods

In this section, I describe the data collection and analysis methods that I have used in the research. I will explain the processes that I have used to create an audit trail to support the rigour of my research. I restate the research questions provided in the Introduction chapter and explain my research design first. I then detail the document and interview review process used, followed by a discussion of my use of Carol Bacchi's (2012) discourse analysis method – *What's the problem represented to be*? (*WPR*) which I have used to critically scrutinise policy from each of the three case study sectors, to illuminate how mental health is framed, and to understand the justification of and implications of the policy responses that are identified in the policies.

3.3.1 Research Questions and Research Design

The research questions that guide my research are:

1. To what extent is mental health and psychological wellbeing considered within the policy of the three sectors (the Health, Natural Environment and Built Environment sectors) and how do the policy framings construct responsibility for mental health and psychological wellbeing?
2. How is population mental health and psychological wellbeing represented in the three sectors?
3. What enables and disables the best exemplars of policy and policy implementation (the nested case studies) and how can these findings inform policy and practice concerning mental health and psychological wellbeing?

To answer these questions, the research is organised into four interconnected stages. The first three stages involve examining various forms of policy related discourse to examine how mental health is understood and being acted upon in each of the three case study sectors. The fourth stage focuses on analysis of two policy implementation exemplars as nested case studies. The four stages are explained in Figure 3.2.

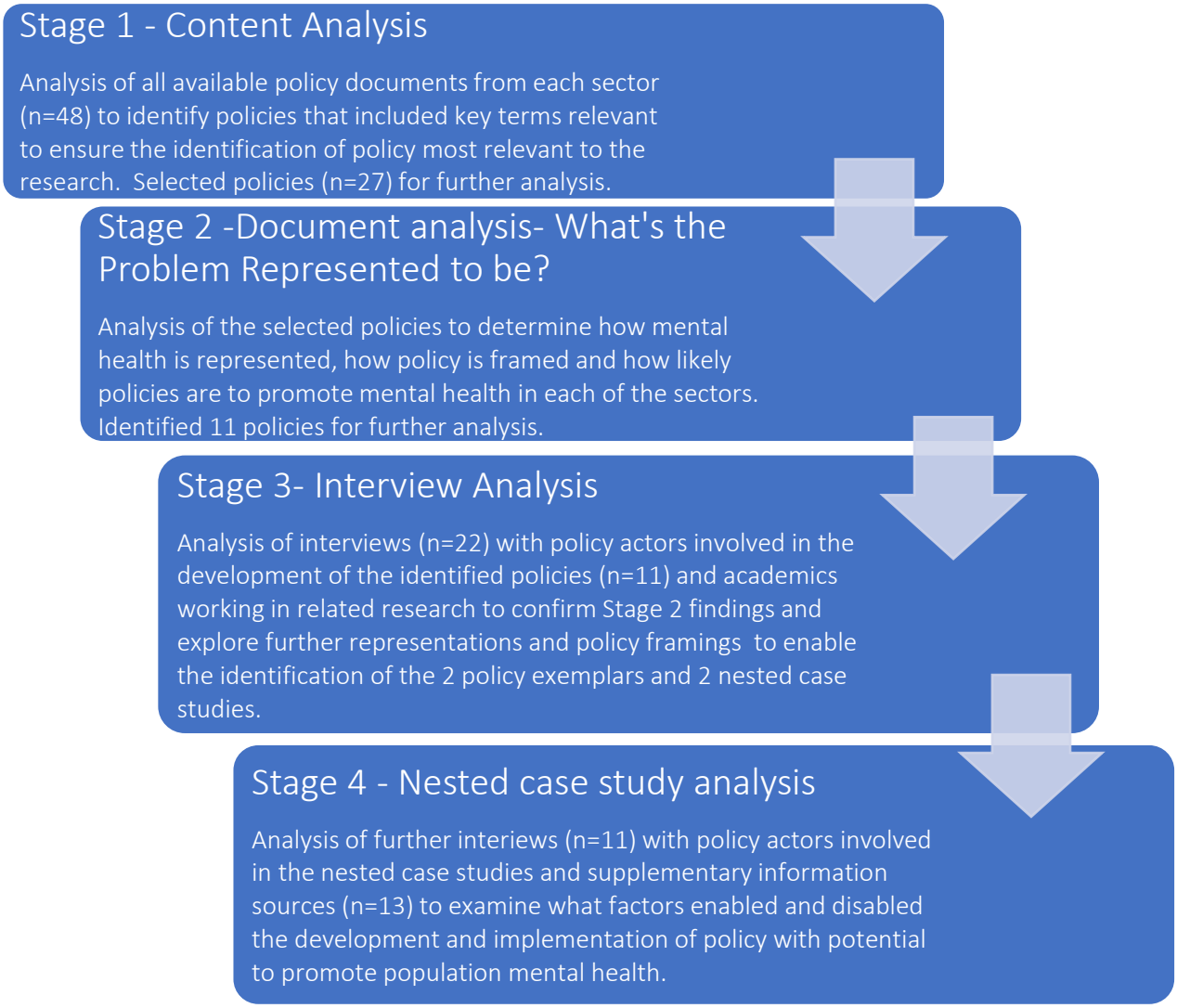

Figure 3.2 Overview of the stages and purpose of the research design

3.3.2 Research stages

In the first stage of research - *Content Analysis*, I reviewed all current policies in each sector identifying those that were relevant to the research using inclusion criteria. Review of organisational and institutional documents, including policy documents, is commonly used in qualitative research (Bowen, 2009) and is well suited to case studies (Yin, 2009). The initial criteria for policy selection were that documents needed to be publicly available, strategic-level policy documents from one of the three sectors and still current at any time within the selection period between January 1st, 2014 and December 31st, 2015. These are the initial criteria for selection, with further criteria applied after content analysis to determine the final set of data for analysis.

I limited selection of policy to the 2-year period in order to avoid having to adjust the data set to incorporate policy change over the life of the project and to ensure that all policies from each sector could be selected and reviewed for inclusion in the same time epoch. As such, applying a date range ensured the consistency and rigour of my research approach. Further criteria were applied after the Stage 1- Content analysis to determine the final data set for further analysis.

In the second stage - *Document Analysis*, I applied a deeper process of discourse analysis (led by Bacchi's *WPR* approach) to uncover fundamental understandings of mental health within policy, the framing of policy relevant to mental health and the role the sector assumes in relation to mental health. The third stage of research involved the use of interviews to provide alternative data and the fourth stage again used interview data, supplemented by further documents, observations and relevant literature. I now detail each stage of the research.

Stage 1 - Content Analysis

The process for undertaking the content analysis involved reviewing policies from the three sectors to identify those policy documents that met the inclusion criteria. The inclusion criteria were: 1. That the document was a working policy document from one of the three sectors; 2. That the document referenced mental health and psychological wellbeing or associated terms (emotional wellbeing, social wellbeing, socioemotional wellbeing, psychosocial health) and 3. That the document referenced the social determinants of health.

Eight questions were asked of each document. The first six questions served to confirm the first inclusion criterion. Through the identification of the purpose, focus, subjects and proposed strategy in the document, I was able to confirm whether the document was a policy document relevant to the work of the sector as identified in 3.2. The last two questions were fundamental criteria to enable the determination of policy relevant to the thesis subject matter i.e. mental health and the social determinants of health. All documents were downloaded as PDF files, imported into QSR Nvivo 11 and coded and analysed.

The following questions guided the content analysis.

1. What type of document is it?
2. What Sector/Department is it from?
3. What is the stated purpose of the document?
4. What issues or problems are identified?
5. What groups are identified?
6. What actions are considered or proposed?
7. Is there mention of health, mental health and/or psychological wellbeing (or associated terms)?

8. Is there mention of the social determinants of health or mental health and/or health equity?

In this process of analysis, I considered both direct and indirect references to mental health or associated terms given that mental health may be less directly referenced in non-Health sectors. This recognises that the core business of policy in non-Health sectors is not mental health but rather the governance of built and natural environments. Thus, mental health terms may not be used explicitly in non-Health policies, but the policy may include relevant content using other, more sector specific language that relates to the literature on the social determinants of health as discussed in Chapter 2.

At the conclusion of the review process, Nvivo coding queries were run to ascertain what policies best featured mental health, the social determinants of health and health equity and the results of this were discussed with my three supervisors to confirm the selection or rejection of policies for inclusion in the second stage of research.

From a total of 48 policy documents reviewed, 27 were selected for further analysis. A summary of the study sample is detailed below in Table 1 and a list of selected policies can be found in Appendix A.

Sector	**Study Sample**
Health sector	14
Environment sector	7
Built environment	6
Total Policy Documents	27

Table 3.1 Summary of the number of policies identified at completion of Research Stage 1.

Stage 2 - Document Analysis: What's the Problem Represented to Be?

Following the content analysis, I applied a deeper level of analysis during the subsequent stages of the research. This second stage of research involved analysis of the 27 policy documents that I identified at the previous stage. In this second stage of analysis, I examined how mental health and psychological wellbeing are represented in policy and how policy strategies are framed, to enable the identification of policy that has potential to promote population mental health.

In my research, policy documents were viewed as an important source of discourse, given that policies serve to authorise, provide expertise and structure a response to public issues and problems (Colebatch, 1998) such as population mental health.

Studying policy as a powerful form of discourse is vital to address my research questions because it is the discourse inherent in policy that informs the development of policy strategy and implementation. Discourses determine how people view the world and are "practices that systemically form the objects of which they speak" (Foucault,1972, p. 49). In relation to social phenomena, Burr (2003) acknowledges her Foucauldian understandings, emphasising that the meanings constructed within discourses occur in the social space, that no phenomenon or knowledge can exist outside of these discourses and that the language we use (and the thoughts and concepts behind it) are reflective of prevalent and dominant discourses. It is in this way then, that discourses become an expression of power, "they convey the potential for language to create and reinforce systems of power and knowledge" (Holstein & Gubrium, 2005, p. 490).

Interrogating how issues are framed as problems within policy discourse and examining how that framing then translates into policy responses is the central premise behind the WPR approach. Bacchi (2000) states, "The premise behind a policy-as-discourse approach is that it is inappropriate to see governments as responding to 'problems' that exist 'out there' in the community. Rather, 'problems' are 'created' or 'given shape' in the very policy proposals that are offered as responses" (p.48). The application of Bacchi's framework to guide my discourse analysis has led me to deconstruct policy from each case study sector to identify what has been 'problematised' in policy, to examine how this shapes the proposed solutions and to consider what remains unmentioned in policy.

In relation to use of the WPR approach in health policy, Bacchi (2012) states: "This form of analysis thus enables critical reflections on the substantive content of policy initiatives in health policy" (p.1). She adds further comment on the potential of the approach to "…illuminate the forms of knowledge that underpin public policies, such as psychological or biomedical premises…" (Bacchi, 2012, p.22).

Bacchi identifies six questions that facilitate the analysis of policy. My study has condensed these questions into three. Condensing to three questions was considered desirable to focus attention on the aspects of policy that were most relevant to my research questions. Selective use of Bacchi's questions is commonly used in like research (Pienaar & Savic, 2016; & Pantazis, 2016).

1. What's the 'problem' represented to be in a specific policy?
2. What presuppositions or assumptions underpin this representation of the problem?
3. What is left unproblematic in this problem representation? (Prompted by the secondary questions -Where are the silences? Can the problem be thought about differently?)

The 27 policy documents identified at Stage 1 of the research were previously downloaded as PDF files and Imported in QSR Nvivo 11. The problem represented in policy was noted at the first stage of analysis, the *Content analysis* but was further examined at this stage of research as was what remains unmentioned in policy.

I applied a coding framework (Appendix B) to analyse the documents based on the three questions listed above and used memos to note where policy silences relevant to mental health were found in the data, which was guided by the literature and discussed with supervisors. At the conclusion of this second stage of analysis, I identified 11 policies as having the potential to support population mental health. These policies are listed in the table below and were progressed to the third stage of research.

The key findings that have emerged from the document analysis, interview analysis and selection of the case study for each policy are visually represented in a table at the start of each Findings chapter (Chapters 4-6). The tables provide a summary overview of the extent to which the policy is consistent with the biomedical model and/or a social view of health and whether it considers mental health and/or mental illness.

Sector	**Policies**
Natural Environment	Aboriginal Reconciliation Action Plan Healthy Parks, Healthy People Strategy
Built Environment	The 30-year Plan for Greater Adelaide SA Housing Strategy MOU-DPTI & DH&A
Health	SA Vision for Aging – Longevity for Prosperity Aboriginal Health Care Plan Eat Well Be Active Strategy Mental Health and Well Being Policy SA Public Health Plan SA Suicide Prevention Strategy
Total Policies	11

Table 3.2 Policies selected as those with potential to support population mental health at the completion of Research Stage 2.

Stage 3 - Interviews

During the third stage of the research I examined another source of discourse: the views of key policy actors, academics and NGO staff who had been involved in developing the policies that are listed in Table 3.2 above. The interviews were designed to elicit further information about the policy and whether the policy was currently active in progressing population mental health.

Interviews were also conducted at Stage 4 of the research as a part of the analysis of the two nested case studies and are discussed in the following section.

Gaining information relevant to each policy from another source of discourse (interview data), served to both extend the richness of the data attained about each policy and enable me to confirm the significance of each policy document in directing the work of the sector. This is important as the presence of policy alone does not signify its valuing. "The researcher needs to determine not only the existence and accessibility but also the authenticity and usefulness of particular documents" (Bowen, 2008, p.38). In this sense, the interviews have been used to enable insight into the currency, authenticity and usefulness of the identified policies in the sectors. Analysis of both document and interview data allows for a "confluence of evidence that breeds creditability" (Eisner, 1992, p.110) enabling me to identify the policies which best progress population mental health. The practice of triangulating sources of data is consistent with good qualitative research practice (Denzin & Lincoln, 2005; Yin, 2009; Patton, 2002).

Interview process

Interviewing is described by Baum (2008) as a "powerful way of getting detailed pictures of how people experience and explain their worlds and semi structured interviews will allow for variance in the interview format and process which will support reflective processes" (p.7). I was aware that the population I was interviewing for my research was diverse, with policy actors, NGO staff and academics working at different levels in different sectors. I anticipated that views regarding mental health, would be varied and for some participants who worked in the non-Health sectors being interviewed about mental health might seem outside their field. For this reason, an interview format that accommodated interview diversity, as Baum suggests above, was required. My aim was to use an interview process characterised by non-judgement and curious intention, for it is in this inter-relational space that open reflective processes are made more possible, and a semi structured interview format was used to support this. More detail on the interview question guide is provided below.

I took practical instruction and meaning from Robson (2002), on the interviewing process, who suggested flexibility during the semi structured interview so that: "…the order can be modified based upon the interviewer's perception of what seems most appropriate. Question wording can be changed, and explanations given; particular questions which seem inappropriate with a particular interviewee can be omitted, or additional ones included" (p 270). By changing wording and focus according to the interview focus and tone, interviews became more characterised by dialogue and conversational exchanges. This enhanced the quality and depth of information that I collected.

My approach to interviewing policy actors was to facilitate interactional reciprocity by ensuring confidentiality, supporting their response to questions but also to encourage the discussion of any issues that they understood to be important (Lancaster, 2017).

In the following sections I describe the interview process and analysis: study population and sample, ethics, interview question guide, ethics, recruitment and participation rates.

Study Population and sample

The lists of potential interviewees included people from the three sectors who had written and influenced the context of each policy or were academics who had contributed literature to the policy area. I compiled these lists by searching for information about each policy on the internet and utilising my supervisor networks in each sector to find out who had been involved in developing each policy.

It was imperative to interview those who were 'information rich', that is those who possessed detailed understanding and experience of how mental health was incorporated into development of the 11 policies. This meant purposeful sampling was required. Patton (2015) discusses 'purposeful sampling' as a technique that is widely used in qualitative research to support the identification and selection of information-rich cases, in order to make the most effective use of limited resources. The identification of those in the study population who were best placed to provide information relevant to the identified policies was needed to progress my research.

Interviews for this stage of research were conducted with 'elite' participants, those who are understood to be people in positions of power with decision making capacity and access to privileged information (Lancaster, 2016). The positions held by participants who were interviewed as policy actors included Acting Chief Executive Officers, Directors and Managers, and all had senior-level roles and responsibilities in relation to one or other of the 11 policies. Because many of the interviewees had oversight over multiple policies in each sector, they were able to comment on broader policy directions being pursued, adding to the depth and quality of the data.

The positions held by academics and non-government agencies included Professors, Associate Professors, Managers and Senior Research Fellows.

The selection of prospective interviewees was enabled by the following:

- identifying the authors and members of working groups who developed the policies and related documents
- reviewing the current organisational structures and related web-based information for all sectors', universities' and Non-Government Organisations.

- discussion with my supervisors who had knowledge of key policy actors, researchers and academics associated with the policies
- Information received from interviewees about other potential interviewees who had also been involved in developing the policies

This process enabled the identification of 27 potential interviewees, of whom 22 were interviewed. Of the 5 invitations to participate in the research that did not eventuate, two people were unable to be contacted, two were in the process of leaving their positions and 1 declined to participate. I have not separated out the Natural and Built Environment policy actors or the NGO representatives and academics in Table 3.3 below, as the study sample numbers are low in order to maintain my commitment to maintain anonymity among the interviewees.

Sector	**Study Sample**
Health policy actors	9
Natural and Built Environment policy actors	8
NGO and Academic	5
Total Interviewees	22

Table 3.3 Summary of the study sample for Research Stage 3

Ethics

Ethics approval was received from the Flinders University Social and Behavioural Ethics Committee on the 21/10/15 (Research Project no 7105). Additional approvals for research with SA Health staff was received from the SA Health Ethics Committee on the 27/5/16 (HREC/16/SAH/34). A revision of internal review practices in SA Health at the time of my application accounts for the time difference in the two approvals. There was no extra requirement for ethics approval from the Natural Environment and Built Environment sectors. Refer to the Appendix for a copy of my Letter of Introduction (Appendix C), Research Information sheet (Appendix D) and Consent form (Appendix E). The right to privacy and confidentiality was addressed in the Information Letter and details about the audiotaping of the interview, storage of audio data, storage of written transcripts and the right to amend transcripts was also communicated, in addition to alternatives to work-site interviews.

Interview question guide

The semi-structured interview guide for the third stage of research (Appendix F) was developed with questions that directly related to the WPR analytical approach. Essentially the same questions utilised in coding the written policy documents were asked of policy actors. Examples are given below of both the questions and how they relate to the WPR approach.

Bacchi's questions	Interview guide questions examples
1.What is the problem represented to be?	What are the key issues being addressed in the policy and does it relate to health or mental health?
2. What key assumptions regarding mental health underpin the policy?	What understandings of mental health are conveyed in the policy?
3. What remains unaddressed in policy?	Were there issues or actions you would like to have been addressed in this policy?

Table 3.4 Examples of how the WPR approach informed Stage 3 interview questions

The development of the interview guide was overseen by my supervisors and was piloted with a former state government policy actor. Following this pilot, some minor changes were made to the interview guide. Importantly though, the piloting process facilitated my reflection on the interview process itself, which served to heighten my awareness of the possible need to extend or reinforce my explanatory preamble about the purpose of the research depending on the interviewee's knowledge, experience and/or role. Such reflection and progressive adaptation of the interviewing tool is consistent with the instruction from Robson (2002) previously discussed.

Interview recruitment, participation and process

I emailed participants and included three attachments, the letter of introduction, research information sheet and consent form. I included a short message in my email requesting assistance with my PhD research by participating as an interviewee and stating my experience in working as a SA Health employed clinical psychologist. This was done to support my credibility. I emailed back potential participants if I had not heard from them in a week and then phoned a week later if I had no reply. I did not pursue further contact after this third attempt. Where auto replies were returned stating times for contact, I complied with those times and recontacted accordingly. Given that many potential participants were in executive positions, several return contacts were from personal assistants, who I then replied to in kind, assuming a shared confidentiality.

Participation rates were high (81%). Interviews for Stage 3 commenced on 6-3-2016 and concluded on the 14-11-2016. The majority of participants engaged in a face to face interview in their workplace while two participants chose a face to face interview in a neutral setting and two chose phone interviews.

I was keen to maximise face to face interviews where possible, given that these provide an opportunity to establish rapport and share a common space in which to discuss issues and co-construct meanings about the phenomena being researched (Holstein and Gubrium, 2005). I conducted all the interviews myself.

I took advice from McEvoy (2006) who suggested interviews start with broad, easy questions that explore the territory 'closer to home', before asking more difficult or abstract questions. I was also specifically mindful of interviewees' awareness of my background as a clinician and the subject being mental health, both which can elicit curiosity, apprehension or invite personal debriefing and in this respect the structure provided by the interview guide was helpful. A significant number of interviewees expressed concern about the rising incidence of mental health issues in the community and for some in their workplaces.

Interviewees were characterised not only by their deep knowledge related to their work area but by the level of energy and enthusiasm for their work and the goal of contributing to the common good. Interviewees were generous with their time and their insights, the majority of interviews spanning over an hour.

Interviews were audio recorded and transcribed by a professional transcriber who had a history of transcribing for Flinders University in the social sciences. Interviewees were sent a copy of the written transcript to peruse and given the opportunity to alter any content they were concerned about. I then analysed the transcripts using NVivo 11 software.

Interview analysis

The interview analysis was completed using the same coding framework as was used in the document analysis, allowing for comparison. The only difference to the framework was the addition of a node to note evidence of convergence between the document and interview data.

The process of analysis involved the following four processes.

Post Interview note taking and reflection

Post interview, I took notes immediately and listened to the interview on the recorder in the days immediately following. I noted my immediate impressions, interview observations, key points that the interviewee raised and returned to and themes that emerged in the interview process. In part, this process relates to what is described as immersion by Green et al. (2007) and I attended to this task with deliberation, reflecting on the interview approach and any aspects of the approach that might be improved.

For example, in my first interview with an Indigenous policy actor, I became aware that my use of the concept, 'psychological wellbeing', as an individualist concept did not translate well for Indigenous Australians and that 'health' and 'cultural safety' were identified in the interview as preferred terms. These terms were viewed as consistent with Aboriginal culture and the concept of wellness as holistic, contextual and situated. This was a salient point and I modified my interview approach and language according. I also attempted to schedule my interviewees by sector as much as possible, to enable my knowledge of the sector to develop.

Reading the transcript for meaning

I read each transcript several times to facilitate immersion. Again, I attempted to read transcripts from the same sector at the same time, which assisted my ability to identify the emergence of common sector-based themes. For instance, it was at this stage that I became aware of the consistent divergence between the information gained from the Health sector policy documents and information gained from Health sector policy actors and academics, as I explain next in Chapter 4.

Coding analysis

I then coded each transcript using both open and axial coding. I started the process with open coding, noting which codes proved to be more relevant as themes emerged and I then used axial coding to examine the data coded to each node and sub-node and the relationships between them. I was mindful of Patton's description of the process of data analysis, being one of qualitative data reduction, essentially a "sense making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings" (Patton, 2002, p.453). This analysis provided additional data relevant to the research questions, enabled further insight into the 'authenticity and usefulness' of the identified policy documents and was also used to review the findings from the second stage of research and in this respect, provided evidence of convergence between the document and interview-based information.

Synthesis of findings from the document and interview analysis

I generated reports from Nvivo to show all data coded to each node. Analysis of the data in relation to each sector and the two stages of research, allowed me to obtain a comprehensive understanding of where the data converged, enabling identification of the themes discussed in the Findings chapters.

Based on the above analysis, and my broader understanding of literature in the field, I identified the policies that I believed, and that had been confirmed by the participants, as most likely to promote population mental health for each sector. This process resulted in the selection of one policy from each of the Natural Environment and Built Environment sectors, that is, the *Healthy Parks, Healthy People Strategy – Making Contact with nature, Second Nature* from the Natural Environment sector and the *30-year plan for Greater Adelaide* from the Built Environment sector. No policy from the Health sector could be identified, as discussed in Chapter 4. Case studies were then chosen as examples of implementation of the two selected policies, the *Healthy Parks, Healthy People Action Plan – Realising the mental health benefits of contact with nature* from the Natural Environment sector and the *Bowden redevelopment* from the Built Environment sector. The selection of these specific policies and exemplars selected is discussed in detail in chapters 5, 6 & 7, respectively.

Stage 4 - Nested Case Studies

The final stage of the research process was the nested case study analysis in which I collected data about the policy implementation exemplars. The examination of these policy implementation exemplars enables the gathering and analysis of data related to the real-world decision making associated with policy, as is consistent with case study methodology (Baum, 2015).

The data for the nested case study analysis included that gained from interviews and from supplementary sources which are listed in Appendix G. The methods applied during Stage 4 included further document and interview analysis, including analysis of documented notes taken from site observations and workshops concerning the case studies. The interviews undertaken during Stage 4 were used to gather information from policy actors who were implementing the identified exemplars. Data from these interviews were also supplemented by data identified from the first round of policy interviews at Stage 3 of the research, where mention of either case study was made. This was enabled by the addition of a node to the coding framework in which reference to either case study was noted and explored. To supplement the interview data, Yin (2003) states the need to access data from other sources to corroborate the interview findings, stressing that case study sources need to be varied. Accordingly, I drew on materials from state government departments and sectors, local government, developers and research related to the nested case studies, in addition to notes from my site visits and meetings and workshops I attended.

In the following section I describe the study sample and the interview question guide (Appendix H) that I used in stage 4 of the research. I will not discuss the study population, ethics, interview recruitment, participation and process or the analysis because these were the same as those applied during Stage 3.

Study sample

Purposeful sampling was utilised again for the nested case study interviews. The identification and selection of information-rich cases for this fourth stage of research meant interviewing policy actors with operational knowledge of each nested case study. The sample included Directors, Managers and Policy Officers. A maximum variation sampling strategy was employed to support a diversity of data (Patton, 2002).

As in the previous round of interviews, an interviewee in a higher-level position or in a position with intersectoral responsibilities was able to offer information relevant to both the nested case studies I was examining, adding to the quality of data.

The determination of interviewees was enabled by the same process outlined in 3.3.3., and 12 potential interviewees were identified, of which 11 were interviewed, a participation rate of 91%. One of the potential participants did not reply to an invitation to participate in the research. As stated, data were also used where relevant from the previous interviewees, that is, 7 of the initial 22 participants cited information relevant to the case study, which was also used as corroborating evidence, totalling a sample of 18 interviewees.

Nested case study	**Study Sample**
HPHP Case study	10
Bowden redevelopment Case study	8
Total Interviewees	18

Table 3.5 Summary of the study sample for Research Stage 4

Interview Question Guide

The semi-structured interview guide for the fourth stage of research (Appendix H) was again developed with questions that related directly to the WPR approach but with a focus on the policy implementation exemplar as opposed to the broader policy. Again, the development of the guide was overseen by my supervisors.

In the following final section, I discuss how I have ensured research rigour in all stages of the research.

3.4 Ensuring research rigour

"Historically, reliability, validity, objectivity and generalisability were viewed as standards against which to judge all research, including qualitative research" (Rossman & Rallis, 2010, p. 505); however, over time, the applicability of these concepts has been revised and extended to take better account of the methods and merits of qualitative research. The concepts of reliability and validity are equally valued in both positivist and interpretivist research but the history and use of these concepts is strongly associated with positivist research, presenting little opportunity for these concepts to align with the key elements of qualitative research. Thus, over the last thirty years, suggestions have been made about alternative approaches to ensure qualitative research quality and credibility.

Rossman and Rallis (2010) suggest that research quality and credibility is linked to the appropriateness of the study's design for the research questions posed, the depth and rigour displayed in the data collection and the richness and integrity of the analysis, highlighting the use of methods that are fit for purpose and applied well. Alternatively, Davies and Dodd (2002) highlight the qualities that a researcher brings to the task as important to research quality and credibility. They stress that trustworthiness and rigour are ensured by the researcher's attentiveness, empathy, carefulness, sensitivity, respect, reflection, conscientiousness, engagement awareness and openness.

Denzin and Lincoln (2005) suggest that when using a constructionist paradigm, the concepts of trustworthiness, credibility, transferability and confirmability need to be addressed and it is these concepts around which I have structured this section, illustrating links between my research and the four concepts they highlighted.

3.4.1 Trustworthiness

I have described the research design and the processes followed in this chapter, linking them to my reasoning and rationale which Patton (2002) considers central to trustworthiness. The articulation of the research questions, the data collection methods, the fit between questions and methods and the analytic concepts applied to the data have been articulated, demonstrating commitment to research processes ensuring trustworthiness. However, as Davies and Dodd (2002) highlight it is not only the processes employed, but the way in which the processes are applied that ensures trustworthiness.

At the commencement of the document analysis, I took guidance from Bowen (2009) who stated, that document analysis is about "…evaluating documents in such a way that empirical knowledge is produced, and understanding is developed. In the process, the researcher should strive for objectivity and sensitivity and maintain a balance between both" (p. 33). I took this lesson across all forms of data collection. In relation to data analysis and interpretation, I learned from Guba and Lincoln (2005) who stress that no research is value free and objective, as is consistent with my epistemological position. It follows that I needed to employ an ongoing and active reflective process at all stages of the research, which I now explain.

Reflexivity is the process of reflecting critically upon the self as a researcher, an instrument within the research (Guba & Lincoln, 2005, p.210) - a process applied in relation to design, data collection, analysis and interpretation. I engaged continuously in a process of reflection throughout the research, challenging myself to maintain an openness to the multiple realities in the data and to bring forward the themes that were present, as is consistent with constructionism. Likewise, I challenged myself to ensure a critical constructionist approach was applied to all data, acknowledging my frames of reference but allowing "the empirical material to inspire, develop and reshape theoretical ideas" (Alvesson & Skoldberg, 2009, p.273).

Davies and Dodd (2002) discuss the importance of researcher adaptability in authentically examining unexpected outcomes outside the stated frames of reference and in relation to this I offer the following example. I initially excluded the *SA Suicide Prevention Strategy* at the first stage of research, given the overt focus on mental illness but having received information from interviewees at the third stage of research, which suggested my decision regarding the exclusion of this policy needed to be revised, I added this policy to the subset of Health policies examined, as discussed in Chapter 4. In this instance I responded to what the interview process revealed and accommodated this unexpected finding and in doing so I developed further insight into what it is that I as the researcher brought to the research.

Further, reflexivity is important to accountability. I took my commitment to data collection and analysis seriously, in relation to both written and interview data. In relation to interviews specifically, I considered my role was to support an emotionally safe environment, use curious intent and ask, listen, respond and interpret interview information accurately and sensitively. As such, this approach aligns with the values discussed by Davies and Dodd (2002) as central to trustworthiness.

3.4.2 Credibility

In researching mental health through a number of different lenses (three sectors), broad and deep understandings have been enabled, which has translated into thick descriptions of data, which are associated with research credibility (Patton, 2002).

The analysis of written documents, interviews and the two nested case studies supported access to a diverse and detailed data set. Using multiple methods and sources, high-quality data has been yielded, data that conveys a diversity of perspectives and authentically represents multiple realities. Patton (2002) highlights that research that uses different sources and methods demonstrates attention to the need to triangulate data to ensure the validity and reliability, linked to credibility.

Purposeful sampling in relation to both policies and interview participants was used to strengthen data quality and validity. The content analysis performed at Stage 1 ensured relevant policies were included in the research and the purposeful interview sampling used at Stages 3 and 4 ensured that participant interviews were conducted with those positioned to provide relevant, rich and critical information. Open ended questioning and the use of a broad range of supplementary material used at Stage 4 of the research are also examples of techniques used to augment the breadth and quality of data.

Further, my experience in interviewing I believe was helpful in providing an opportunity for meaningful discussion and obtaining rich data. Two observations made over the course of the interviews demonstrated a strong engagement with the subject matter: the significant length of interview time and participants appreciation of the opportunity to think differently about their work role and the intersection with mental health.

Triangulation was also supported by the involvement and participation of my three supervisors in the process of research. My supervisors have read through transcripts, reviewed my coding framework, reviewed my coding practice and reviewed my findings at each stage of research prior to progressing onto the next, allowing me a forum to be questioned and to review research as it progressed, adding to research quality.

3.4.3 Transferability

Transferability is supported when data consistently links the phenomena being researched to the cultural and social contexts in which it exists, allowing for a rich understanding of how, why and what i.e. thick descriptions of data (Patton, 2002). I believe that positioning my research in multiple sectors adds to the transferability of my findings. Lincoln and Guba (1985) state that transferability is established by producing research that provides rich and robust material relative to the phenomena being examined and linking it to contexts that surround it, that is, providing thick descriptions of data. My attention to the positioning and framing of text in policy, the emotional overtones present in interviews and the observation of who in a workshop assumes authority, are all examples of approaches that support thick descriptions. As an example, it is through listening and reflecting on interviews, not only for meaning but for emotion, that I became aware of frustration, resignation, hope, delight, conviction and only rarely mediocrity.

This knowledge “contributes to the depth of understanding that can be generated and provides greater potential for thick description of findings and analysis” (Patton, 2002, p. 437) enabling transferability.

3.4.4 Confirmability

In writing up this chapter with details of the research design, data collection, analysis and interpretation, I have recorded what was done in this investigation, establishing an audit trail. I have provided details relevant to the steps taken from decisions regarding research design and rationale to the interpretation of the findings and in supporting transparency into my research processes, I support confirmability (Patton, 2002). In relation to my research I have confirmed the rationale behind the selection of data utilised, the processes associated with the gathering of data, the rationale behind the coding framework and the utilisation of qualitative research strategies such as coding queries and reports to enable the reconstruction of data into findings and concepts relevant to the research questions.

In summary, this chapter has explained the philosophical foundations on which this research is based, and the methodology and methods I employed to design and undertake the research. The next chapter is the first of three Findings chapters, Chapter 4 will discuss the findings from the Health sector, followed by Chapter 5, the Natural Environment sector and Chapter 6, the Built Environment sector.

CHAPTER 4 HEALTH SECTOR

Overview

The next three chapters of this thesis present the research findings from the analysis of written policies and strategic level interviews from the following three sectors:

- Chapter 4: Health sector - Department of Health and Ageing[3].
- Chapter 5: Natural Environment sector - the Department of the Environment, Water & Natural Resources[4].
- Chapter 6: Built Environment sector, inclusive of the Renewal SA, Housing SA and the Department of Planning, Transport and Infrastructure.

The findings in each chapter are presented using the same format.

- First section - Policy document analysis (Research Stage 2)
- Second section - Strategic interview analysis (Research Stage 3)
- Third section - Case study analysis (Research Stage 4)

This chapter presents the findings that have emerged from the policy analysis and interviews relating to the 14 Department of Health and Ageing (DH&A) policies selected after the initial content analysis.

In the first stage of research policy documents were scrutinised and analysed using Bacchi's methods. These methods have been applied to enable the identification and examination of the problematisations, assumptions and silences present in policy and their relationship to health and mental health. Where problem representations were assessed as consistent with a focus on mental health (not mental illness), an understanding of the impact of the social determinants of health on mental health, or the need for population-based approaches, policy was determined to have the potential to promote population mental health and psychological wellbeing.

Analysis identified six DH&A policies that demonstrated potential to promote population mental health and these policies progressed to the second stage of research. The results of this first stage of analysis are reported in the first section (4.1).

[3] Since the 1/7/18 the Department of Health and Ageing has undergone a name change to the Department of Health and Wellbeing, however for the sake of consistency I continue to refer to the name of the department at the time of commencing research.

[4] Since the 1/7/18 the Department of the Environment, Water & Natural Resources has undergone a name change to the Department of the Environment and Water, however for the sake of consistency I continue to refer to the name of the department at the time of commencing research.

In the second stage of research, data were collected to enable further exploration and interrogation of the identified policies. Strategic level interviews were conducted with DH&A policy actors and academics associated with the identified policies (13 interviews in total, 10 policy actors and 3 academics). The purpose of this stage of research was both exploratory and confirmatory: exploratory in that the strategic level interviews enabled further insight into the implementation of each policy, its positioning within the sector and its relationship to current departmental goals, culture and practice; confirmatory in that this data enabled an informed assessment of whether the identified policies were active policies with potential to enable population mental health promotion. These results are reported in section 4.2.

In the third stage of research, data relevant to a case study would have been presented as per the two other findings chapters. However, despite the identification of six Health sector policies, at the first stage of research, none of these policies sufficiently represented mental health promotion to justify their inclusion as a nested case study.

4.1 Document analysis

The results from the document analysis of the fourteen policies from the Health sector, utilising Bacchi's, *What's the Problem Represented to be?* approach are presented in this section. Analysis applied the following three questions.

1. What is represented as a problem in the selected Health sector policy and how does mental health fit with that problem representation?
2. What assumptions regarding mental health underlie this representation in the policy?
3. What was left unaddressed in the policy examined and where are the silences regarding mental health?

Each policy is introduced prior to analysis.

A summary of the research process is provided in the following table. The table lists all health policies, research stages and results.

Health and Aging Sector	**Document analysis**							**Interview analysis**	**Nested case study analysis**
	Stage 2 Research							**Stage 3 Research**	**Stage 4 Research**
Year	Document	Problem representation	Policy consistent with the biomedical model	Policy consistent with a social view of health	Critical scrutiny identifies the consideration of mental illness in the document	Critical scrutiny identifies the consideration of mental health in the document	Policies for 2nd stage research	Evidence of policy to practice actively promoting mental health for all	Case Study
2007-2016	SA Health Care Plan	Need to plan, build and organise infrastructure development of the RAH hospital and other state health infrastructure					NO		
2009-2016	Health Service Framework for Older People	Need for a state response to the increased health needs of the population of older people					NO		
2009-2018	Chronic Disease Action Plan	Need for plan for the care of older people with chronic disease, specific illness or palliative needs.					NO		
2012-2016	SA Framework for Veterans	Need to develop policy that outlines continuing veteran medical care in alternative health facilities.					NO		
2011-2016	Alcohol and Other Drugs Strategy	Need to reduce harm associated with the					NO		

		use of alcohol and other drugs							
2012	Youth Mental Health and System of Care Document	Need to articulate policy and strategy for the stepped system of care for young people with mental illness.					NO		
2014-2019	Mental Health Guideline: Pathways to care Policy	Need to articulate policy and strategy for the stepped model of care working across the lifespan for those with mental illness.					NO		
2012-2015	SA Dental Health Promotion and Practice	Need for a specific focus to improve oral and dental health in the population and prevent the need for dental services and care.					NO		
2014-2019	Prosperity for Longevity – SA Ageing Plan Our Vision	Need to challenge the discourse associated with ageing: disability, dependence and decline.					YES	NO	
2010-2016	Aboriginal Health Care Plan	Need to develop an intense and culturally appropriate health care focus on the health needs of the Aboriginal population.					YES	NO	
2011-2016	Eat Well Be Active Strategy	Need to address the increasing level of obesity in the population given its					YES	NO	

		relationship to chronic disease.							
2013	SA Public Health Plan - A Better Place to Live	Need to articulate the public health measures taken at a state level to strengthen, develop and support population health and wellbeing.					YES	NO	
2010-2015	Mental Health and Wellbeing	Need to articulate key policies concerning the range and implementation of state mental health services to support recovery processes of those with mental illness and promotion of positive mental health.					YES	NO	
2012-2016	SA Suicide Prevention Strategy	Need to address the incidence of suicide.					YES	NO	
Total – 14 Policies									**Case study selected = 0**

Table 4.1 Summary of Health sector policies, research stages and results

The State Health Care Plan 2007-2016

The SA Health Care Plan (2007-2016) details action to address the state's health challenges and outlines the services, workforce and infrastructure that will enable this. The plan has a 10-year timeframe and positions hospitals as central to state health care. The new Royal Adelaide Hospital (Opened in October 2017) is highlighted as the nations' most advanced hospital with 'state of the art' medical technology and innovation. Health care challenges for SA Health care are identified and include: the ageing population, chronic disease, obesity, diabetes, the growing demand on hospital services, the health workforce, ageing infrastructure and safety and quality.

The *State Health Care Plan* is focussed primarily on the development of the new Royal Adelaide Hospital and associated state health infrastructure i.e. hospitals and clinics. This is demonstrated through the inclusion of text such as:

> *The plan outlines the most significant single investment in health care in South Australia's history* (p.3).

and

> *SA's Health Care Plan will reform our health system so that it meets the health challenges of an ageing population, the increasing incidence of chronic diseases, international workforce shortages and ageing infrastructure. These changes will ensure South Australians have access to the best available health care in hospitals, health care centres and through GP and other health professionals* (p.9).

These quotes exemplify the text in the plan which discusses health care and health outcomes for South Australians as associated with hospitals, clinics and health professionals. Much of the text concerns the need to reform the health system to meet the needs of an ageing population and the increasing incidence of chronic disease. The link between ageing and chronic disease is explicit in the document but the link between the social determinants of health and chronic disease is absent, suggesting the dominant application of a biomedical lens to the issue. The concept of prevention is mentioned in relation to chronic disease i.e. "*illness prevention aimed at keeping people healthy and out-of-hospital" (p. 26)*, but is suggestive of a secondary prevention focus, that is to intervene to prevent increased disease severity. The document identifies the GP Plus Health Care Centres as the community-based infrastructure central to the aim of preventing chronic disease. The "*GP Plus Health Care Centres will help South Australians take control of their health care, stay healthy and out-of-hospital*" (p.11). The emphasis on individual responsibility for health reflected here is consistent throughout the plan as is illustrated in the section titled "*Helping you choose a healthy lifestyle*" (p.11) and although not overtly stated, the implied problem representation is that, people are not taking adequate individual responsibility for their own health. The role of the health system, given this representation is one of educator and supporter.

> *We will provide greater access to information on how to maintain a healthy lifestyle, and more importantly, we will ensure there is greater support to assist you* (p.11).

In the eight health challenges outlined in the document, mental health does not feature. There is a section titled 'Mental Health', which concerns information regarding facilities, services and the stepped model of care, essentially the components of the health system in place for those with mental illness. Despite the term 'mental health' being used in the document, the problem represented is one of illness. This representation enables policy solutions relating to medical intervention and access to service, facilities and treatment, not solutions relating to the promotion of mental health or the prevention of mental illness. Mental health as a separate construct to mental illness does not feature in the document and the prevention of mental illness or the promotion of mental health is absent. Acknowledgement of the impact of the social determinants of health is likewise absent in *SA Health Care Plan* as is health inequity.

The Health Service Framework for Older People 2009-2016

The Health Service Framework for Older People 2009 – 2016 articulates strategies to address the increasing health needs of the ageing. A health service model of care is proposed to address the needs of older people in the community, given the increased demand on health services and hospitals. The proposal outlines a continuum of care to be provided across the community, including: services provided at home, residential facilities, GP Plus Health Care Clinics, hospitals and rehabilitation centres.

The *Health Service Framework for Older People 2009 – 2016* further asserts the need to reform the health system to respond better to the health needs of older people and those with chronic illness, as discussed in the *State Health Care Plan*. The problem addressed in this policy is the need to stem the treatment demand on hospital and clinics that is represented as resulting from increased incidence of chronic disease due to ageing and increased longevity as was highlighted in the *State Health Care Plan*. There is emphasis in the document on the delivery of interdisciplinary person-centred care and treatment out of hospital. As in the *State Health Care Plan*, the document replicates the emphasis on individual responsibility for health, as the following reference affirms. The second reference reflects an individual-behavioural view of health.

> *Healthy ageing and individual responsibility for health will be promoted and supported across the health system* (p.11).

> *The increasing prevalence of chronic diseases is linked to unhealthy lifestyles, particularly the consequences of under nutrition, obesity, smoking, alcohol and a lack of physical exercise* (p.12).

The *Health Service Framework for Older People* aligns ageing with increasing difficulties, dependence and disabilities and proposes health management solutions accordingly.

Consistent with the individualisation of health/illness, the document does not consider the older population as a whole group, the focus is on specific illness groups within the older demographic. Sections in the document outline specific treatment and health care management strategies for older people diagnosed with cancer, dementia, delirium, cognitive decline, mental illness and stroke and in need of palliative care and it is these older people that are considered to be subjects of this policy. Those older people outside of these specific populations remain excluded from the *Framework*.

The *Health Service Framework for Older People* articulates two key aims*: "to support the older person to take the best care of their health (p.12)"* and *"adjust services to match the shifting patient profile" (p.10).* Both approaches illustrate an individualised treatment approach consistent with a biomedical and/or an individual – behavioural view of health, which is the dominant representation of health in this document.

Consistent with this representation of health, solutions relate to treatment and tertiary and secondary prevention, i.e. care that prevents further disease development. Approaches to support the prevention of illness, ie primary prevention, are absent. Interestingly though, the document acknowledges the value of primary prevention, and indicates that this is the work of the *Primary Prevention Plan (2011-2016).* However, this document was withdrawn as an active policy in 2012, following a SA Health Review (McCann Review, 2012) and no similar replacement plan was identified during this research. *The Chronic Disease Action Plan (2009)* also acknowledges the need for such an approach. However, the release of the *Primary Prevention Plan* in 2011 and its withdrawal in 2012, five years prior to its expiration, represents a serious impasse on the ability of the Health sector (at the time of the research) to engage in primary prevention.

Mental health is again conflated with mental illness in the *Health Service Framework for Older People* and as in the *State Health Care Plan*, and mental health as a separate construct to mental illness does not feature. Mental illness is discussed, with specific attention directed to those older persons with neurodegenerative conditions and those with depression and/or at risk of suicide. The representation of mental illness as a neurological and/or psychiatric condition enables solutions to be developed that focus on additional specialist treatment and the development of aged care facilities with expert psychiatric care. Ironically, as the research was being undertaken, one of the state aged care facilities developed to care for older people with mental illness was shut down given proven allegations of abuse and neglect (Siebert, 2018).

The dominant representation of health as a biomedical condition, precludes consideration of the health and wellbeing consequences of social isolation and loneliness in old age or the changed family structures, social networks or economic challenges that predispose older people to poor mental health (Courtin and Knapp, 2017; Lim, 2018).

Likewise, structural inequalities in conditions of living and access to health services and resources, which contribute to socioeconomic inequities in chronic disease, are not considered.

Chronic Disease Action Plan (2009 - 2018)

The Chronic Disease Action Plan (2009- 2018) is focused on: asthma, musculoskeletal conditions i.e. osteoporosis and osteoarthritis, diabetes, heart disease and chronic airways obstruction. These conditions are considered preventable and the document articulates the need for a range of strategies (prevention, early intervention and disease management) to address the rising incidence of chronic disease and prevent hospitalisation.

The *Chronic Disease Action Plan*, like the previous document the *Health Service Framework for Older People,* aims to address the increased likelihood of hospitalisation for older people with chronic disease, again representing the problem as older people not taking adequate care of their health.

Both documents stress the increasing cost of health care associated with this population cohort, illustrating the economic driver that underlies the emphasis in the document on establishing services in the community to avoid hospitalisation.

The strategies proposed in the *Action Plan* relate to secondary and tertiary prevention. The need for primary prevention strategies is recognised, however, is not seen to be the responsibility of the *Action Plan*, but is rather deferred to the *Primary Prevention Plan (2011-2016*) [yet to be released at the time that the *Action Plan* was developed] and as stated, this Plan was withdrawn soon after its release.

Importantly, the social determinants of health are acknowledged in the *Chronic Disease Action Plan (2009)* and the need for primary prevention strategies to address the health inequities related to the incidence and prevalence of chronic disease is confirmed.

> *SA Health will develop a Primary Prevention Plan to address statewide primary prevention planning needs. The aim of this strategy is to ensure a consistent approach to primary prevention. The Plan will include actions that address primary prevention of chronic disease at all life stages in a variety of settings, and take into account the broader environmental, economic and social causes of health inequities… Policies, initiatives and programs addressing prevention and the broader causes of chronic disease are a vital part of the overall chronic disease prevention and management strategy in South Australia* (p.10).

The last statement affirms the role of the *Primary Prevention Plan (2011-2016)* as the policy instrument central to the task of addressing the broader causes of chronic disease i.e. the social determinants of health and health inequalities and affirms the need for such approaches within the sector.

In relation to mental health, the document fails to discuss mental health as a separate construct to mental illness. Discussion about mental illness as a chronic condition itself, is also left unproblematised. Mental illness features most strongly, when represented as a factor that can compromise chronic disease treatment.

> *Mental illness, particularly depression and anxiety, contributes significantly to the burden of disease in South Australia, and is commonly associated with the prioritised chronic diseases…For these reasons, depression and anxiety, as co-morbidities of chronic disease, should also be considered in the implementation of the actions listed in this Plan* (p.14).

The understanding of the inter-relatedness of mental and physical health in this instance is dominated by a physical representation of health.

The *Chronic Disease Action Plan* has a focus on 'primary care', that is individual medical and health care provided in the community by a range of health professionals. Analysis of this policy revealed some conflation of the terms, 'primary health care' and 'primary care'. This tendency was highlighted by Keleher (2001) who noted that while 'primary medical care' or 'primary care' is important, it is not consistent with approaches to address the social determinants of health or health inequity, which is fundamental to 'primary health care'.

SA Framework for Veterans (2012-2016)

The SA Framework for Veterans (2012-2016) conveys the continuance of veteran-based health care given the infrastructure changes that are presented in the SA Health Care Plan. The document identifies a model of health care for this specific population group, highlighting 'four pillars of care': mental health, primary care, oral care and aged care and articulates an ongoing commitment to specific health needs of veterans.

Two key messages are conveyed in this *Framework*. The first, is the Health sector's respect and recognition of the contribution made by defence personnel and their acknowledgement of the specialised health needs of veterans. The second, is the Health sector's plan to integrate veteran with non-veteran health services, due to a decision to close the Repatriation General Hospital, the historical repository for information, knowledge and support for SA Veterans. The main problem being addressed in the document, is the need to confirm the availability and access to specialised health infrastructure and services for veterans, given recent departmental changes.

Mental health is highlighted in the document, however critical scrutiny indicates that despite the use of the term, the problem representation in this document is primarily one of mental illness requiring medical and psychiatric intervention. Affective disorders, anxiety disorders including post-traumatic stress disorder and alcohol harm disorders are all specified.

The diagnosis of mental illness presupposes the need for treatment, which is aligned with the new veteran mental health (read illness) care sites at Flinders and Glenside Hospitals. The *Primary Prevention Plan* is again referenced as the Plan through which other aspects of veterans' needs will be supported.

In terms of policy silences, there is no recognition of the relationship between health outcomes for veterans who are subject to social or economic disadvantage, indicating little attention to health inequities or the social determinants of health. Equity in terms of recognition of service for previously marginalised groups of defence personnel, such as Aboriginal and Torres Strait Islander soldiers and women is present in the Framework, recognition that in turn, affords access to health care and services. However, acknowledgement of the injustice of non-recognition over many years, is unaddressed and the broader issues of diversity and inclusion in general, are absent, despite current national defence policy (Defence Diversity and Inclusion Strategy, 2012-2017).

Recognition of the link between social harm, mental illness and alcohol and drug use or acknowledgement of trauma informed principles and practices was absent in this policy, as they were in the *Mental Health and Wellbeing Policy or the Alcohol and Other Drugs Strategy* (yet to be discussed).

Alcohol and Other Drugs Strategy (2011-2016)

The Alcohol and Other Drugs Policy (2011-2016) features a strong focus on harm minimisation. Four objectives are detailed in the policy: 1. Reduce illicit drug use and harms 2. Reduce the rate of alcohol related harm 3. Reduce drug related harm to young people and families of those with substance misuse issues and 4. Reduce harm from substance misuse among Aboriginal people. The partnerships and priority actions necessary to address the stated objectives are outlined. The document also articulates the need for a prevention focus, identifying the need for increased education in schools and increased community-based monitoring systems.

The *Alcohol and Other Drugs* strategy is a strongly structured document, with minimal text. Specific objectives, key priorities, lead agencies and defined measurement indicators for strategy success comprise the majority of the document. The four objectives outlined in this strategy represent alcohol and drug abuse in two related but distinct ways. The first, is as a criminal justice issue, the second, as an individualised behavioural/medical/psychological problem. These representations enable approaches that require the use of law enforcement options and access to treatment and therapy, respectively, both enabling the individual to make more responsible health and lifestyle choices. Again, individual responsibility for behaviour and health is a dominant theme in this document. Despite the two sets of problem representations and solutions being presented however, the following stated objective demonstrates the dominance of law enforcement tools over therapeutic tools.

> *Conduct substance use testing among offenders in the community to monitor the risk of re-offending and associated threats to public safety. This assists in implementing an appropriate response through the courts, Parole Board and corrections system, with consideration being given to a therapeutic intervention in some circumstances* (p.5).

The dominance of the focus on management of the individual with a drug/alcohol issue, renders the complex links between the social and cultural milieu and drug and alcohol use silent in the policy. Issues such as the advertising of alcohol, the associations between sport, gambling and alcohol, the ease of availability and the use of both drugs and alcohol in homes, institutions and workplaces are unproblematised and consequently, solutions regarding population based and/or regulatory measures are absent.

There is no reference to the social determinants of health or health inequity in the strategy and the role of culture and context in the development and maintenance of alcohol and other drugs dependencies is unaddressed. In illustration of this, the strategy notes the need to address the 'social harms associated with injecting drug use' but fails to note the social harms that can underlie the development and maintenance of injecting (or other) drug use. As stated, the strategy fails to recognise the connections between experiences of social harm, mental illness and/or alcohol/drug use (Van der Kolk, 1996; Siegel & Solomon 2003, Courtois, 2014) which remain unproblematised. It fails to consider trauma informed practice or social and structural solutions.

Failure to acknowledge the relationships between trauma and alcohol and drug use was also evident in relation to Aboriginal and Torres Strait Islander populations, although reducing the incidence of harm was identified as an outstanding need. There was minimal detail regarding strategy to address disproportional harm.

> *Addressing the disproportional harm from substance misuse within vulnerable population groups, particularly the Aboriginal community* (p.1).

Failing to draw on connections between colonisation, chronic, repetitive and layered experiences of trauma and the development of drug and alcohol use, again illustrates a problem representation of drug and alcohol use that is situated within the individual, and neglectful of social, economic and/or cultural context.

The Youth Mental Health System of Care Framework (2012) and Mental Health Guideline - Pathways to Care Policy Guideline (2014-2019)

The Youth Mental Health System of Care Framework (2012) and Pathways to Care Policy (Mental Health Guideline) (2014-2019) relate strongly to the provision of treatment, care and service delivery, utilising the stepped model of care. The Youth Mental Health System of Care Framework details the accessibility and availability of treatment for young people with mental health issues (read mental illness). The document emphasises the need for collaborative partnerships to enable recovery from mental illness for young people. The Pathways to Care document presents similar information relating to treatment, the stepped model of care and service delivery, but for those adults with mental illness.

These documents are considered together as they both serve to articulate the system of care for those youth and adults with mental illness.

> *The stepped system of care, composed of less to more intensive services from community-based service to inpatient care, allows people to move flexibly between the service system, steps which are integrated, coordinated and underpinned by collaborative partnerships* (Youth Mental Health and System of Care, p.16).
>
> *South Australia has a stepped model of care, delivering a range of service types and settings to accommodate the varying needs of individuals requiring assistance with their mental health. All settings are part of an integrated whole, providing flexible care and treatment options to adjust to the changing needs of the person, their health status and stage of life* (Mental Health Guideline – Pathways to Care, p.1).

Both documents concern the management of mental illness and articulate the systems and protocols developed to provide treatment and care to those with mental illness. Recovery is a central concept in both documents, the assumption being that recovery requires access to a best practice model of treatment and an efficient system of care. Despite the use of the term mental health in both these documents, the problem representation in both documents is one of mental illness. Mental health as a separate construct, is again, not present in these documents.

The two documents do differ however, in that they serve different demographics. The *Youth* orientated document emphasises the need for collaborative service provision, that is, working towards recovery with families, educational bodies, community-based supports and GP's. The specific mental illness needs of vulnerable or at-risk populations are recognised in the document, including youth who are homeless, fostered or from CALD (Culturally and Linguistically Diverse Backgrounds) or indigenous communities. However, the problematisation of individual mental illness, means that this recognition translates into protocols to prioritise service delivery for at risk populations. Strategy that addresses the mental health inequities associated with the social and relational contexts of vulnerable youth, however, was not prioritised in the *Framework*.

The social determinants of health are unacknowledged in both documents. Given recognition of increasing levels of mental illness for disadvantaged children and young people in Australia and the potential impact on future relationships, education and work (Eckersley, 2008; Australian Research Alliance for Children and Youth, 2018), it might be expected that attention to the social determinants of health as a strategy to promote youth mental health and the prevention of mental illness would be prioritised. Prevention is mentioned in relation to the need to increase the early detection of mental illness, that is, an individualised approach to minimise the extent of the condition.

Interestingly, in the *Mental Health Guideline - Pathways to Care Policy Guideline*, it is acknowledged that those with mental illness may have difficulty coping with socioeconomic disadvantage but the evidence that socioeconomic disadvantage can lead to mental health issues and predominantly accounts for mental health inequities (Allen et al. 2014) is not mentioned.

The *Pathways to Care Policy Guideline* additionally, references the need to reduce the stigma associated with mental illness, the need for care and respect for those with mental illness and the need for consumer participation in care and service planning. Such strategies, despite their appeal to care, civility and engagement, are consistent with a problem representation that consolidates mental illness as an individual condition, invites the person to consider themselves as 'sick' and requires an acceptance of clinical and medical management. As such, these strategies serve to reinforce the power of the biomedical discourse in relation to mental illness and psychiatric treatment. That is, they are consistent with the production of the 'psychiatric subject' (Roberts, 2005).

SA Dental Service – Health Promotion and Guideline (2012-2015)

The SA Dental Service: Health Promotion and Guideline (2012-2015) presents information and strategies relevant to the promotion of oral health and the prevention of dental problems, noting the significant impact of oral health problems on physical, mental and social health. The guideline supports an equal focus on clinical and promotion approaches within SA Dental Service. A range of strategies and supports relevant to individual, community and population approaches are promoted.

The main problem being addressed in the document concerns the need to reduce the incidence and prevalence of oral health issues. The utilisation of the WHO (1986) Ottawa charter within the document, provides evidence of a problematisation of oral health that is consistent with the social determinants of health, and recognises inequities in oral health.

> *A population health approach, that combines both public health and clinical services, and addresses the social determinants of oral health is the most effective way to maximise oral health outcomes for all Australians, particularly those with poor oral health* (p.4).

Importantly, this statement references the use of both public health and clinical models in progressing the work of this policy, outlining the compatibility and value of both approaches. Universal programmes (*SA Dental Health Population Oral Health Programme*), targeted approaches (*Aboriginal Oral Health programme & Better Oral Health in Residential Care*) and individual clinics are described as equally important tools to promote better oral health outcomes.

The guideline highlights the need to address the social determinants of health given their relationship to oral health problems, stressing the need for structural changes to address health inequities and warning about the risks associated with policy that attends to symptoms and not causes.

The relationship between physical and mental health is recognised in the guideline with specific acknowledgement of the impact of poor oral health on mental and social health, leading to low self-esteem, decreased employment opportunity and decreased quality of life (p.5), however mental health is minimally discussed.

Prosperity Through Longevity -SA's Ageing Plan Our Vision

Prosperity through Longevity -SA's Ageing Plan Our Vision (2014-2019) promotes viewing of the older person as an active participant in the economic and social life of the community. The document identifies three priority areas for action: Health, Wellbeing and Security; Social and Economic Productivity and All ages Friendly Communities and serves as a discussion paper, prior to release of an action plan.

In contrast to the discourse of decline, disability and dependence that underlies the *Chronic Disease Action Plan* and the *Health Services Framework for Older People*, this plan aims to provide an alternative view of older people as active participants in the social and economic aspects of community. The plan has direct links to the South Australian Thinker in Residence programme in 2012-2013, where Dr. Alexandre Kalache supported discussion about ageing, care and cultural attitudes to ageing. Two of the priorities presented in this vision are:

> *Recognising seniors as vital drivers of the state's social infrastructure and economy*
>
> and
>
> *Promoting the participation of seniors in civic life and supporting opportunities for lifelong learning and social and economic engagement* (p.5).

Wellbeing as a broader concept is constantly employed throughout the document and relates to a problem representation of health that is consistent with the social and economic determinants of health (Kalache & Kickbusch, 1997).

The assumption conveyed in the document is that 'healthy ageing' is enhanced by maintaining economic independence and participating in the economy, engaging in social and/or learning activities and taking responsibility for maintaining health and wellbeing. The Vision is that both individuals and communities have a role in developing the living conditions, both physical and social, that foster healthy ageing i.e. a healthy setting. Reference to the unequal and inequitable distribution of the built and social elements that comprise a healthy setting or the need to address access to the determinants of healthy ageing is minimal. Importantly, this document is not a plan, although it was envisaged at the time of research that an accompanying document, *Prosperity through Longevity: Action Plan* would be released soon.

Acknowledgement of either mental health or mental illness in the document is also minimal, however, specific reference to the mental health needs (read illness) of the older Aboriginal population, Veterans and carers is referenced. Mental health as an aspect of health for all the population is not discussed, despite the considerable potential for positive mental health outcomes for older people living in communities where an anti-ageist discourse is informing policy and practice and influencing societal culture (Oster et al. 2016).

The Aboriginal Health Care Plan (2010-2016)

The Aboriginal Health Care Policy identifies the following priority areas for policy action on Aboriginal health: child health and a healthy start in life; youth health and safety; chronic diseases; oral, ear and eye health; social and emotional health and mental illness; and preventable injuries. The Plan emphasises the need for health care for the very old and the very young. The document references the need for intersectoral action to address health inequity and the social determinants of health.

The *Aboriginal Health Care Plan* (2010) problematises health for Aboriginal people as an outcome related to the provision of biomedical care and to the social determinants of health. There is acknowledgement that long term improvements in Aboriginal health require action to address the significant inequities experienced by Aboriginal people, by addressing the social determinants of health. The assumption conveyed in the plan is that to address the social determinants of health, collaborative policy and practice needs to be developed and actioned. That is, the 'levers' for long term health gains are seen to lie largely outside of the health sector and it is therefore required for DH&A to work intersectorally to achieve improved health outcomes for the Aboriginal population.

The problem representation of both health and mental health in the document is one which positions health within both a sociocultural and historical framework. The linking of health and mental health, not only to current living conditions but to past conditions and experiences, allows a focus on the expression of health within culture and community. This focus allows the visibility and impact of chronic, repetitive, and layered forms of trauma across the population on mental health to be acknowledged as an outcome related to the past and continuing processes of colonialization and as an outcome that had and has intergenerational impacts.

> *Poor mental, physical, social, spiritual and emotional health and wellbeing is a central issue for Aboriginal people in South Australia and is interconnected with historical and contemporary experiences of trauma, loss, discrimination, social dislocation and isolation. Poor mental health is frequently associated with substance misuse, poor physical health, illness, poverty, unemployment, educational underachievement, family and community violence and incarceration* (p.31).

However, as stated, the plan also focusses significantly on health care delivery, drawing attention to the much higher levels of diabetes, chronic obstructive airways disease, convulsive disorders, cardiac disease and kidney disease that are experienced in the Aboriginal population. There is a tension inherent in the policy regarding the balance between the need for social reform and the need to address immediate health needs. However, as discussed later, the second stage of analysis suggests that the prioritisation of medical needs dominates strategy to address the social determinants of Aboriginal health.

The *Closing the Gap* report from the Commission of Social Determinants is referenced in the document, as is the National Indigenous Reform Agreement, also named *Closing the Gap* (Council of Australian Governments, 2008) and the WHO *Alma-Ata Declaration* (1978) which outlined a commitment to the principles of primary health care. However, Anderson, Baum & Bentley (2007) have raised concern that despite such recognition, links between Aboriginal rights as First peoples, self-determination and health outcomes have not been realised.

The Eat Well Be Active Policy (2011-2016)

The Eat Well Be Active policy (2011-2016) proposes strategies and actions to address the rising incidence and prevalence of obesity and inactivity in the South Australian community. Five action areas are emphasised in the policy as necessary to reduce obesity and increase physical activity: 1. Mobilising the community 2. Making it easier to eat well and exercise 3. Enabling policies that improve our environments 4. Providing accurate and helpful information and 5. Ensuring enablers and supports for change. Strategies ranged from individuals to the population and emphasise the necessity of collaborative governance to improve health outcomes.

The understanding that health is related to our physical and social context is strongly conveyed in this policy, that is, health is problematised as an outcome associated with the social determinants of health.

> *It is difficult to make healthy choices when you are surrounded by barriers, for example no footpaths or poor lighting that make walking difficult; or catering platters full of fried food and vending machines stocked only with sugary drinks and chocolate bars that make it difficult to make a healthy choice. Creating environments that support and encourage healthy behaviours is critical to success* (p.30).

The policy states further that the role of the government in this framing of health, is one of leadership.

> *Strong leadership is required because implementing policies or legislative or regulatory changes or introducing economic instruments such as taxation or pricing measures, is one of the strongest mechanisms to create safer, healthier environments, products and settings, and achieve widespread changes in behaviour across the population* (p.30).

By discussing the availability and possibility of a range of levers in supporting healthy lifestyle changes, the policy acknowledges the need for government leadership to progress legislative or regulatory changes. The introduction of taxation or pricing mechanisms to create safer, healthier products and settings is proposed in order to achieve widespread changes in relation to healthy eating and activity levels across the population. In doing so, it aligns its strategies with the (withdrawn) *Primary Prevention Plan (2011-2016)*. Demonstrating attention to health inequity, the strategy includes both universal and targeted strategies and supports for those who are most disadvantaged.

Mental health is not a central concept in the document; however, attention is drawn to the reciprocal relationship between mental and physical health, identifying positive mental health as an outcome associated with increased physical activity and reduced sedentary behaviour and conversely, identifying the adverse impact of obesity and overweight on mental health. Mental health is therefore problematized in the policy as a dynamic and integrated state viewed as a part of a holistic state of health.

Importantly, the biomedical assumption is not disputed in the document. Both views of health are equally considered.

SA Public Health Plan – A Better Place to Live (2013)

This plan was the first public health plan developed following the changes to the Public Health Act (2011), which legislated local councils to assume an increased role in progressing public health policy. The document identifies four key players as integral to this new collaborative process: local councils, government sectors or agencies that partner with Public Health, the non-government sector and DH&A. The document articulates four priority areas which include: 1. Stronger and Healthier Communities and Neighbourhoods for All Generations Increasing Opportunities for Healthy Living; 2. Healthy Eating and Being Active; 3. Preparing for Climate Change; and 4. Sustaining and Improving Public and Environmental Health Protection.

Within this document, health is problematised as an outcome associated with the social determinants health in *Public Health Policy: A Better Place to Live*.

> *Public health is about the social conditions, the environments character and the opportunities that are available or need developing. It's about the very fabric and structure of our physical and social environments* (p.10).

The *Plan* acknowledges the *Commission on the Social Determinants Health* (2008), the link between socioeconomic status and health and demonstrates recognition and awareness of the impact of health inequity.

> *There is a strong economic dimension to public health outcomes. A higher proportion of people in the lowest socioeconomic groups have poorer health…live in areas characterised by poor urban design and inadequate infrastructure and facilities…* (p.58).

The *Plan* differs from the majority of documents analysed, in that mental health is problematised

not mental illness. Strongly linking mental health to social factors and living conditions, mental health and psychological wellbeing are viewed as outcomes associated with access to the social determinants of health, community safety and social connection. The assumption is that in supporting community we enable and promote the mental health of community members. The document focus is directed towards structural and settings-based change as opposed to individual change. As stated in the plan's introduction the changes to the Act have transferred significant accountability for public health to local councils, which raises concern about the distancing of the state health departments from public health responsibilities.

The Mental Health and Wellbeing Policy (2010-2015)

The Mental Health and Well-being Policy (2010-2015) outlines key policy directions aimed at improving South Australia's mental health care system and the mental health status of South Australians. The emphasis is on an improved system of care, delivery of quality treatment and the need to support a seamless service through the stepped model of care.

Despite reference to promoting mental health, the dominant problem being addressed in this policy is one of individual mental illness and the need to develop systems, strategies and processes with which to manage and treat mental illness. Much of the policy content concerns the systems and services that are needed to provide a person centred, recovery orientated process supported by a stepped model of care that bridges hospital and community mental health care.

> *This policy embraces a number of key policy directions aimed at improving South Australia's mental health care system, promoting positive mental health and supporting the recovery process for everyone who experiences mental ill-health* (p.3).

Thus, despite the explicit reference to positive mental health above, the general discourse of the document is dominated by a focus on mental illness. None or few of the strategies relate to mental health or mental health promotion, which silences promotion work and allows a treatment focus to dominate.

Importantly however, the *Mental Health and Wellbeing Policy* references the social determinants of health and their relationship to both mental health and mental illness. The following statement demonstrates recognition and acknowledgement of the SDH, the living conditions and the impact of traumatic life events on mental health.

> *Good relationships with friends and family, stable housing, employment, education, income security, social inclusion and participation in community life can all promote positive mental health. In contrast, people who experience social isolation or disadvantage, unemployment, family breakdown, violence, abuse, poor educational attainment, income or housing insecurity or who have substance abuse problems are more vulnerable to mental ill-health* (p.14).

This recognition, which draws attention to the mental health inequities that arise in the absence of social and economic resources, could provide the rationale for promotion and prevention approaches in addition to treatment. However, the *Policy* fails to articulate a role for the Health sector in addressing the social determinants of health. The following quote clearly articulates a role for the Health sector in ensuring action is progressed within other areas of social policy i.e. Department of Communities and Social Inclusion (DCSI), and Housing SA. The identified Health sector role in this respect is one of partnership, that is, this work is not seen as the core business of the *Mental Health and Wellbeing Policy* or of the Health sector.

> *Ensure mental health is a key focus in South Australia's social inclusion and community building agendas to strengthen community resilience and to address risk factors such as unemployment, homelessness and family violence to create environments that support positive mental health* (p.8).

In this light, the *Mental Health and Wellbeing Policy* fails to embrace the recommendations of the *National Mental Health Review* (2014). The *Policy* maintains a strong illness focus and assigns responsibility for SDH to other sectors, failing to consider how the Health sector could adopt social or population approaches to promote mental health and prevent mental illness (Friedli, 2009; Allen et al. 2014). Instead, the strength of the biomedical model in the policy serves to focus prevention and promotion approaches on the individual, with stated objectives characterised by health literacy, psychoeducation and help seeking, as illustrated below. That is, they do not seek a social reform agenda.

- *Support community awareness campaigns to improve mental health literacy, promote positive mental health and increase help seeking behaviours.*

- *Support the provision of training to give people the skills to better recognise mental health (read illness) conditions.*
- *Increase awareness of the signs and symptoms of depression and anxiety and options for help and illness management* (p.8).

The *Policy* additionally fails to assign significance to trauma informed principles and practice, whereby the links between trauma, emotional dysregulation and the development of mental illness and/or alcohol and other drugs use (Van den Kolk, 1996; Siegel & Solomon; 2003, Courtois, 2014) are acknowledged. In downplaying the accumulative impact of social and relational stress, "treatment only interventions are likely to fail because populations will be forced to go back into the urban living and working conditions that made them sick in the first place" (Corburn, 2015, p.48).

The SA Suicide Prevention Strategy – Every life is worth living (2012-2016)

The SA Suicide Prevention Strategy (2012-2016) outlines seven goals to prevent suicide. The strategy stresses the loss associated with every suicide and the impact on family and community. Goals focus on the need to promote mental health and wellbeing, prevent the likelihood of suicide and provide professional help and care to those affected by suicide. The need to work within the national framework is emphasised.

As articulated in Chapter 3, the *Suicide Prevention Strategy* was only included in the subset of policies following interview feedback. Upon my initial assessment of the document I did not find it to be within the selection criteria because of the overt focus on the management of suicide and mental illness. However, this policy was perceived by policy actors as providing the clearest mandate for the promotion of population mental health and psychological wellbeing. Therefore, I included it in the analysis.

Critical scrutiny of the document identifies that problem representation of mental illness and suicide in the strategy is inclusive of both the biomedical model and the social view of health as is evident in the following statement.

> *Suicide is complex and does not result from one single cause. Our uniqueness provides a plethora of reasons that one might engage in suicidal or self-harming behaviours. There are several factors that may contribute to a person engaging in suicidal behaviour. Some of these factors are personal whilst others lie in the fabric of society* (p.14).

Acknowledgement of the need to address factors at a social and community level is central to the document and the strategy identifies that support and participation from a significant number of agencies, sectors, non-government organisations and community groups is essential to successful implementation. Evidence of the population focus in the strategy is found in the following goal: *To provide a socially inclusive community with resilient individuals and supportive environments* (p.7) as demonstrated in the following strategies.

> *Promote and support well designed neighbourhoods which facilitate safe, walkable access to services, recreation facilities and community meeting places that enable community connectedness* (p.29).
>
> *Provide targeted education to people whose jobs place them in positions of 'confidante' – like hairdressers, barbers, taxi drivers, charity store staff, housing, Centrelink staff and hotel staff* (p.30).

However, as discussed in relation to the Mental Health and Wellbeing Policy, the Health sector understands that in relation to promotion and prevention, its role is focussed on the individual, which suggests these above-mentioned strategies will not be prioritised within the sector. Additionally, possible structural changes to government legislation and regulation to reduce suicidal risk are proposed in the Strategy, albeit not convincingly.

> *Consider regulation in areas such as poker machines and alcohol licensing to address problem gambling and alcohol use* (p.29).

The fact that the association between gambling, alcohol and mental health remains unproblematised in the state's *Mental Health and Wellbeing Policy*, also suggests such action to be unlikely.

Despite this, mental health is central to this policy and is viewed as a separate construct to mental illness. Mental illness is significantly but not exclusively aligned with suicide and those who are mentally ill are viewed as one of a significant number of 'at risk' groups identified. Considerable focus on other 'at risk' or disadvantaged groups ie Aboriginal and Torres Strait Islanders, those identifying as LGBTIQ, those in contact with criminal justice system, those living in rural areas and victims of trauma and abuse, was also present in the strategy. Social exclusion is positioned as a significant risk factor in the strategy.

> *It is about increasing opportunities for people, especially the most disadvantaged people, to engage in all aspects of community life* (p.19).

4.1.1 Document Analysis summary

This section of the chapter draws together the findings of the Health sector document analysis detailed in 4.1.1. As stated, the analysis has been structured using Bacchi's methodology. Three questions have been utilised to identify the Health sector policy/policies that demonstrate potential to promote population mental health and psychological wellbeing.

What is represented as a problem in the selected Health sector policies and how does health/mental health fit with that problem representation?

The findings demonstrate that within the health policies analysed, despite the use of the terms 'health' and 'mental health', the problem representations are predominantly ones of illness and mental illness. These implicit representations in the majority of policies mean that the proposed solutions are framed in biomedical, psychological or behavioural terms. The main strategies put forward in the policies are concerned with the management of hospitals and health services and systems to provide treatment for those who are ill.

In relation to mental health specifically, the use of the term 'mental health' to mean mental illness was consistent in all policy and serves to mask policy focus and intent. The dominant representation of mental health as illness produces discourses concerned with deficit, disorder and pathology which serve to strengthen the predominance of policy strategies and clinical systems to deliver treatment. Given this, the consideration of mental health as a state of psychological wellbeing, does not fit with the dominant problem representation found in the majority of policy. Subsequent framing minimises the policy space in which to consider health and mental health as positive states which can be supported through salutogenic practice (Antonovsky, 1993) and/or as states of wellbeing, which are impacted by the social determinants of health.

What assumptions regarding mental health lie under this representation?

Despite the presence of both the biomedical model and the social model of health in six of the fourteen health policies examined, the assumption that 'illness' is a purely individual, biomedical health problem was found to be dominant in policy and strategy. This enabled the predominance of strategies focused on 'fixing' individuals rather than on changing the social factors contributing to illness. Illness and mental illness were consistently represented in policy as an individual problem, and as physical, psychiatric and/or psychological disorders requiring treatment, rather than as conditions affected by the social, economic and cultural contexts. This framing of illness decontextualises diagnosis, medicalises social and personal distress and motivates actions focussed on individual surveillance and medicalised treatment. The assumptions that individuals do not adequately manage their health was present in a number of policies including: *The SA Health Care Plan*, the *Health Service Framework for Older People* and the *Chronic Disease Action Plan.* These discourses mirror those that were operating in the lives of Steve and his mother from the Introduction to this thesis. Steve's behaviour was being interpreted solely through a biomedical lens of deficit, and his mother felt at risk of individualised blame for poor parenting. This individualised view however was completely decontextualized from the environments in which Steve and his mother were living.

It follows that where the individual biomedical discourse dominates mental health policy, delivery of medical treatment via hospital and clinical systems will be privileged to provide this care. The treatment of illness is prioritised, effectively marginalising policy or public health approaches to address the contexts in which mental illness develops, or to enable the contexts in which psychological wellbeing is sustained and strengthened. However, it is important to emphasise that the policy failure is not one of having access to treatment and care options. The problem is that formulating polices with a dominant focus on access to treatment and care options for illness, in effect excludes consideration of population level strategies to prevent illness and promote mental health.

Where are the silences regarding mental health in this dominant discourse?

The lack of adequate focus on the social determinants of health in the policies examined served to enable a separation of illness from the context in which the illness and mental illness developed, constituting a silence. The association between adverse social and economic conditions and mental health impacts, and between socioeconomic inequalities and inequities in mental health failed to be acknowledged in *the SA Health Care Plan, Alcohol and Other Drugs strategy*, the *Veterans Framework*, *Mental Health Pathways to Care* and *Youth Mental Health and System of Care*. The need to address the health and mental health inequity is an additional and significant silence in the majority of health policies.

Lack of acknowledgment of the association between adverse social and economic conditions and mental health has led to a silence in relation to the acknowledgment of trauma informed principles and practice, as was evident in the *Alcohol and Other Drugs Strategy*, *the Veterans Framework* and to a lesser extent, the *Mental Health and Wellbeing Plan.* Failure to acknowledge the ongoing socioeconomic and social adversity and the intergenerational consequences in the *Aboriginal Health Care Plan,* was also a significant silence.

Interestingly, the *Primary Prevention Plan*, as a policy which focused on strategies to address the SDH to prevent illness, was referenced in four of the policies examined (the *Chronic Disease Action Plan, Health Services for Older People Framework, Eat Well Be Active Strategy* and the *SA Veterans Framework)* suggesting that prior to its withdrawal in 2012, the plan was considered a significant and valued policy within the sector. On an organisational level, the lack of a policy in the sector that is focussed on primary prevention is an additional silence.

In summary, the application of Bacchi's analysis has enabled the identification of the following six policies to progress to Stage 3 of the research (See Table 4.1). These are the policies that were considered most likely to represent mental health (read health), assume a social view of health and consider non-individual approaches to promote mental health.

Therefore, these policies are considered most likely to enable population level strategies to promote mental health and prevent mental illness through action that addresses the social determinants of health and reduces health inequity.

Health sector policies	
1	Prosperity Through Longevity: South Australia's Ageing Plan - Our Vision (2014-2019)
2	Aboriginal Health Care Plan (2010-2016)
3	Eat Well Be Active Strategy (2011-2016)
4	State Public Health Plan – A Better Place to Live (2013)
5	South Australia's Mental Health and Wellbeing (2010-2015)
6	South Australian Suicide Prevention Strategy (2012-2016) Every Life is Worth Living

Table 4.2 Health sector policies selected at the completion of Research Stage 3

4.2 Interview analysis

This section reports on the findings of the analysis completed on the interviews with policy actors and academics associated with the six policies listed above in Table 4.1. The second stage of research sought further knowledge and insight into how the selected policies were operating within the sector to effect mental health promotion. In this sense interviews were both exploratory and confirmatory, seeking to interrogate both the policy and the policy context.

The analysis of data from the Health sector interviews (10 strategic policy actors and 3 academics) was unable to identify a policy that was currently guiding the work of the department to enable population mental health and psychological wellbeing by addressing the social determinants of health. The analysis demonstrated the incompatibility of a mental health promotion approach with dominant representations and problematisations in the selected policies. Additionally, organisational goals, culture and practice in the Health sector, were found to be inconsistent with health promotion practice.

A case study for the Health sector (Department of Health and Ageing) has therefore not been selected. The findings that informed this decision are detailed in this section and summarised in the concluding summary.

Interview data were coded using Nvivo software and the same coding framework was used for each sector. Analysis of coding (open and axial) was completed in relation to the data set and confirmed the emergence of five themes pertinent to the research questions including:

1. Reviewed health policy had a strong focus on illness, treatment and hospitals, making health promotion or mental health promotion unlikely.
2. The work of the Health sector foregrounds the biomedical model of health and distances the social determinants of health.
3. The work of the Health sector prioritises an individual and clinical response to mental health concerns which minimises consideration of the social determinants of mental health.
4. Changes to the Public Health Act and changes to role for public health in SA Health impacts negatively on capacity for health and mental health promotion.
5. Metrics and budgetary requirements associated with the political and economic framework shape the models of health care practised.

I now discuss these themes in detail, prefacing each point with a salient quote.

4.2.1 Reviewed health policy has a dominant focus on illness, treatment and hospitals, making health promotion or mental health promotion unlikely.

> *And what South Australians would see, is that it is all about hospitals, hospitals, hospitals* (NGO/Academic, #20).

Reference to *Transforming Health*, as the major policy initiative that SA Health was engaged in at the time of the interviews, was strongly communicated by participants. *Transforming Health - Best care. First Time. Every time.,* was a state initiative spanning four years (2014-2018) in which the state's health systems and services were reviewed to 'better provide for the health needs of South Australians' which was also associated with the building of the new Royal Adelaide Hospital. The review was characterised by a focus on health care systems, technologies and infrastructure, the delivery of medical treatment and the quality of clinical services. The following comment highlights the hospital-centric and medically focussed nature of *Transforming Health*.

> *The very clear message is, you know, it's all about Transforming Health, which is around hospitals* (Health Policy Actor, #1).

Concern over how the *Transforming Health* agenda was narrowing the sector's focus to one concerned predominantly with hospitals and the clinical management of illness was a major theme in the data.

> *I'm just mystified as to how this government could suddenly have become convinced that health is all about hospitals* (NGO/Academic, #21).

> *It is needed to have the health service acknowledge that it is a health service, not a hospital service* (Health Policy Actor, #18).

Participants provided evidence of the increasing focus on medical treatment and clinical services and the decreasing focus on prevention and promotion, referencing policy decisions made over the last six years, including:

- Withdrawal of the *Primary Prevention Plan* (South Australian Government 2011b)
- *Review of Non-Hospital based Services* (McCann, 2012) from which a plan was developed to consolidate health resources to better meet hospital and clinical service needs
- SA Health *Response to the McCann Review* (South Australian Council of Social Services, 2013) which saw a significant contraction of non-hospital health services including health promotion and illness prevention
- Closure of the *Health Promotion Unit* and *the Health in All Policies* Unit (2014)
- Merging of the Chief Medical Officer and the Chief Public Health Officer roles (Siebert, 2017)

Comments relating to these policy decisions included:

> *They (the Health Promotion Branch) did some terrific stuff and I'm just - I was very shocked to hear that that whole unit had just been crossed off the list* (NGO/Academic, #20).

> *Everyone's thinking about treatment and I figure there's sort of 8.5 of us left and those of us left need to make sure we push the prevention line and promotion line* (Health Policy Actor, #12).
> *I mean the fact that we now have a combined Chief Public Health Officer/Chief Medical Officer, like Paddy's attention (Chief Medical Officer) can't be - you know it has to be over so many different issues that, you know, for him to sort of maintain that focus (Public Health) would be quite difficult I think, a real challenge…* (Health Policy Actor, #1).

The corollary to the increased hospital focus was seen to be decreased public and community health focus.

> *When you put money in hospitals, hospitals are like a big balloon and if you remember your Physics 101, if you get a big bubble and put a little tiny bubble next to it and then break the seal between them, the little bubble goes into the big bubble and that's what's happened to public health* (Health Policy Officer #18).

> *I mean the increased availability of treatment is a very good thing...but it's, you know, like drinking from a fire hose; it's never going to solve the problem* (NGO/Academic, #21).

Public health initiatives with a focus on primary prevention were reported to be minimalised in the policy context. Where there was a focus on prevention it was seen to be a secondary prevention focus, the following quote identifying such an approach in relation to chronic disease.

> *The Department of Health is only interested in that (chronic disease) and I mean it's not really that interested in preventing them, they would rather manage people once they're sick* (Health Policy Actor #19).

The following comment relates to a very pragmatic position on 'waiting out' the current policy focus on illness hospitals and treatment.

> *If Transforming Health can get the new Royal Adelaide Hospital built, feel that it's made those changes and start thinking about 'okay how do we start preventing all this?' and then put some thought and effort into it then we'll be able to - we'll be in a position to do more* (Health Policy Actor, #18).

The data indicates that the organisational culture and policy context within the DH&A, was focussed on hospitals, illness and treatment to the detriment of promotion and prevention generally. This finding is confirmed by Littlejohns (2016) who found that the system building blocks that enabled health promotion in SA had largely been disassembled over the previous 10 years.

The lack of promotion and prevention was also viewed as pertinent to mental health and psychological wellbeing. The first quote below expresses concern about the increased clinical culture in mental health (medical, psychological and psychiatric) and the absence of mental health promotion generally; the second, relates to the dearth of mental health promotion in the Health sector, in effect indicating it as a silence.

> *...so, there's been a huge focus on treatment and interventions. I don't think there's been anything like a corresponding increase in the energy and funding given to prevention and health promotion… mental health promoting interventions are extremely few, extremely few.* (NGO/Academic, #20).

> *We have completely lost the dialogue around mental health promotion ... I just don't feel it's been … it's been almost invisible* (Health Policy Actor, #16).

These previous quotes stand in contrast to the findings discussed in the written analysis in 4.1 which indicated that mental health promotion and prevention was considered in both the *Suicide Prevention Policy* and the *Mental Health and Wellbeing Policy.* The following quotes further explain the absence of mental health promotion in relation to these two policies.

> *The Mental Health and Wellbeing Policy is very focused on improving outcomes for people with mental illness* (Health Policy Actor, #19).

In relation to the *Suicide Prevention Strategy,* the following quote indicates that strategies are individually focussed and largely fail to offer population-based promotion and/or prevention approaches. The second quote references the failure to support vulnerable populations or address mental health inequities.

> *It's (mental health promotion) strongest in health in the Suicide Prevention Strategy because at least that says 'prevention' and … there's a recognition that there's a whole of government buy-in but again that still ends up being about what government can do to deal with people that have got mental illness… So, it's like the mental health first aid programs, it's all at the early intervention end rather than promotion. It's definitely at the early intervention end and maybe a little bit about prevention but there's not much about mental health promotion* (Health Policy Actor, #16).

> *I think if we're talking about - seriously talking about illness prevention, mental illness prevention and promotion then I would be focusing on children and young people and I think that's where I just kind of go, no-one's getting this area. No-one's really understanding that if you want to reduce the load of mental illness into the future then you've really got to kind of look at how you support vulnerable groups* (Health Policy Actor, #19).

The depth of commitment to the full implementation of the *Suicide Prevention Strategy*, and to mental health promotion more generally, given the lack of financial resourcing for prevention and health promotion, is additionally questioned by policy actors. In the following quote, the potential of the strategy to achieve improved mental health outcomes is viewed to be challenged by predetermined priorities relative to the focus on illness, treatment and hospitals and the fallout from department restructuring.

> *Well, like in mental health, we have thrown money after money after money into emergency departments when if we'd spent that amount of money on the back end... You know, all of our promotional/prevention stuff (re mental health) has gone… I think the networks that I'm developing are probably the last of any promotional/prevention stuff and I'm not sure how it's surviving* (Health Policy Actor, #15).

4.2.2 The work of the Health sector foregrounds the biomedical model of health and distances the social determinants of health.

> *A lot of people tend to think in a really clinical way* (Health Policy Actor, #15)

The findings from the written analysis, indicated that the social determinants of health are significantly overshadowed by the biomedical model and a clinical approach to individualised treatment. This finding was confirmed by the majority of interviewees.

> *There's a resurgence in dominance of the biomedical model of health, a really massive resurgence in that, and a refreshed marginalising of either disciplines that contribute to public health and marginalising of conversations about health promotion or community development… I think the whole hospitals push in this state tells us that the social determinants are disregarded* (Academic, #21).

> *My concern is that the evidence around population health approaches, the social determinants of health, preventative health generally, has been there for a really long time. The arguments have been accepted at a theoretical level. The challenge is that governments find it easier, I think, to focus on initiatives that look at the wellbeing of individuals rather than addressing more complex and difficult-to-shift issues associated with structural and systemic inequalities* (Health Policy Actor, #13).

The statement above refers to the difficulty in achieving government support to address the structural and systemic barriers to population health. The *Eat Well, Be Active Strategy* is an example of such a strategy, given it presents strategy to limit food advertising (structural) and support the availability of healthy food in local communities (systemic). However, policy actors anticipated that this policy will be discontinued (Health Policy Actor, #12).

Downstream approaches that focus on individual change, whether that be motivational, behavioural or pathological are preferred. Actions that address structural and systemic inequalities are highly significant for those population groups that experience disproportionate disadvantage (CSDH, 2008). For the Aboriginal and Torres Strait Islander population, who experience poorer health and mental health outcomes than the majority of Australians, the need to overcome Indigenous disadvantage by addressing the social determinants of health is understood as central to improving health and wellbeing outcomes (Anderson, Baum & Bentley, 2007; Baum & Dwyer, 2014). This assumption was evident in the *Aboriginal Health Care Plan* scrutinised in 4.1, however, analysis indicated that the biomedical model was prioritised. This finding is replicated in the interview data.

> *…so the social determinants of health is what the people I work with think about all the time but definitely the biomedical model dominates and I think that's why we don't make much progress with Closing the Gap in Australia, because Closing the Gap needs to happen from a social determinants point of view, not a biomedical point of view* (Health Policy Actor, #17).

> *…health alone is not going to improve Aboriginal health. We need all of those other things, you know, the ability to be economically independent, the ability to practise culture, have an education. All of those things - have a safe environment to live - are critical to the health of Aboriginal people…HiAP informed work is happening but not in Health* (Policy Actor, #17).

In relation to the population generally, the need to focus on the social determinants of health was a very strong theme in the data and the mismatch between the data gained from the written and interview analysis regarding this point is discussed further. Statements regarding the need to acknowledge the significance of the social determinants of health were consistently made by interviewees.

> *All the data analysis suggests there are a significant number of people who are in housing stress and that number is increasing, but it's seen purely in financial terms whereas I think what's actually happening is people's health and wellbeing is being impacted…* (Academic, #6)

> *…it is recognising the importance of people, feeling safe in their communities, being healthy, eating well, being active…(that) improves wellbeing* (Health Policy Actor, #12)

4.2.3. The work of the Health sector prioritises an individual and clinical response to mental health concerns which minimises consideration of the social determinants of mental health.

> *So, it's not just nature by itself; it's about the social environment* (Health Policy Actor, #19)

A strong theme found in the data was concern about the lack of Health policy and practice that recognises the relationship between the social determinants and mental health/illness. The quotes below express concern regarding the growing medicalisation of mental health and the minimisation of the social determinants of mental health. The first quote highlights how the social issue of unemployment has become individualised, which invites the unemployed person to consider their predicament as a personal failing or a lack of psychological resilience. The second quote emphasises the failure of the clinical system to balance presenting symptoms with a focus on the causal mechanisms which are found in the individual's relational, social and economic environment which the interviewee suggests are overlooked.

> *It's the medicalisation of mental health when people who have no jobs to look forward to or very insecure work, you know, the precarious - I think (they) have every right to feel anxious or despairing and that's a legitimate response… We've been taught to individualise our failures. Our responsibility is to craft our own biography, you know, this DIY future, but its structures letting these people down* (NGO/Academic, #21).

> *All those social determinants that prohibit a person from flourishing are also factors that can lead a person to take their life because it's about - it's the meaning of how they interpret that and if it seems to be a barrier that is so insurmountable that they can't find their own solutions to it then it's like 'what's the point?... But they (the health system) don't make referrals to those social determinant type solutions. They medicalise it*. (Health Policy Actor, #15).

This last quote suggests that clinical practice fails to adequately consider the impact of social factors on the development of mental health issues, an observation that emphasises the strength of the biomedical discourse in mental health.

The following comment concerns the mental health impact of experiences of discrimination, a social issue experienced in the community and like unemployment, poverty, financial stress, homelessness or violence, one that poses a significant threat to mental health and psychological wellbeing (Allen et al. 2014). The participant decries the employment of an individualising discourse that enables access to a 'personal mental health plan' through the *Better Access to Psychiatrists, Psychologists & General Practitioners Initiative* and disables a systemic and structural approach to racism.

> *… but I still don't think they understand how - you know, like how do you address discrimination for Aboriginal people through a mental health plan?* (Health Policy Actor, #19).

The interviewee goes on to identify that such practice is evidence of a socially harmful policy and discourse which fails to acknowledge and address health equity.

> *[But] mental illness is an outcome of a social inequality …people being made more vulnerable environmentally and socially…I mean if the distribution of mental illness is much greater for those who've got less….resources, then we actually have to say, well - how do we actually shift that, because that is an unfair burden* (Health Policy Actor, #19).

Coming from a different perspective, the lack of recognition of the relationship between the social determinants of health, mental health and disadvantage was seen to be reinforced by the uptake of positive psychology concepts in policy and strategy, influenced by the 2011 Thinker in Residence, Martin Seligman. Seligman supports the view that mental health can strengthened, and psychological resilience enhanced through attention to five key areas of life: positive emotion, engagement, relationship, meaning and achievement (Seligman, 2011), a model that helpfully shifts away from a focus on psychological deficits to psychological strengths. However, the following comments express concern that this has increased the focus on individual psychological resilience as opposed to creating the relational, social and economic contexts that enable individual psychological resilience.

> *I think the Seligman stuff advantages people who are already advantaged…the other thing I really struggle with is I don't understand all of this emphasis on resilience. I feel like it's a word that's bandied about greatly and again I feel there's a risk that it can be victim blaming, that if you're not resilient it's your fault* (Health Policy Actor, #19).

> *…because it (positive psychology) doesn't acknowledge the lack of opportunities and lack of resources that some people have available to them. It doesn't recognise that inherent inequity in our society and treats everyone as being equal* (Health Policy Actor, #16).

Reference to the need to think about resilience and wellbeing on a social and community level, in addition to the individual level, was captured in the following two quotes, which highlight the need for population-based approaches.

> *Likewise, you can have all the wellbeing and resilience training but if your community's not open to you how does that work?* (Health Policy Actor, #14).

> *There're two levels of wellbeing - there's individual wellbeing and then there's social wellbeing, so how you actually promote wellbeing at a broader level… so what are the kind of levers that promote wellbeing at a broader level* (Health Policy Actor, #19).

Promoting community wellbeing through population approaches aligns with the goals 'Creating supportive environments' and 'Strengthening community action', two of the five health promotion strategies articulated by the Ottawa Charter (1986). The ability to enable this goal within the Health sector, however, was viewed to be blocked by the dominant problem representations and assumptions that had enabled the overt focus on illness, treatment and hospitals. Additionally, where health promotion was enabled, it was primarily an individualised approach as the two following quotes infer.

> *I think health promotion itself hasn't been practised for a long time by governments, according to the Ottawa Charter version of it at least* (Health Policy Actor, #18).

> *I think community development initiatives are another thing that really has been undermined (in Health) and it should be brought back...* (Health Policy Actor, #19).

4.2.4 Changes to the Public Health Act and changes to the role for public health in SA Health impacts negatively on the capacity for health and mental health promotion.

> *It needs to be driven by the state government and be their priority as well as something councils do* (NGO/Academic, #21).

The majority of interviewees spoke of the changes to the *SA Public Health Act* (South Australian government, 2011a) and resulting changes to the planning objectives and strategies outlined in the *SA Public Health Plan* (2013), which was the first plan developed after the legislative change. Two general themes emerged in relation to the plan: concern for what was considered by some as a devolution of responsibility for public health primarily to local governments, and concern regarding the capacity of local governments to assume these increased responsibilities. Interestingly, these two themes were expressed four years after changes to the Act and two years after the release of *SA Public Health Plan* (2013).

In relation to the first theme, the following statements are pertinent:

> *Getting councillors and senior council administrators in a room and talk about public health planning where they're really worried about cost shifting and the state withdrawing and putting more pressure on councils to do what they feel the state should be doing…* (Health Policy Actor, #18).
>
> *It also heightens this idea that the state government does hospitals and the poor cousin stuff (public health and health promotion) is done by councils. This concerns me, but I feel that advocacy and information around this is shrinking* (Academic, #21).

The first quote highlights the difficulties with establishing new policy from a top down authoritative process, where the new responsibilities have not been negotiated, are not necessarily welcome and as the quote suggests, are possibly not resourced. The second quote discusses the meaning ascribed to these changes, the interviewee concerned that the state's revised role and partial withdrawal from public health and health promotion, conveys assumptions that attach value to hospitals but not to public health. A similar concern, questioning the valuing of public health Federally is also relevant to this discussion.

> *…federal government are useless in public health at the moment; they're a dead loss…they've just walked away basically from public health entirely and the COAG and principal committee on health has dropped the ball…What would help greatly is better federal leadership because without federal leadership there isn't a whole lot that states and territories are likely to do* (Health Policy Actor, #18).

Reflecting on the lack of federal leadership, the last quote displays a sense of powerlessness and frustration in advancing the public health agenda and health promotion at the state level given the national inertia (Miller and Orchard, 2014) at the time of research.

In relation to the second theme, the following quotes are pertinent. The ability and capacity of councils to shift work practices beyond their historical foci on environmental and physical health and begin to address the social and cultural factors that impact health and mental health is questioned,

although the last comments also reflect on councils' awareness and willingness to further develop capacity. This is evidenced by the use of the Model for Community Wellbeing utilised in this research (Figure 1.2) which was adopted by a local Adelaide council.

> *…most councils don't have a deep understanding of public health… their tradition is in physical environments and it's as - most of these things (health and wellbeing) are also social and cultural and I don't think the local governments have got the ability to do that or the resources* (NGO/Academic, #20).

> *I guess I feel like actually local government has lots of opportunity to create positive mental health space, but they have really limited expertise in the area and they kind of recognise they don't have that* (Interview, Policy Actor, #16).

> *…when you start talking to these people (in councils) about the things that they do…recognise and acknowledge the public health good they do… that they do because their community expects it and the community wants and needs it… they feel that it's quite appropriate* (Health Policy Actor, # 18).

4.2.5 Metrics and budgetary requirements associated with the political and economic framework shape the models of health care practised

> *There are people in the community who are really hurting and who want to have a conversation about their future where they belong to a society, not to an economy* (Academic, #20).

The majority of participants reported on some aspect of difficulty in coping with budgets and short-term goals and providing metrics in relation to programmes and services which are subject to changes in political governance. This was viewed by many as incompatible with effecting long term change, which requires addressing the social determinants of health and structural causes of health inequity. A significant level of frustration and resignation was expressed in relation to this theme. Health sector decisions, detailed in 4.2.1, were seen as primarily driven by a perceived need to reduce Health sector spending, and some expressed the view that when money is tight, promotion and prevention are an easy and possibly, inevitable target.

> *Health needs to identify what is its domain and where its priority is at the moment because, as I said, our financial situation is in such a diabolical position that we can't be investing in areas where we can't get the direct impact…and the evidence around health promotion is there in the longer term, but you can't get an instant fix* (Health Policy Actor, #9).

The influence of management strategies in health budget decision making and expenditure is clear in the above statement through the use of the word 'investment' and the phrase 'financial situation'. The statement demonstrates the felt pressures on policy actors to conform to perceived budgetary requirements and the incompatibility of such demands with approaches that require long term commitments as health policy actors well understood. There was a resigned acceptance of working with this tension, however resistance was also offered, in that suggestions were made as to the need for an alternative timeframe and bi-partisan politics to be applied to health goals; and the need to use alternative metrics, as indicated in the following quotes.

> *It seems like we're bound into four-year planning when health should be like a 12 or 15-year plan and it should almost be a bipartisan topic* (Health Policy Actor, #15).

> *The problem with preventing something is you're averting something that didn't happen and then it's...invisible and so that's very hard to demonstrate and maybe we needed to have been smart and got health economists on board to demonstrate more clearly how much those health promotion initiatives were worth…maybe that's what we (Health) needed to do* (Academic, #21).

The second quote suggested the need for different evaluative paradigms, paradigms that do not measure illness reduction but health outcomes. The current metrics were seen to be narrowly focussed and therefore at risk of losing sight of the bigger goal, that is, improved health for all.

4.2.6 Analysis summary of the thematic data from interviews

The first three themes that emerged from the interview analysis were: the pronounced focus on hospitals, the dominant positioning of the biomedical model and the emphasis on individual treatment, which were findings that were consistent with Stage 2 of the research. That is, the dominant representation of health as illness and mental health as mental illness focussed the sector predominantly on the need for clinical services and the development of health systems, services and infrastructure to provide for the needs of the individual. The withdrawal of the *Primary Prevention Plan* in 2012, as a policy that did provide a mandate to address the social, economic and environmental determinants of health to promote health and mental health, provides further confirmation of this. Collectively, these findings indicate that achieving a focus on health and mental health promotion in the sector appeared unlikely and irrelevant to the organisational goals, culture and practice of the Department of Health and Ageing at the time of research.

The two remaining themes are: concern over changes in the role of the Health sector in relation to public health, and concern over the budgetary requirements and need for illness-related metrics that highlight outcomes-associated illness recovery but not health improvement.

Both these findings provide further confirmation of the unfriendliness, if not incompatibility, of current departmental policy, structure and systems to activating population-based health or mental health promotion.

In conclusion, this chapter has analysed Health sector policy that met the inclusion criteria for the research. Document analysis was conducted on fourteen health policies and six policies were identified as having potential to enable population mental health and psychological wellbeing. Interview analysis was then conducted to further interrogate these six policies and the policy context, to determine if any of the policies were guiding the current work of the department in promoting population mental health. However, none of the policies met this criterion sufficiently to justify their selection as a case study.

Specifically, interview data were able to confirm that the *State Public Health Plan* was not considered to be a policy that was guiding the work of the department, given the partial devolution of public health responsibilities to local governments. Interview data confirmed that the *Mental Health and Wellbeing Policy* was primarily focussed on the management of individual mental illness and that the *Eat Well be Active Strategy* was to be discontinued. The *Longevity for Prosperity Plan* was both minimally referenced in interviews and failed to deliver a focus on either mental health or the social determinants of health. Interview data also indicated that the *Aboriginal Health Care Plan* failed to enable the intersectoral approaches necessary to address the SDH and the *SA Suicide Prevention Plan* was viewed as prioritising individually-based strategies to reduce the incidence of suicide.

Had a policy been able to be identified as an exemplar, further in-depth analysis of data relating to the Health sector nested case study would be reported in 4.3, however this section is omitted in this chapter. The following chapter, Chapter 5 concerns the Natural Environment sector. The chapter repeats the structure of this chapter in reporting the findings from the policy document analysis and the policy actor interviews but also includes data relevant to the nested case study, the *Healthy Parks, Healthy People Strategy*, presented in section 5.3.

CHAPTER 5 NATURAL ENVIRONMENT SECTOR

Overview

This chapter presents research findings from the Department of Environment, Water and Natural Resources (DEWNR), the state government organisation that managed the natural environment at the time of the research. Following the content analysis of all available DEWNR policies at Stage 1 of the research, 7 policies were identified as relevant to the research subject matter.

The first section of this chapter presents the results of the analysis of these 7 policies, analysed using Bacchi's methods to examine what has been constructed as a problem in the policies before critical scrutiny of how these problems shape responses that may be potentially beneficial to mental health and psychological wellbeing. Silences within the policies are also examined. These results are discussed in the first section (5.1).

The second section of the chapter (5.2) presents the results of the strategic level of interviews conducted with DEWNR policy actors and academics. The interview data confirmed the potential for the policy, *Healthy Parks, Healthy People Strategy - Making Contact with Nature Second Nature* (*HPHP Policy*) to contribute to population mental health and further, that this strategy was actively guiding work within the Department, enabling it to be selected as the Natural Environment policy exemplar. From these strategic level interviews, themes were identified that enabled insights into the positioning of the *HPHP Policy* within the department and its relationship to current departmental goals, culture and practice.

The third section of the chapter (5.3) outlines the nested case study, the *Healthy Parks, Healthy People Action Plan – Realising the mental health benefits of contact with nature (HPHP Action Plan)* which was a strategy outlined in the policy that was being progressed at the time of the research. The *HPHP Action Plan* details targets and goals that are relevant to the policy exemplar. Interviews at both strategic and operational levels were supplemented by the analysis of specific *HPHP* related documents and minutes relating to meetings and workshops, that were used to identify themes and answer the research questions.

5.1 Document Analysis

The seven policies analysed in this section are predominantly concerned with the natural environment and policy concerns both the use and conservation of environmental resources. Policy relates to individual, community and ecological health.

These policies, in a sector other than Health, have significant implications for health and health equity but these implications may not be explicitly recognised in policy discourse. The research methodology employed enables these implications to be identified and scrutinised.

As in the previous findings chapter, the same process of analysis has been applied to understand the construction of the problem being addressed in each policy examined and to further scrutinise the policy to reveal the underlying assumptions and silences in relation to mental health and psychological wellbeing. Again, analysis is guided by the following questions:

1. What is represented as a problem in the selected Natural Environment sector policy and how does mental health fit with that problem representation?
2. What assumptions regarding mental health underlie this representation in the policy?
3. What was left unaddressed in the policy examined and where are the silences regarding mental health?

Each policy is introduced prior to analysis.

A summary table, detailing the DEWNR policies analysed in this chapter, the results of the three stages of research and the selection of the case study is presented first.

Environmental sector	**Document analysis**					**Interview analysis**	**Interview and document analysis**
	Stage 2 Research					**Stage 3 Research**	**Stage 4 Research**
Year	Document	Problem representation	Policy consistent with a social view of health	Critical scrutiny for the consideration of mental health in the document	Policies for 2nd stage research	Evidence of policy to practice actively promoting mental health for all	Case Study
2009-2050	Water for Good – Ensuring our Water Future to 2050	Need for a state water management plan given climate change and drought.			NO		
2012	People and Parks – A Visitor Strategy for South Australia's National Parks, Marine Parks and Reserves	Need a plan to both manage parks tourism and visitors and environmental conservation, so as to benefit the economy.			NO		
2012-2050	SA Climate Change Strategy 2012-2050 – Towards low carbon economy	Need to build state economic opportunities and reduce carbon by enabling growth in low carbon industries.			NO		
2014-2015	DEWNR Corporate Plan	Statement outlining the goals and related plans, processes and structures of the state's environment department.			NO		
2012-2017	Natural Resources management Plan -Our Place, Our Future	Need a plan to support the sustainable use the state's natural resources and to meet economic and social need.			NO		
2014-2015	Aboriginal Reconciliation Action Plan	Need for an internal organisational plan to contribute to the process of Aboriginal reconciliation.			YES	NO	
2015-2017 2016-2021	MOU and ToR - Healthy Parks, Healthy People Healthy Parks, Healthy People Strategy	Need to support processes that enable the public valuing of parks and nature to benefit both the health of parks and people.			YES	YES	YES
Total = 7 policies							**Case study selected = 1**

Table 5.1 Summary of the Natural Environment sector policies, research stages and results

Green – great extent Amber – some extent Red – little extent

NRM Plan – Our Place, Our Future (2012-2017)

This is an overarching plan that supports the work of the state's eight regional natural resources boards. The purpose of the plan is to outline the policies, strategies and programmes that enable sustainable management of the state's natural resources. The document strongly acknowledges Aboriginal people as the traditional owners of the land and stresses their past and current relationship to country, including the continuing role in caring for Country. A range of stakeholders are acknowledged as key to the aims of natural resource management, including primary producers, landholders, conservationists and community-based groups. Recognising the economic and social benefits of the natural environment, the plan outlines strategies to foster relationships more broadly with South Australians to manage the natural environment. These strategies include: increasing people's knowledge, involvement and capacity to care for our natural resources; balance resource use with nature conservation and not only protect but improve the present health of country.

The problem being addressed in this plan is the need to balance natural resource use with conservation and environmental protection. Health and wellbeing outcomes are viewed as related to the economic and social benefits of sustainable resource management, which is consistent with a social view of health.

> *NRM recognises that people, their wellbeing and their livelihoods rely on the health and productivity of our landscapes; and it understands that community stewardship of our land, water, air and sea is critical to maintaining that health and productivity* (p.6).

The plan outlines the role of the NRM boards in delivering sustainable outcomes for both the environment and for people. The plan outlines strategy to meet two broad goals: support the sustainable use of natural resources; and increase community knowledge and participation in environmental management. Both are viewed as essential to achieving ecosystem integrity. This theme is consistently presented in a number of DEWNR policies, including the *DEWNR Corporate Plan* and *the Healthy Parks, Healthy People strategy* and *Parks for People* strategies, discussed further in this section.

The document acknowledges the relationship between health and wellbeing and environmental resources, however much of the strategy articulates the link between the use of natural resources and economic outcomes. The predominant message in the document is that the use of land, water and environmental resources provides economic support (business, employment & income) for people and in doing so supports health and wellbeing. Liveability and productivity are viewed as outcomes of sustainable resource management. Links with mental health are minimal in the document.

Acknowledgement of the environment's social and cultural value and of its intrinsic value is present in the plan. Recognition of the links between the environment and the social and cultural aspects of wellbeing are most clearly articulated in relationship to the Aboriginal population. The plan acknowledges the significant cultural and spiritual links to country for Indigenous Australians and the importance of 'connection to country' to health and wellbeing.

This understanding represents the strongest link in the document between the natural environment and mental health. This link is not replicated in relation to non-Indigenous Australians where the link with country is seen to relate to liveability and productivity.

Reference to the recognition of the relationship between the health of Country and the health of Aboriginal people (both individuals and communities) is found in the Aboriginal Acknowledgement which prefaces the *NRM Management Plan.*

> *The connection to land and waters across South Australia for Aboriginal peoples is through the unique relationship to country via creation stories, family ties and kinship arrangements, responsibility for protecting important places of cultural and spiritual significance and responsibility for maintaining traditional practices and, where practicable, increasing responsibility to care for their country. These matters are most important to maintaining the overall wellbeing of South Australia's Aboriginal peoples today* (Document cover).

The *NRM Plan* acknowledges the past damage and destruction endured by Aboriginal people and communities through processes of colonisation, however, no reference is made to current colonising practices, including the ongoing legal processes concerning native title and land rights, which continue to provide barriers to traditional country for Aboriginal people. While the concept of 'terra nullius' (that Australia was not owned by anyone prior to colonisation) was legally overturned in 1992, applications to have native title acknowledged for regional Aboriginal communities and ascribe land rights have been very slow (Baum, 2015).

Consistent with the Aboriginal Acknowledgement, the plan articulates goals to increase the valuing of Aboriginal culture and peoples and the relationship to Country.

> *Increase the involvement of Aboriginal people in NRM across South Australia and increase the recognition and use of Aboriginal knowledge* (p.20).

However, goals which relate to Aboriginal leadership are not articulated in the document. It is noted that the Alinytjara Wilurara Regional NRM Board is an all Aboriginal board managing natural resources in the Anangu Pitjantjatjara Yankunytjatjara (APY) region where land rights have been secured. There has been no other granting of land rights in the state of South Australia. Goals to increase the involvement or leadership of Aboriginal organisations and communities (as opposed to individuals) are likewise not in the plan. Such goals would support self-determination, a key factor in improving the health and mental health of Aboriginal people (CDSH, 2008).

Direct reference to mental health and psychological wellbeing is absent in the plan, however, interestingly, the following statement made by Michael Leunig, an Australian cartoonist, poet and social commentator is found at the conclusion of the document.

> *Yet all too easily a nation that is predominantly urban in character may lose sight of its natural setting and spirit of country – and be all the poorer, sadder and less vital for such loss of connection; it may suffer some deadening loss of imagination, joyous humility and visionary innocence. A nation may turn its back on its greatest source of wisdom and underestimate how much it needs the natural world* (Document cover).

The importance of Country in the Australian psyche is commented on in this cautionary postscript. The statement directly references emotional states and implies that mental health will be negatively impacted if connection to the natural environment is unappreciated. The postscript stands apart to the text of the document and poses questions about the significance of the human-environment connection for both individuals and the population, which are not considered in the document. Concepts related to the importance of the natural world to mental health and psychological wellbeing, are however acknowledged within the sector, and these concepts are discussed later in this section in the analysis of the DEWNR *Healthy Parks, Healthy People* strategy.

Water for Good (2009-2050) – Ensuring Our water future to 2050

Water for Good was released in 2009 and projects forward until 2050, with goals and objectives pertinent to the plan articulated over shorter time frames. The aim of waterproofing the state was the significant driver for the plan, following a period of drought at the time of the plan's development (2009). Realisation of the need to improve the state's water management given climate change and the state's increased population were secondary drivers. The plan articulates 90 strategies and actions to decrease the state's reliance on rivers, aquifers and reservoirs. It details the development of a range of diverse water sources for the state, including a desalination plant, stormwater and wastewater harvesting, increased water storage capacity and the need to minimise demand on water supply from the Murray River.

The Water for Good plan is a document that articulates a range of strategies to ensure water security and quality for the state. The long history of the relationship between water and public health is referenced in the document, with emphasis on access to clean water and sanitation services, as the foundation of public health.

> *Public health is the paramount consideration for managing drinking water quality, therefore drinking water systems must have, and continuously maintain, robust multiple barriers to potential contamination* (p. 59).

The direct relationship between our basic needs and water is discussed in the document, as is the need for continued vigilance to water supply, safety and quality in support of public health. The plan progresses the need for change in water management from a centralised system of single use water to recycled water, that is total water cycle management, which is key to the development of a water sensitive city. This focus mirrors the sustainability focus evident in the previous policy.

Emphasis on the need to remain vigilant to water safety over the significant period that this plan ensues is a constant theme throughout the document.

Health and wellbeing are discussed in the document as being supported by effective water access, not only in relation to basic needs, but in relation to lifestyle, economic outcomes and the environment.

> *Water is our most valuable resource. It's fundamental to our health, our way of life, our economy and our environment* (p. 191).
>
> *Rainfall, rivers, reservoirs and aquifers do more than just provide drinking water, sustain agriculture and industry, and support recreation, tourism and cultural opportunities. These resources are also valuable assets that support plant and animal ecosystems* (p. 56).

These references relate to the broader SA Water objective of developing a water sensitive city, which is defined as a city where diverse urban water management solutions are developed in the context of the city's social values, and institutional and regulatory structures and processes (Fitzgerald, 2018), which is seen to relate to health and wellbeing.

> *Achieving a water sensitive city that supports wellbeing, means equally considering the social, cultural and economic needs of communities and the benefits, including the building of public amenity through the greening of open spaces, which aid health and well-being and community prosperity and growth through water recycling which supports business and tourism* (p. 85).

Intersectoral work is essential to achieve the goals articulated in the *Water for Good* plan, and accordingly, the document makes mention of numerous government sectors and agencies, including the agencies associated with the built environment, which is discussed in Chapter 6.

Outside the Greater Adelaide area, reference to the challenges of supplying quality water to remote Aboriginal and Torres Strait islander communities and rural towns, precedes the aim to "Develop and implement a strategy to improve the quality of water provided to remote communities" (p. 133). As such, this would suggest that Aboriginal communities in remote areas have access to poorer quality water, which is a health equity issue. Targeted income support is proposed as a strategy to increase access to water where it is available but clearly this strategy does not secure the provision and quality of water for vulnerable non-urban, rural and remote communities.

As stated, attention to health in the plan resonates strongly with traditional public health understandings and there is no direct reference to mental health and psychological wellbeing. This is despite research identifying the association between high levels of personal and community stress and increased mental illness (anxiety, depression, post-traumatic stress disorder and suicide) when coping with drought, climate change and lack of water (Stanke et al. 2017).

Drought, climate change and lack of water are the very problems being addressed in the plan however critical scrutiny reveals that the associations between these factors and mental health issues are silent in the plan. During the millennium drought from 2001-2009, lack of action on climate change and mismanagement of the water in the Murray-Darling basin brought about serious degradation of the natural environment, loss of fauna, loss of livelihood, overwhelmed communities and poor individual health, including poor mental health in South Australia (Sobels, 2007).

People and Parks- A Visitor Strategy for South Australia's National Parks, Marine Parks and Reserves (2012)

The Parks and People strategy articulates strategy to build park visitor experiences in SA's national parks and reserves, with the intention to support an increase in the valuing of parks and the natural environment for South Australians. Increasing the valuing of parks is a central DEWNR goal, and this strategy aims to increase the appreciation, knowledge and enjoyment of parks to enable the achievement of this goal. Four goals are articulated: Enhancing our Lives, Enhancing Parks, Shared Stewardship for Parks and Growing Community Benefits and Prosperity. The strategy acknowledges concern about the state's ecological integrity and the need for park integration and consolidation given the recent addition of 19 marine parks. The need to balance nature conservation and protection with increased visitor experiences in the park network is additionally highlighted.

This document again advances three key sector goals: to protect and conserve parks (National, Conservation, Marine and Recreation parks); to increase the valuing of parks; and to support the economy through increased park utilisation. The central problem being addressed in *the People and Parks Strategy* concerns the need to increase the valuing of parks in order to increase park use. As stated previously, this is a common theme in the policy in the sector, most strongly represented in the *HPHP strategy*, discussed later. The strategy proposes that engagement with parks is good for wellbeing, the environment and the economy. The joint consideration of social, economic and health benefits is noted in *Parks and People* and health and wellbeing are problematized as outcomes associated with a social view of health.

The following reference stresses the links between engagement in parks with health and wellbeing.

> *Conservation remains paramount; however, parks are also a community asset; important for our own wellbeing and that of regional economies. People and Parks outlines a vision, goals, guiding principles, strategies and actions to ensure that we can enjoy parks without compromising them* (Document Foreword).

The *Visitor Strategy* represents health and wellbeing as benefitting from: engagement in recreational activities within a park setting (physical health benefits), joining in an educational or recreational activity (learning and social benefits), and developing economic activities associated with park settings (economic benefits).

The document references health but not mental health and the opportunities for mental health promotion through 'being' in the environment that are central in the *HPHP Policy* are unmentioned in the document. Physical health promotion through 'doing' activity in the environment is a central message as evidenced in recognition of the policie's contribution to Target 83 of the South Australian Strategic Plan (South Australian Government, 2004): *To increase the proportion of South Australians participating in sport or physical recreation at least once per week to 50% by 2020 (p.27)*. The equivalent target relative to improving psychological wellbeing is not referenced.

Analysis also reveals significant emphasis in the document on creating economic opportunities within parks, including discussion of the creation of local jobs associated with economic partnerships and the financial benefits associated with park visitation, including opportunities for Aboriginal communities. As such the strategy demonstrates policy that in part considers equity of access to the economy.

Health inequity, however, is unacknowledged and the impact of disadvantage on access to or enjoyment of parks-based recreation and engagement is undiscussed in the document. Equity of access is discussed.

SA's Climate Change Strategy 2012-2050: Towards a low carbon economy

The Climate Change Strategy – Towards a low carbon economy acknowledges the need to respond to climate change by transitioning to a low carbon, prosperous and resilient economy. Moving towards zero emissions; building a carbon neutral Adelaide and building community capacity to respond to climate change are key to the strategy. The paper considers the implications of the Kyoto protocol (1997) which extended the United Nations Framework Convention on Climate Change (1992), for South Australia and the requirement to meet the commitments to reduce greenhouse gases. Exemplars are provided to demonstrate how a low carbon economy can be developed with equal emphasis on reducing emissions and supporting the economy.

The problem addressed in this strategy is the need to mitigate climate change but continue with economic development. The strategy presents objectives over a 38-year time frame, suggesting acknowledgement of the complexity of climate change strategy and the need for long-term commitment to the task, although this is not mentioned. The strategy argues that the state can continue to enjoy economic growth based on the extraction of fossil fuels while transitioning to an economy based on renewable energy.

The strategy acknowledges social, environmental and economic factors, reflecting a social view of health, however the dominant factor presented as essential to wellbeing and health is economic security. The economic focus is demonstrated by use of the words *markets* and *innovation* as evidenced in the following reference.

> *Decarbonised, compact cities have reduced infrastructure costs, provide more vibrant markets and create an environment that encourages innovation and ideas. They are more liveable, with improved air quality and green space, providing health and well-being benefits* (p. 8).

The aspects of health that are discussed in the document relate to the physical health impacts of climate change, such as the impact of poor air quality on respiratory disorders or extreme heat on medical conditions but there was no acknowledgement of the psychological and emotional impact of these same factors. Mental health was a silence in the strategy, despite growing literature evidencing the rising negative mental health impact associated with climate change, continued fossil fuel use and environmental degradation (Bourque & Cunsolo Willox, 2014).

The need for individual and population strategies to mitigate climate change is acknowledged in the document, however the strategies presented are largely individualised behavioural approaches. Local government is viewed as central to progressing population approaches. This is consistent with the "Preparing for Climate Change" (p.50) objective identified in the *SA Public Health Plan.* The stated role of the natural environment sector in relation to climate change is as follows.

> *Provide comprehensive information, support and advice to help people to understand the implications of the net zero emissions target and empower them to take effective action* (p. 53).

Focussing on the need for individual behaviour change, the strategy articulates awareness that within the community there are those who are highly susceptible to climate change impact, demonstrating attention to health inequity and awareness of the multiple sources of inequity and disadvantage i.e. age, living conditions, financial factors and topographical situation.

> *Vulnerable members of the community will be particularly susceptible, including the elderly, the very young, those who live in remote or vulnerable coastal communities and low-income households* (p. 21).

Stating responsibility in responding to this disparity, the state government proposes action that is financially supportive as opposed to structural change.

> *Government has a responsibility to prioritise support for these groups by working with the community services sector to build capacity to provide assistance* (p. 52).

Aboriginal Reconciliation Action Plan – 2014-2015

The purpose of the plan is to guide the work of reconciliation within DEWNR and the need for continued development of, commitment to and action for practices that support reconciliation. It provides strong endorsement of the wrongs of the past, referencing colonisation, settlement and displacement. Four areas of action are outlined: 1. Symbolic Action; 2. Cultural Awareness; 3. Partnerships and Agreements; and 4. Employment, Training and Engagement, which are associated with targets, responsibilities and timelines highlighted in the plan.

The Aboriginal Reconciliation Plan strongly references the unique relationship between Aboriginal and Torres Strait Islanders and Country. It aims to progress reconciliation internally within DEWNR. Within the policies analysed, the DEWNR Reconciliation plan stands out as the document that most clearly acknowledges and recognises the colonial past, articulating the profound impact of colonisation on Aboriginal culture, health and wellbeing and demonstrating intention and responsibility for change. Strongly articulated in the plan is the intention to achieve an active process of reconciliation. Reference to current discriminatory or colonialist practices, such as the non-granting of native title and land rights, however, are not made.

> *We will endeavour to repair the damage, and where that is not possible, to reconcile the past. We will build respectful and honest relationships through our work and develop a better awareness of Aboriginal history, knowledge and culture. We will ask and listen, before we act* (p .3).

The plan demonstrates knowledge and an action plan in support of reconciliation, constructing health and wellbeing as an outcome associated with the recognition and valuing of Aboriginal people and culture. The support of connection to Country for Aboriginal people is a constant theme in the plan and a theme that is progressed more strongly in the natural environment sector. Outcomes related to Aboriginal health and wellbeing and the social determinants of health are enabled in the plan, conveying a problematisation of health that is consistent with a social view of health. However, within this broader conceptualisation, employment and economic opportunity are specifically targeted, viewed as the key determinants to progress health and wellbeing. Supporting Aboriginal people to 'participate, prosper and progress' (p. 7) is a catchcry in the plan, words that are reflective of the strong economic paradigm that dominates the plan.

> *DEWNR recognises that cooperation between the department and Aboriginal people should lead to advances in health and well-being, employment and economic opportunities, and increased public awareness of the value of Aboriginal culture and heritage, and their contribution to the Natural Resource management activities associated with DEWNR* (p.6).

Plans to shift from the rhetoric of reconciliation into action are seen in the document, with the naming of four action areas to support reconciliation: 1. Symbolic Action; 2. Cultural Awareness; 3. Partnerships and Agreements & 4. Employment, Training and Engagement.

Through action in these areas the plan aims to increase the valuing of Aboriginal culture within DEWNR and promote opportunities for employment and economic independence. Such action is viewed as supporting agency and relationships, core elements which potentially foster health, mental health and wellbeing.

Mental health and psychological wellbeing are not concepts that are referenced in the plan, but aligned concepts are.

> *We observe that country is central to the social, cultural and spiritual lives of Aboriginal people (p. 3).*

Absent in the text is any reference to racism or discrimination, both key risk factors for mental health issues and endemic in our culture and workplaces (Paradies, 2006). Health inequity, social justice and self-determination are likewise unreferenced.

Acknowledging the cultural responsibility that Aboriginal and Torres Strait Islander peoples hold in relationship to caring for/on Country, the *Reconciliation Action* plan, like the *Natural Resource Management* plan, stresses the shared goal of 'caring for Country'. Presenting this as collective goal between Indigenous Australians and the sector is problematic, given the inconsistency with the analysis from the *NRM Plan*, discussed earlier, in which the plan represented a difference in the understanding of the 'meaning of Country' for Aboriginal and Torres Strait islanders (cultural and spiritual) and non-Indigenous Australians (productivity and liveability). In this respect, suggesting that there is an alliance of purpose potentially carries as assimilative agenda, inconsistent with the process of reconciliation.

DEWNR Corporate Plan 2014-2015

This plan outlines the four goals central to the work of the environmental sector: 1. Sustainability; 2. Water; 3. Parks and Public Assets and 4. Corporate Affairs. The document uses visually engaging graphics and images, emphasising the balance that needs to be achieved in SA between the use of the state's resources and conservation of the environment. The role of NRM boards in achieving that balance is identified. Discussing the environment as 'natural capital', it identifies the roles, organisational structure and processes of the sector in achieving these corporate goals.

This plan is an overarching document in which the organisation articulates and communicates DEWNR values and goals in an accessible way. The goals are highlighted in the plan, which brings together the various and diverse sector goals from the documents discussed as well as goals that fell outside of the research parameters i.e. improving the organisational structure and delivering on election commitments.

The plan outlines the structures and processes to support the environment with community involvement and help '*South Australians, conserve, sustain and prosper*' (p. 2) and articulates four departmental roles to enable the achievement of sector goals: facilitator, steward, custodian and authority. In explaining the work of the department, the focus on health and wellbeing was brief and there is no direct mention of mental health in the document.

The central message conveyed in this document is the significant focus in the sector on increasing the public valuing of parks and reserves; that is, progressing public appreciation, knowledge and participation in parks to benefit people and enable environmental conservation and protection and resource management. Analysis of the policies has confirmed this message, as being central to the majority of documents analysed and is specifically detailed in the NRM plan.

> *For our vision to be achieved, people need to be able to make a living in ways that enhance rather than diminish our natural capital. To be sustainable and prosperous as a community we must balance people's needs with those of nature. If we get this balance right, the land, water, plants and animals of our state will endure in a way that can benefit the whole community, now and into the future* (p.3).

The tone conveyed in the document is one of immediacy. There is communication of the need to 'take responsibility' for our environment, on both an individual and a corporate level. The imperative of '*looking after our natural capital*' for both economic and environmental reasons is strongly communicated in the document and the need for this to be a shared responsibility across the population.

Healthy Parks and Healthy People (2016-2021) – Making Contact with Nature, Second Nature
(Memorandum of Understanding and Terms of Reference - Healthy Parks, Healthy People (2015-2017)

Healthy Parks, Healthy People' is a nature-based approach for population health. "It is guided by our vision to ensure that all South Australians are connected to nature and recognise it as an integral component to their health and wellbeing" (p.9). Articulating seven foci in the policy, the policy works to support contact with nature, on individual, social and community levels and to build intersectoral processes that support both environmental and health goals. It works to address two goals: 1) to promote population health and mental health outcomes through engagement with nature and 2) to increase the appreciation, respect and valuing of SA parks and reserves. The strategy presents a holistic understanding of health, seeking to increase the understanding that all aspects of health: physical, social, mental and spiritual are supported through contact with nature. It is a joint initiative between DEWNR and DH&A (Public Health Partnerships Unit).

The problem being addressed in this document, is the need to enable health and wellbeing through contact with nature.

There is focus on the relational aspects of health for people and health for the environment and how that relationship progresses physical, mental, social and spiritual health and wellbeing. The explicit mention of mental health and the promotion of mental health makes this policy an exception, not only in relation to environmental policy but to all examined policy. The *HPHP-Making Contact with Nature, Second Nature Strategy* was initiated in 2015 by a Memorandum of Understanding (MOU) and Terms of Reference (ToR) that supported intersectoral collaboration between the Health and Natural Environment sectors. The establishment of DEWNR as a Public Health Partner provides an example of the Partnership principle in action, a principle drawn from the *SA Public Health Act (2011)* which supports and encourages sectors other than health to develop healthy public policy.

Critical scrutiny of the representation of mental health within these documents, reveals that mental health is viewed as a holistic and dynamic state that is context dependent. This representation enables a focus on mental health promotion and the use of 'healthy settings' approaches. Contact with nature as an opportunity to improve psychological wellbeing is directly referenced in the policy.

> *Connection to nature is therefore critical for disease prevention, and to promote positive psychological states* (p.17).

Seven strategies are articulated in the policy, relating to health and mental health. The second strategy specifically focusses on the "Mental health benefits of contact with nature" highlighting positive psychological states, improved attention, restoration of mental fatigue and improved psychological resilience and coping skills as outcomes attributable to contact with nature.

By drawing direct links to health promotion and illness prevention, the *HPHP Strategy* supports an upstream population mental health approach that has co-benefits for both the Health and Natural Environment sectors. The document also discusses contact with nature as beneficial for those recovering or rehabilitating from mental illness. Other strategies, which are also supportive of health promotion, include: Promoting physical activity in nature, Promoting the cultural value of country for Aboriginal health and wellbeing, Community health and wellbeing in a changing climate, Child development and nature, Supporting green infrastructure in urban settings and Biodiversity, nature and human health.

Importantly, while the findings from the Health sector analysis (Chap 4) indicated that mental health promotion was not enacted through current policy or practice, the processes associated with the *SA Public Health Act (2011)* and the Public Health Partner Agreement have been instrumental in enabling the Natural Environment sector to enact this policy.

5.1.1 Document analysis and selection of policies for the next stage of research

Next I address the three questions that are guiding my analysis, summarising my findings in regard to policy problemisations, representations and assumptions regarding health and mental health and silences.

What is represented as a problem in the selected Natural Environment sector policies analysed and how does health/mental health fit with that problem representation?

The problems addressed in the selected policies concern: sustainable management of natural resources and water, conservation and protection of the natural environment, managing the impact of climate change and the need to increase the public valuing of the natural environment. The Corporate plan reinforces the significance of needing to address the problems of water management and environmental sustainability, which is challenged by the economic growth agenda. All DEWNR policies frame health as an aspect of wellbeing and wellbeing as an outcome related to economic, social, cultural and environmental factors. This framing of health and wellbeing is consistent with a social view of health and within the policies analysed indicates that DEWNR consistently recognises and acknowledges the relationship between the issues they are responsible for and health and wellbeing. However, despite the framing, mental health features in only two policies: the *Aboriginal Reconciliation Action Plan* (where the concept aligned with cultural safety and spiritual wellbeing) and the *HPHP Policy*.

The *HPHP Policy* explicitly considers mental health, demonstrating that mental health is viewed to be a part of DEWNR core business in a way that isn't considered either by the Health or Built Environment sectors. The problem representation of mental health as a holistic and dynamic concept in the *HPHP Policy* enables the sector to develop strategy and action that promotes mental health and links the contact with natural environment to mental health and psychological wellbeing.

What assumptions lie under that representation?

DEWNR consistently demonstrates that it works with the assumption that the health of the environment and people are inextricably linked. It is assumed that environmental action will impact human health in a range of ways. There are co-benefits that flow between the environment and health. The sector assumes a socioecological framework as demonstrated in the Barton and Grant Settlement Health Map (2006) in which it is understood that change at the global ecosystem and natural environment level will impact human health and vice versa. However, there is consistent and dominant referencing in policy to the use of natural resources to achieve economic outcomes, which threatens to marginalise social and environmental goals and ecological health.

The dominance of the economic imperative is particularly evident in the *Water for Good*, *SA Climate Change Strategy* and the *NRM Management Plan*, which are the policies that grapple with the need to achieve sustainability. However, it is also evident in the *Aboriginal Reconciliation Action Plan,* which seeks to maximise economic opportunities and employment for Aboriginal and Torres Strait Islander peoples.

It is also an assumption in some documents that spiritual and cultural elements of wellbeing need to be recognised and supported and specifically for Indigenous Australians, the sector communicates respect for the social, spiritual and cultural connection to Country which is strongly linked to Aboriginal health and wellbeing.

There is also an assumption that to promote valuing of parks and human health, people need to engage with parks, an assumption most evident in the *HPHP Policy*, the *Aboriginal Reconciliation Action Plan, People and Parks Strategy* and the *Corporate Plan.* This relational focus is very different to an assumption that holds that people needed to be deterred from entering parks because they are fragile and endangered ecosystems which need protection from, not engagement with, people.

What is left unproblematised and where are the silences in the dominant discourse?

The concepts of mental health and psychological wellbeing are silent in the *Water for Good* Plan, *SA Climate Change Strategy*, the *People and Parks Strategy and the NRM plan and present in* the *Aboriginal Reconciliation Action Plan, Corporate Plan* and as stated, they are best represented in the *HPHP Policy*. Additionally, my analysis indicated that the recognition of physical health is greater than mental health in the majority of DEWNR policy. Importantly, this is not different in either the Health or the Built Environment sectors.

The health inequities associated with access to parks and to nature are a silence in all policy excepting the *HPHP Policy*. The most notable silence is in the *SA's Climate Change Strategy*, which fails to address the health and mental health inequities associated with the impacts of climate change (McMichael et al. 2008) or to address the wickedness of the problem of using environmental resources to support individual and community wellbeing, when continued destruction of environment resources threatens ecological wellbeing.

In summary, the application of Bacchi's analysis has enabled the identification of the *Aboriginal Reconciliation Action Policy and Healthy Parks, Healthy People – Making Contact with Nature, Second Nature* as the policies from the Natural Environment sector most likely to enable the promotion of population mental health and the prevention of mental illness.

5.2 Interview Analysis

This section reports on the findings of the analysis completed on the interviews with policy actors and academics associated with the two policies identified at 5.1.1. as most likely to enable population mental health. The second stage of research sought further knowledge and insight into how the identified policies were considered within the sector and whether they were significant in driving the work of the department. Again, interviews were both exploratory and confirmatory, seeking to explore both the policy and policy context.

The analysis of data from the interviews (8 interviewees) was used to determine which of the two policies best enabled population mental health. In relation to the *HPHP Policy,* given the use of a MOU between Health and the Natural Environment sectors to initiate the policy, Health sector policy actors were also included in the interview process. Of the two policies, the *HPHP Policy* initiative, was found to have a direct mandate to promote population mental health, was focussed on the whole population and was viewed to be significantly guiding the work of the department at the time of research.

Again, interview data were coded using Nvivo software and the same coding framework. Analysis of coding (open and axial) was completed in relation to the data and confirmed the emergence of five themes pertinent to the research questions including:

1. The public valuing of parks
2. The natural environment is a setting that promotes wellbeing, health and mental health
3. Direct and indirect policy impacts mental health and psychological wellbeing
4. 'Connection to Country' is essential to Aboriginal and Torres Strait Islander health and mental health
5. Metrics that reflect health and wellbeing outcomes are needed

I now discuss these themes in detail.

5.2.1 The Public Valuing of Parks

The strongest theme that emerged from the interviews with environmental sector policy actors was the need to increase the public valuing of parks, which is consistent with the policy analysis finding. The assumption underlying this theme is that it is only by increasing the value assigned to parks and the environment by the general population that ecological integrity will be conserved and protected. The following quotes highlight this point and indicate that the department is in a process of transition regarding this assumption.

> *…the department and the NRM Boards as well have undergone quite a transition with the way we think about nature. We conserve and preserve nature for its own sake, but it is now well realised that that's not going to happen unless the community themselves see the benefit in conserving and preserving nature* (Natural Environment Policy Actor, 2016, #7).

> *and this is a bit of a mind shift for us - probably only really in the last, say, three or four years that we realised we actually don't manage resources; we help manage people. We help people to manage resources and that's - we're still grappling with that*… (Natural Environment Policy Actor, 2017, #24).

Policy actors explained that traditional work in the sector, such as managing environments, conserving ecosystems and preserving fauna and flora needed to be held in balance with engendering the public valuing of parks and raising the level of public support for the environment to ensure environmental sustainability. A recent DEWNR survey of public opinion indicated that only 11% of the state's population reported that a focus on the environment needed to be a state government priority (Natural Environment Policy Actor, 2017, #24), serving to introduce a sense of urgency into the goal to increase the public valuing of parks. The following quote illustrates the perceived challenge of this task.

> *So, we're (DEWNR) just trying to figure out what is the way that you can connect the parks, the outside world, nature, the environment, …outside to people or people to the outside* (Natural Environment Policy Actor, 2017, #24).

The fact that this task involves working to strengthen the relationship between nature and people, was seen as a marked departure from traditional environmental policy (Policy Actors, #7 & #24). One senior policy actor reflected on the broadening of scope in the sector's agenda saying, *"I describe it as the things you wouldn't expect an environment department to do"* (Natural Environment Policy Actor, 2016, #8). This comment reveals the interviewee's opinion that DEWNR are pushing the boundaries of the traditional environmental sector by opening up a policy space to support strategy that connects people to parks and a policy space for mental health promotion.

Policy actors reflected on the difficulty of improving the public valuing of parks and the environment while also acknowledging the instrumental valuing of the environment for the economic and social resources it provides. They expressed concerned about the communities' intrinsic valuing of the environment, the valuing of the environment for its health benefits and the valuing of connection to Country for Indigenous Australians. The following comments demonstrate these concerns. The first two relate to intrinsic valuing; the third relates to health benefits; and the fourth to connection to Country.

> *It's a difficult conversation for me to have to talk about the bigger, the holistic benefits people get from a healthy environment… but (the fact that I need to do it) shows the disconnect that people have about the intrinsic value of the environment*… (Natural Environment Policy Actor, 2017, #24).

> *People need permission to do it (engage with the environment) …the back yard is the most important room in the house. It isn't the study, it's not the TV, it's not the home theatre, it's what you do in your back yard… firstly get out the door, just go for a walk…* (Academic, 2016, #7).

> *… so they (specific groups within DEWNR) want people to sort of love nature and see it as something to value and I really want the same thing but I want it because it's good for their health and they want it because it's good for the environment* (Natural Environment Policy Actor, 2017, #30).

> *What you need to teach is value and connection and that's an enormous power that Aboriginal people can bring to the table… there's a lot of learning on Country but it's not mainstream by any stretch of the imagination… we are so far from reconciling with Aboriginal values…* (Academic, 2016, #7).

This last comment suggests that non-Indigenous Australians have much to learn about the valuing of the environment from Aboriginal people, the interviewee indicating that there is a need to respect and empower this Indigenous knowledge but acknowledging a deep divide between the different valuing systems.

The same interviewee discussed the use of three approaches, of which two have been developed in the sector to promote improved public valuing of parks.

> *So, the two approaches to take are, firstly, around the business of nature, so ecotourism, recreation and how nature supports enterprise and then the second one is how nature supports health and wellbeing, which then links kind of to the third, which is a lot smaller, which is about creating a sense of place and community stability* (Academic, 2016, #7).

This first approach can be seen in the *Parks and People Visitor strategy,* the second approach in the *Healthy Parks, Healthy People Policy*. Incidentally, the third approach, 'creating a sense of place and community stability', aligns with the first priority of the *SA Public Health Plan* – Developing stronger and healthier communities and neighbourhoods', however as the interviewee pointed out at the time, that this was a small goal within the environmental sector.

5.2.2 The natural environment is a setting that promotes health, mental health and wellbeing.

The majority of interviewees discussed mental health as an important component of wellbeing. Appreciation of the natural environment as a setting that is fundamental to psychological wellbeing was also a strong theme in the data, the following quotes demonstrating an awareness of the importance of this to individuals and populations.

> *Wellbeing is a physical health thing and it's a mental health thing, whether it's mental health for recovery or management of a mental health issue, it's just nice to be* outside (Natural Environment Policy Actor, 2017, #24).

> *…building wellbeing at population level, this green stuff is integral to that* (Natural Environment Policy Actor, 2017, #25).

> *So, there's that sort of nature as well, the interaction with wildlife, which can be incredibly important (for mental health) … urban nature is incredibly important. That's why if you can get people outside, they start to experience it - the easiest way to get them outside is through the animals… particularly magpies, incredibly important for many people who are lonely or isolated* (Academic, 2016, #7).

Additionally, policy actors demonstrated a strong interest in supporting personal and population mental health and wellbeing, advocating for the role of the environmental sector in supporting and maintaining mental health and psychological wellbeing.

> *(Engagement in nature is)...a real game changer for some people that even little things - like we do citizen science where you get people involved… and for some people, you know, this is an example of their improving their mental health or their wellbeing* (Natural Environment Policy Actor, 2017, #24).

> *(DEWNR) recognise the importance of nature … make sure the quality of public spaces is suitable for mental health and wellbeing outcomes as well as physical health outcomes* (Natural Environment Policy Actor, 2016, #30).

Policy actors detailed a range of current initiatives set in the natural environment that have potential to yield health and mental health outcomes. These include: formalised programmes supporting engagement with nature for those in the criminal justice system; volunteer bush care groups for those who are currently unemployed; shared programmes with regional Aboriginal communities to build capacity and skills and to learn about caring for Country; targeted programmes supporting vulnerable migrant communities or other minority groups to connect with place; or Natureplay opportunities supporting children to connect with nature.

Awareness of the need to focus on improving environmental quality, infrastructure and access for the whole population to benefit from potential health and mental health outcomes, was raised by a number of participants, despite this being a silence in written policy. The following quotes are relevant to this point, highlighting the need for improvement regarding equity of access to the environment.

Referring to Natureplay

It tends to advantage the advantaged and middle class… (NGO/Academic, 2016, #7).

Referring to disability access to parks

> *The disability side of things, we tend to do but we do it really conventionally, really safely, like making toilets with a ramp. That's not really enabling people with physical disabilities to get into a park, that's enabling them to go to the toilet* (Natural Environment Policy Actor, 2017, #24).

Referring to quality greenspace

> *I use Google Maps all the time to look for all sorts of things and when you look at the satellite images, they really help in identifying green spaces in urban areas. I went to a meeting with an NGO who supports a large immigrant community in Kilkenny and most of whom don't have cars, they rely almost entirely on public transport or local support services and if you look at Kilkenny on Google maps there is almost no green space in the whole suburb. I think they have one footy oval which is not a great space for mental health* (Natural Environment Policy Actor, 2017, #25).

This last quote conveys the recognition that it's not just environmental setting that matters but the quality of that setting, reflecting research that articulates that the purpose, size, shape and features of parks and natural environments are consistently related to the experience of that space and therefore to the health and mental health benefits (Francis et al. 2012).

Advocacy for the role the environmental sector can play, not only in supporting mental health but also in addressing mental illness, was a strong theme in the data. Participants indicated an awareness that contact with nature can support positive health outcomes for all, regardless of current mental health status.

> *One in five people suffer from a mental health condition at some point in their lifespan... when you look at the statistics, yeah, how could you not sort of play a role in that* (Natural Environment Policy Actor, 2016, #3).

> *We need to have the health professionals who are the doctors who say 'I'm prescribing you a walk in the park three times a day, then come back and see me* (Academic, 2016, #7).

Reference to a DEWNR led volunteer programme conducted on Kangaroo Island that supports engagement with nature for those with mental illness (depression) was highlighted as an example of the sector's commitment to playing a role in addressing mental illness (Natural Environment Policy Actor, 2016, #8). However, one interviewee highlighted that where the focus shifts to mental illness as opposed to mental health, this then becomes problematic, as it draws attention to individual illness and treatment options, which serves to invite increased input from health professionals and reduce the capacity for those from other sectors to contribute. The following quote refers to a joint working group between the Health and Natural Environment sectors and relates to this.

> *I felt a little bit out of my depth because I didn't - because I was in the mental health working group and I'm not quite sure how I can contribute so I've just kept on doing my normal business, which is to try and get into this space, but probably not using the language that this uses…*(Natural Environment Policy Actor, 2017, #24).

This comment alerts us to the distancing of DEWNR input that can potentially occur when the topic concerns mental illness, as opposed to mental health, discussed further in the nested case study analysis. Mental illness clearly demands the involvement of mental health practitioners, which shifts the focus to service delivery. In doing so, it shifts the focus away from the 'setting' to the 'individual'. The previous quote is illustrative of this, the participant experiencing discomfort in an intersectoral setting when discussion shifts towards illness and the biomedical model. The comment highlights that where the focus remains on 'health' as opposed to 'illness', medical paternalism is minimised and opportunity for the environmental setting to play a role in supporting mental health is enhanced.

5.2.3 Direct and indirect policy impacts mental health and psychological wellbeing

Awareness of the potential of the sector to contribute positively to both health and mental health was a strong theme in the interview data, a finding that is in part related to the final theme in this section. Policy actors demonstrated their awareness of the direct mental health and psychological wellbeing outcomes being achieved through the *HPHP Policy* but also wished to bring attention to how other policy and practice in the sector yields mental health outcomes. The following quote identifies that environmental policy generally, can work directly or indirectly to contribute to health and mental health, articulating that such policy serves a 'common good'.

> *…apart from the HPHP Policy I think there's other policies and drivers with these benefits being recognised …more community, social good, tourism type of aspect but it has social benefits at the end…rather than (just) thinking about 'we've got our park estate; we want to improve mental health, how do we connect them?'* (Natural Environment Policy Actor, 2016, #8).

While this quote reflects an awareness and acknowledgement of the *HPHP Policy* as a policy that promotes works directly to influence mental health and psychological wellbeing, the interviewee brings attention to the broader work of the department, explaining how other policies also indirectly benefit health and mental health by enabling social and community activity in the environment.

Further evidence is provided by the next quote. The quote again references the *HPHP Policy* but also applies a health lens to other work of the environmental sector, giving operational examples of how building bike trails or having dogs in parks provides opportunity for engagement with the environment which can indirectly enable mental health.

> *…everything DEWNR is doing could be Healthy Parks, Healthy People like, you know, improving bike trails or letting dogs into parks* (Natural Environment Policy Actor, 2017, #30).

5.2.4 'Connection to country' is essential to Aboriginal and Torres Strait Islander health and mental health

The acknowledgement of the significance of country to the health and wellbeing of Aboriginal people that was found in DEWNR policy documents was confirmed in the interviews.

Data indicated an awareness and acknowledgment of 'connection to country' as integral to Aboriginal health and wellbeing. Physical, mental, social and spiritual aspects of health were viewed as being supported by social and cultural practice and access to country. The need to support the ecological health of country to enable Aboriginal health and wellbeing was additionally expressed.

> *If country is healthy, people are healthy'* (Policy Actor, 2016, #4).

It was viewed by policy actors that the sector was well positioned to work with Aboriginal communities to better support health and wellbeing by enabling the development of increased economic and business options and employment for Aboriginal people on country as illustrated in the following quotes.

> *…there's an Aboriginal sort of nature-based tourism focus there that's about connection to country, which is about health, has health and wellbeing outcomes…* (Natural Environment Policy Actor, 2017, #30).

> *There's a real commitment to not just increasing employment internally but also building capacity for Aboriginal people externally so that they are able to work with us on an equal level, they're able to provide input into the partnerships that we have at an equal level* (Natural Environment Policy Actor, 2016, #4).

This last quote also discusses how the sector is working to achieve equal partnerships in relation to supporting employment, both internally and externally, demonstrating a broader commitment to progressive action around employment and subsequently health and wellbeing.

The following quotes also relate to partnerships, discussing the need to support consultation processes and build capacity for both Aboriginal people and the Department to enable improved partnerships and subsequently improved health, mental health and wellbeing outcomes. The second quote discusses the importance of Indigenous representation on the local Natural Resource Management (NRM) Boards, the boards that are central to making decisions regarding land use and environmental management.

> *Capacity has built for Aboriginal people and it's built for the Department, so that we're in a reasonably good space to be able to look after the wellbeing of Aboriginal people* (Natural Environment Policy Actor, 2016, #4).

> *…there's a commitment from the Department to be able to build the leadership capacity (of Aboriginal people) within the new NRM management boards, so that we do have strong boards and strong board members* (Natural Environment Policy Actor, 2016, #4).

This following quote expresses a positivity about progressive relationships between Aboriginal communities and the sector, demonstrating an awareness that open, shared and respectful engagement and consultation processes need to be both practised and embedded in policies if they are to yield a continued focus on improved health and mental health outcomes.

> *…we are working directly with Aboriginal community members and leaders… we have a really strong commitment around consultation with them, we are reinforcing that in our policies and our practices and the way that we go about* (Natural Environment Policy Actor, 2016, #3).

The following quotes, however, reflect on the complexity of achieving improved outcomes given the systemic and structural barriers to health and wellbeing that are faced by Aboriginal communities (Anderson, Baum & Bentley, 2007). Both quotes imply the outstanding need for self-determination, while the second also suggests the unenviable position that the sector assumes in trying to counter the effects of dispossession of land.

> *I'm just interviewing some Aboriginal people…to talk about what connection to country and wellbeing means to them in their words…It has to be hand in hand and led by them, Aboriginal people…* (Natural Environment Policy Actor, 2017, #30).

> *Even though - all the land is theirs, they don't actually own any of it so what we're trying to do is create small opportunities for them - their elders, their people, (asking) how can we build their capacity for some self-determination about how they can connect to the landscape because that has a wellbeing outcome* (Natural Environment Policy Actor, 2017, #24).

The last quote acknowledges the centrality of issues of ownership, land rights and access to land for to Aboriginal health and wellbeing and the difficulties for the environmental sector in engaging helpfully given these broader issues often remain unaddressed. It suggests that within the parameters of the organisation, the sector, or a part of the sector has adopted a role to support connection to Country, recognising the centrality of this issue to the wellbeing of Aboriginal people.

The same participant comments further on the role that the sector plays in trying to support the practice of cultural responsibilities and thereby enable agency and connection for Aboriginal people, drawing attention specifically to mental health.

> *Aboriginal people have cultural responsibilities to their country…whether they like it or not they - whether they can act on it is another thing... people are waiting to be welcomed to country… people waiting for native title, how can we complement their cultural responsibilities and that's - I think for a lot of people that's - that in itself creates a lot of mental health challenges for them* (Natural Environment Policy Actor, 2017, #24).

This quote refers to the situation with ongoing legal processes involved in the determination of native title and land rights and the heavy emotional and mental health demands of living this reality. To put this quote into context, the impact of the difficulty in accessing and connecting to country for the Kaurna people (the Greater Adelaide area) is particularly difficult given that the vast majority of Kaurna land is owned freehold. Regarding Kaurna native title, a recent decision was made in Federal Court, that acknowledged native title after an 18-year legal process (Eacott, 2018).

Thus, although the significance of 'connection to country' for Aboriginal health and wellbeing is highly recognised, acknowledged and valued within the sector, support of connection to Country is impacted by unaddressed issues regarding land ownership, rights and access to country.

5.2.5 Metrics that reflect health and wellbeing outcomes are needed

Interviewees largely recognised and valued the sector's contribution to mental health as indicated by the findings presented at 5.2.2 and 5.2.3. However, the majority of interviewees commented on the difficulty of progressing healthy public policy in the sector. The interviewees explained that it was difficult to advocate for the promotion of health and mental health because of the lack of appropriate measurement and data, which they viewed as essential to achieving recognition and funding. This theme is repeated in the findings for the urban environment in the following chapter.

There was a frustration for participants in trying to advance healthy policy while also focusing on achieving key performance indicators attached to perceived core sector business. There was a perception that if the co-benefits of environmental policy such as health and mental health outcomes, which policy actors acknowledged, were comprehensively measured this would enable recognition and support funding.

There was additional perceived concern regarding the sustainability of environmental policies that supported health and wellbeing, such as the *Healthy Parks, Healthy People* because of the lack of measurement. The following comments from DEWNR policy actors exemplify the frustration and thoughts related to this theme.

The first comment specifically discusses the positive but silent mental health impact of the work of the sector and the need for measurement and targets. The second highlights the need to broaden current measurements to enable health and wellbeing outcomes associated with a social view of health to be recognised.

> *If you funded the environment department to do these things (promote parks as good for mental health) or other people to do these things, then your health bill would steady, hopefully reduce…and so I think getting the statistics for that is a real challenge….but it's sort of this silent impact... ...because if you look from a government perspective, you know, one of the big issues for the government is the cost of health provision... and until you put sort of a target on there and -- you know, a focused target, often ideas and things that you want to happen in that space won't happen in that space* (Natural Environment Policy Actor, 2016, #8).

> *I suppose the indicators that we've used have been somewhat quite narrow and given sort of the broader social type agenda our agency is [seeming] to take on a little bit broader where we're looking at how we can change our monitoring and evaluation to be able to capture some of those outcomes, health and wellbeing outcomes* (Natural Environment Policy Actor, 2016, #3).

5.2.6 Interview analysis summary and selection of the nested case study

Analysis of the interviews and policies suggests that the natural environment sector frames health as an outcome related to economic, social and environmental factors. This social view of health is adopted as a relevant underpinning for environment policy due to recognition that the health of people, communities and the environment is linked, and this is central to the *Healthy Parks, Healthy People Strategy*. The first three findings that emerged from the interview analysis demonstrate that the sector understands that the public valuing of the environment can enable both environmental and human health and that the environment is a setting that enables health both directly and indirectly. The fourth finding is discussed further on and the fifth finding concerns the limitation of current evaluative processes in measuring the health outcomes achieved by sectors other than health. This finding effectively indicates the significance of the sector's recognition of the link between their core goals and health outcomes and importantly links to the valuing of wellbeing.

The findings across the policy and interview analysis differed in relation to mental health. Where the analysis of policy documents found only two policies that directly considered mental health, the *Healthy Parks, Healthy People Policy* and the *Aboriginal Reconciliation Action Policy,* most policy actors acknowledged mental health as an intrinsic part of health.

Additionally, representation of mental health for Indigenous Australians as an outcome related to relationship to Country, was revealed in the fourth theme of the interview data. The concepts of practising culture, cultural safety and spiritual wellbeing were viewed as aligning with Indigenous mental health and the significance of connection to country was represented in the majority of policy. This was best conveyed in the *Aboriginal Reconciliation Action Policy*; however given that this internal policy was not focussed on population health whereas the *HPHP Policy* was, it was not selected as the best policy exemplar to progress to the last stage of research.

The data gained from the policy analysis and the interview analysis has confirmed the *HPHP – Making Contact with Nature, Second Nature Policy*, to be the Natural Environment policy exemplar that best promotes population mental health, progresses access to and contact with nature and was assessed to be active in guiding the work of sector.

The following section presents my findings from the nested case study of the policy exemplar, *the Healthy Parks, Healthy People (2016-2021) Action Plan – Realising the mental health benefits of contact with nature (HPHP Action Plan)*. The findings from the previous stage of research indicated that the *HPHP Action Plan* was the only piece of active policy implementation occurring under the *HPHP Policy* at the time of research and was examined on this basis.

5. 3 Case Study – HPHP Action Plan – Realising the mental health benefits of contact with nature (2016-2021)

The findings presented in this section which details Stage 4 of the research are drawn from the strategic and operational interviews (13 participants) for Stage 4, documents disseminated by the Health and the Natural Environment sectors in relation to the nested case study, internet based searches and notes from my attendance to workshops about the nested case study, the *HPHP Action Plan* (Appendix F). As a researcher, I was invited to participate in three workshops that concerned the implementation of the *HPHP Action Plan.* Participants included staff from both the Health (public health and mental health) and Natural Environment sectors, representatives of Australian Health Promotion Association, Department of Education and Child Development, Conservation Council of SA and SA, Adelaide and Flinders Universities. I was also invited to review and respond to 3 disseminated *HPHP Action Plan* documents (regarding the Five ways to wellbeing initiative and the policy discussion paper). I took notes from these activities which became further data for analysis.

There are four key themes that have emerged from the case study analysis.

1. *HPHP Policy* and the nested case study, *HPHP Action Plan* are valued but under-resourced initiatives
2. Intersectoral structures and processes enabled the *HPHP Action Plan*
3. Opening policy space in the Health sector for mental health promotion through the development of the *HPHP Action Plan*
4. Health sector influence potentially shaping the *HPHP Action Plan* possibilities into probabilities

These themes are now examined in detail.

5.3.1 HPHP Policy and the nested case study, the HPHP Action Plan are valued but under resourced initiatives

A strong theme present in the data was the consistent acknowledgement of the *HPHP Policy* as a valued policy. Executive policy actors and political leaders relevant to both sectors endorsed both the *HPHP* policy and the nested case study: *HPHP Action Plan*.

> *Minister Hunter (State Minister for the Environment), when he came along to the first Healthy Parks leadership team meeting, told the group that he would like to see some further investment and action directed into the areas of mental health and children and nature* (Natural Environment Policy Actor, 2016, #3).

> *Jenny Richter, (Deputy CEO of DH&A) is very supportive of this work* (Health Policy Actor #16).

> *Sandy Pitcher (CEO, DEWNR) is right there, behind this work* (Natural Environment Policy Actor, #12).

Importantly, *HPHP* was also valued by the State Mental Health Commissioner, Chris Burns, and the Chief Psychiatrist, Aaron Groves, who provided sponsorship and support to the HPHP leadership group (Policy Actor, 2017, #16) as noted in the *HPHP Action Plan*.

> *We want to increase mental health throughout our community. Irrespective of whether a person may have a mental illness. For most people spending time in contact with nature promotes and reinforces the positive protector factors we need to engage in to keep mentally fit and healthy* (Aaron Groves, p.7).

> *Parks and green spaces can have a restorative effect and assist in the strengthening the mental wellbeing of South Australians* (Chris Burns, p.4).

A *HPHP Action Plan* Discussion paper published in March 2017 titled, "*Connecting nature and parks to mental health promotion and mental illness prevention strategies in South Australia*", provided a literature review to reinforce the benefits to psychological wellbeing of connecting people with nature. This paper served as a foundational document that provided detailed and comprehensive evidence and practice examples specific to South Australia, establishing the evidence for the *HPHP Action Plan* to be viewed as "*a viable asset for broader population mental health*" (p.3). The paper strongly references the social determinants of health, the social gradient and the imperative to employ settings approaches to promote mental health and address the preconditions of mental illness.

However, despite the confirmation and valuing of the *HPHP Action plan*, and the evidence-based Discussion paper, my research revealed that there was concern among interviewees concerning the *HPHP Policy* and the *HPHP Action Plan's* sustainability, given underfunding as indicated in the following quotes.

> *I think it's - politically it's a terrific document, a terrific aspiration to have… I think we have a lot of strategic political support but then not much at the actual doing because it takes a lot of resources, people and money, to turn these sorts of aspirations into something that can actually happen, so that's where I think the disconnect is really more obvious because this is a good document. This is a good thing to do but it doesn't come for free* (Natural Environment Policy Actor, 2017, # 24).

> *…there's no funding attached to it, only staff time, so that's the downside to* it (Academic, 2017, #25).

> *… if we had some funding where we could seed things - it doesn't have to be lots of money, but you could seed new ideas and test ideas. Particularly in the Connection to Country space I don't think it's really possible for us to make much headway without actually having some resources…* (Health Policy Actor, 2017, #16).

This lack of funding was also referred to by interviewees associated with NGO organisations (Trees for Life, Conservation Council and Natureplay) who were pursing similar goals to the *HPHP Policy* and *HPHP Action Plan*. Failure to obtain support, funding or grants relative to their goals from the Health sector, in relation to mental health related initiatives from these bodies, was reported as disappointing and served to compromise partnership relationships (Natural Environment Policy Actor, 2017, #31).

Given that an allocation of funding to policy is indicative of government and/or sector-based commitment, the fact that resources for the *HPHP Policy* or *HPHP Action Plan* were limited, caused interviewees to question the valuing of both initiatives and further, to question the valuing of mental health promotion generally. However, the third theme identified in the data, concerns how the *HPHP Action Plan* was viewed to be successfully opening up a policy space for mental health promotion, despite the reported funding issues and the complexity of the dynamics in actualising both the *HPHP Policy* and *Action Plan*. That is, the lack of funding associated with the *HPHP Policy* was perceived by interviewees as failure to fully commit to the Policy, however the *HPHP Action Plan* was perceived by interviewees as successful in enabling mental health promotion to regain a foothold in a crowded policy space which, it is speculated, may well further the opportunity to fully commit to the policy, over time.

5.3.2 Intersectoral structures and processes enabled HPHP Action Plan

As previously stated, the *HPHP* initiative was supported by a Public Health Partner Authority Agreement between the environment and health sectors. This mechanism had strong links to the Health in All Policies (HiAP) approaches which were progressed in the state following llona Kickbusch's presence in South Australia as a Thinker In residence in 2007. Although the dedicated HiAP unit has now been dissolved and the team was reorganised into a broader Strategic Partnerships Branch (2012), the HiAP approach continues to inform government policy and practice (Baum et al. 2017). The majority of participants viewed both HiAP and the Public Health Partnership Agreements as parallel intersectoral approaches which were and are supported by mechanisms associated with the Public Health section of the Health sector.

> *I mean the whole sort of philosophy around the work of the Public Health Partner Authority is Health in all policies* (Health Policy Actor, 2017, #23).

The Public Health Partner Authority agreement and the use of intersectoral structures and processes associated with the agreement were reported to be integral to the development of the *HPHP* policy and the *HPHP Action Plan*. The following quotes from participants cite the benefits enabled by the underlying partnership mechanisms.

> *… (HPHP) is a partnership approach and supported by an MOU arrangement which really gives a different level of authority and meaning and the ability to connect to different sectors. I don't think we would be able to do this agenda as successfully as we have if we didn't have that MOU arrangement* (Natural Environment Policy Actor, 2016, #3).

Intersectoral relationships are main enabler of the HPHP and not being too fixed to what you want to do is probably going to help as other people we're collaborating with might have a different idea about how that should work…time to develop the shared understandings before KPI's need to be produced (Health Policy Actor, 2017,# 23).

We're working together to influence government policy to try and recognise the role of - importance of nature as a setting for mental health promotion and wellbeing (Natural Environment Policy Actor, 2017, #30).

The Action Plan details four goals: 1. The development of a discussion paper on the evidence and opportunities of connecting nature and parks to mental health promotion and prevention strategies in South Australia; 2. The incorporation of the benefits of contact with nature into the new Suicide Prevention Plan; 3. Masterclasses to be developed and offered within the environment and health sectors on nature and mental health; & 4. Identify opportunities to jointly support communication campaigns that promote the value of nature for mental health.

The HPHP documents, activities and outcomes that have resulted since the initial MOU and ToR processes enabled the policy to be initiated in 2015, are listed in the table below in chronological order. They illustrate the consistent and progressive work towards the defined HPHP goals during the research period, as a result of the use of intersectoral structures and processes. Data collection stopped at the end of 2017.

Year	Activity	Documents	Outcome
2015	Leadership and Reference mental health and nature groups established	HPHP MOU and ToR (2015-2017)	Established guiding documents and principles under the Partnership Authority, articulating a HPHP Framework
14/8/15	People, Parks and Wellbeing Conference		Conducted conference to introduce key government sectors and NGO agencies to concepts, research and evidence regarding the HPHP framework
May 2016	HPHP Policy launched and workshop held (Present for workshop)	Policy document released: Healthy Parks, Healthy People Making Contact with Nature, Second Nature (2016-2021) released	HPHP Policy identified 7 focus areas: 1. Promoting physical activity in nature 2. Mental health benefits of contact with nature 3. Promoting the cultural value of Country for Aboriginal health and wellbeing 4. Community health and wellbeing in a changing climate 5. Childhood development and nature 6. Green infrastructure in urban settings 7. biodiversity, conservation and human health

17/6/16	Seminar and Workshop - Realising the mental health and wellbeing impacts of contact with nature (Present for workshop)		Conducted seminar and workshop with key speakers and panel to advance the case study
October 2016	Action plan for the next 5 years launched	Action Plan released: Healthy Parks, Healthy People - Realising the mental health benefits of contact with nature Plan (2016-2021)	Action plan identified 4 Action areas: 1.Develop a discussion paper on the evidence and opportunities associated with nature and mental health 2. Incorporation of evidence into the development of new policies i.e. Suicide prevention 3. Convene discussion groups in both sectors to support uptake of action plan 4. identify actions to support the communication of key concepts regrading nature and mental health to the population
March 2017	Discussion paper finalised detailing the current research, evidence and practice related to the mental health benefits of contact with nature	Discussion paper released: Connecting nature and parks to mental health promotion and mental illness preventing strategies	Key recommendation made to design and promote a state-wide campaign to support dissemination of the 5 ways to wellbeing approach.
20/8/17	Workshop and discussion of the White paper and the key recommendation with HPHP leadership and reference groups (Present for workshop)	Documents and strategy detailing the campaign and launch of the 5 ways to wellbeing disseminated and discussed with feedback invited	Plans and processes made in support of the implementation of the 5 ways to wellbeing campaign implementation.
10/10/17	Meeting held to identify pertinent research, key contributors and timeframe for research that supports or contributes to HPHP evaluation	Research meeting minutes and research outline	Three broad areas of research established with nominated DEWNR and DH&A researchers. Themes include: identification of what enhances/discourages visitation to nature, better understanding and recording the avoided health costs through engagement with nature and better understanding the link between health and biodiversity.
6/12/17	Launch of the 5 ways to wellbeing by Minister for Health and Minister for Environment		Campaign for 5 ways to wellbeing launched
6/12/17	Workshop to discuss the operationalisation of the 5 ways to wellbeing in both sectors and the potential support of other agencies (NGO's, local councils and community centres)	Workshop notes identifying strategies, activities and commitments	Develop campaign materials that support the take up of this approach within community groups and agencies. Support 5 ways to wellbeing approaches through liaison with the SA Suicide Prevention Network

Table 5.2 Details of intersectoral activities, documents and outcomes associated with the HPHP Policy and Action Plan

As previously stated, the support of intersectoral structures and processes within the Health sector was closely aligned with the reconfigured HiAP, however, analysis of interviews found that HiAP as an intersectoral approach was consistently and knowledgably referenced by the majority of participants. It was additionally viewed as the approach most pertinent to improving the health and mental health of Aboriginal and Torres Strait Islanders which is reflected in the *HPHP Policy*.

The following statement relates to the third *HPHP Policy* strategy, *Promoting the Cultural Value of Country,* which promotes the need for Indigenous Australians to have the 'ability to practice culture', viewed as instrumental to improving Aboriginal health and mental health. I highlight this not as it relates to the case study but as it relates to the potential of continued intersectoral work between the Health and Natural Environment sector to contribute towards improved mental health outcomes for Aboriginal and Torres Strait Islander peoples. This was enthusiastically acknowledged by six of the thirteen interviewees.

> *We really wanted to steer away from disease and illness with the Aboriginal focus. It is really about how connection to country is healing and nurturing* (Health Policy Actor, 2016, #16).

> *Connection to country is a critical component of Aboriginal culture and is recognised as an important determinant of Aboriginal health and wellbeing. Evidence shows a positive association between caring for Country activities and physical and mental health outcomes* (HPHP Policy, p.2).

5.3.3 Opening policy space for mental health promotion through the development of the HPHP Action Plan

The current gap in mental health promotion in the state was highlighted in the *HPHP Action Plan* (2016-2021) and the Discussion paper highlighted in Table 5.2, as is evident in the following references.

> *Currently the South Australian mental health system is strongly focussed on the treatment of mental illness and does this very well. Historically, South Australia has also undertaken work that recognised the role of mental health prevention and promotion and early intervention. However, the mental health promotion and primary prevention space has been identified as a gap in the current system* (*HPHP Action Plan*, p.5).

> *The last time that mental health promotion was a key priority in the national mental health agenda was in the 2000's… this discussion paper highlights an opportunity for renewed focus in South Australia* (Discussion paper - Connecting nature and parks to mental health promotion and mental illness prevention strategies in South Australia, p.5).

Interviews suggested further that promotion and prevention approaches were absent or underutilised. The following comments indicate that policy actors perceived funding for promotion and prevention to have been reduced, the second comment expressing the opinion that this reduction is related to the high demand for acute care services for those with mental illness.

> *(Re mental health) … you know, all of our promotional/prevention stuff has gone…I think the networks that I'm developing is probably the last of the - of any promotional/prevention stuff and I'm not sure how it's surviving … this department went from 52 down to about 20* (Health Policy Actor, 2016, #15).

> *I think that they would agree, they (Mental Health section of DH&A) have a small agenda around prevention and that's probably because of the high demand for acute services* (Health Policy Actor, 2016, #12).

Pertinent to the situation and indicative of the Health sector context, at the time of this research, was an ongoing Inquiry into the state's management of a mental health facility for the treatment of older persons with psychiatric disabilities which had confirmed allegations of maltreatment, abuse and neglect (Groves, Thomson, McKellar & Procter, 2017). This resulted in the closing of the facility and the resignation of the Chief Psychiatrist. It is likely that the workload and level of stress for Health sector staff and specifically those in mental health services, associated with these events would have impacted the sector's focus and allocation of resources. The tension between investing in treatment approaches or more upstream and promotion approaches (referenced in the above quote) that is present in Australian health sectors generally (Parham, 2007) is likely to have been heightened at this time.

The difficulty in re-establishing a focus on promotion when working with the context described above and the increasing imperative of addressing mental illness was acknowledged by the majority of policy actors. However, the history of intersectoral work detailed in 5.3.2 and the timely opportunity to contribute to the development of a new *Mental Health and Wellbeing Policy* and

SA Suicide Prevention Plan effectively opened a policy window of opportunity (Kingdon, 2011) in the Health sector for mental health promotion. Reflection on the beginnings of a shift in focus towards promotion was noted by the following policy actors, the first interviewee reflecting on recommendations that included consideration of mental health as health, not illness.

Mental Health Commission and the Office of the Chief Psychiatrist who are both consulting on different mental health plans…recommended that both of their plans have a mental health promotion section, not just illness, and acknowledged the importance of nature as a setting for mental wellbeing, … sort of saying 'work with Healthy Parks, Healthy People and we can help support suicide prevention networks' (Natural Environment Policy Actor, 2016, #30).

Well, I think public health has kind of got it (mental health promotion) happening… its very embryonic at this stage (Policy Actor, 2017, #19).

It was the Five ways to wellbeing programme that was launched as a part of the *HPHP Action Plan*, an initiative developed by the New Economics Foundation (2008) that sought to disseminate a message about a set of five activities that support mental health and psychological wellbeing. These are articulated in the postcards below.

Figure 5.1 Postcards developed for the Five ways to wellbeing initiative

Importantly, contrary views were also expressed about the increased policy space for mental health promotion, that is, there were concerns expressed about the fit and receptivity of the *HPHP Action Plan* from policy actors in the both sectors.

The policy actor in the first quote expressed curiosity as to why implementation of the *HPHP Action Plan* failed to foster interest with all policy actors in the Health sector and the policy actor in the second quote expressed the challenge of integrating the *HPHP Action Plan* with the portfolio of other Natural Environment policies. Both comments are viewed as effectively expressing the inherent complexity and uncertainty within and between systems (sectors) and the need for iterative and ongoing processes between policy actors and sectors to ensure an openness to adjusting to new ways of working (Corburn, 2015) that will support convergence.

> *(Despite) positive response from both the Mental Health Commission and the Office of Chief Psychiatrist…it (the HPHP Action Plan) didn't resonate with people that are already delivering different programs and projects (in Mental Health)"* (Natural Environment Policy Actor, 2016, #3).

> *Most of the work that's happening in the team (DEWNR) relates to different legislative amendments or policy issues across the whole branch – (this is different) – its externally focussed policy…(its) fit within the department is* tricky (Natural Environment Policy Actor, 2017, #30).

This last quote relates directly to the tension that is inherent in joint policy work a point that relates to the discussion in this last theme.

5.3.4 Health sector influence potentially shaping HPHP Action Plan possibilities into probabilities

This section presents data that highlights the challenges of maintaining a focus on the possibilities offered by *HPHP Policy* and the *HPHP Action Plan* within the current culture of the Health sector. Thus, although this data largely relates to the Health sector, it is discussed in this chapter, given that the Natural Environment sector was a Public Health partner when setting the policy and selecting the policy implementation. The particular intersectoral strategy utilised in the development of the *HPHP Policy* and the *HPHP Action Plan* has opened doors to new knowledges and possibilities for mental health promotion while also opening doors to relational and systemic channels of influence that could potentially shape those possibilities into probabilities.

Three points are summarised that relate to my interpretation of the challenges to ensuring as much as possible that the particular intersectoral strategy utilised supports healthy public policy while maintain an openness to all possibilities.

Firstly, as briefly mentioned, the structure and purpose of the Discussion paper (which was written by policy actors from both the Health and Natural Environment sectors) was to present the research detailing engagement with nature as an upstream health approach that can provide mental health and psychological wellbeing benefits. The fact that the paper had purposefully and explicitly been structured to present this evidence, could be conceived to have been considered necessary to counter the dominant problematisations and assumptions in the Health sector about mental health (read illness) that may serve to influence practice that is consistent with the findings from 4.2.1. That is, practice that is individually focussed and linked to illness and treatment.

The two quotes from Health policy actors below express concern about precisely this. The first quote expresses concern that despite the renewed focus on mental health promotion, strategy will continue to privilege a predominant focus on the individual. The second quote expresses awareness of the different implementation knowledges offered by the Natural Environment sector and hope that this may better enable population mental health strategies.

> *There are a lot of them (mental health promotion strategies) in the space in terms of particular people (i.e. individuals) but I think they need to be in the space in terms of making sure that their community's mental health is improving* (Health Policy Actor, 2017, #19).

> *From my observation they (DEWNR) seem to have a much better sense of population reach. They aren't working at a one to one individual level in the same way that Health does* (Health Policy Actor, 2016, #12).

Secondly, the lack of action on mental health promotion in the Health sector which was identified in 5.3.3., together with the involvement and guidance from the Chief Psychiatrist and the Mental Health Commissioner identified at 5.3.1, could have served to provide motivation for an explicit focus on individual mental health. Other strategies which focus on the greening of urban environments, facilitating community-based climate change adaptation strategies or promoting the cultural value of Country to support Aboriginal health and wellbeing not only offer approaches that support population mental health but it is argued are more inclusive of contributions from the Natural Environment sector. From my observation of the HPHP Workshop (20/8/17) I noticed that when the discussion featured mental illness and suicide prevention, the involvement of policy actors from sectors other than health was minimised. Where discussion featured mental health as opposed to illness, broader social or environmental based options to promote population mental health were enabled.

Thirdly, the ability of the Natural Environment sector to focus on environmental settings as places that promote mental health, as identified in 5.2.2, enables a focus on how equitable access to quality parks and urban greenspace matters to population mental health.

This has been discussed in the data, albeit minimally but as the following quotes demonstrate there is hope for practice that universally progresses green urban environments through the *HPHP Policy* and the *HPHP Action Plan* as will be discussed in the following chapter.

> *One of the things that we're really concerned about as we move forward… how can you make sure that the parks are available to the people who most need them? … we want to develop some sort of tool to support quality elements being taken up (at the population level)* (Health Policy Actor, 2016, #16).

> *I do think that there are things happening in our social environment that are changing… for example, greater engagement in nature and so on… but I wonder whether people's access is the same?* (Health Policy Actor, 2016, #19).

5.4.5 Summary of nested case study

This section has highlighted the case study for the natural environment sector HPHP – *Realising the mental health benefits of contact with nature Action Plan*. Four themes that emerged in the analysis have been discussed.

The *HPHP Policy* and *Action Plan* have been identified as examples of valued but under resourced initiatives that have potential to promote population mental health and psychological wellbeing through engagement with nature and the environment. The Natural Environment initiative was supported through the Public Health Partner Agreement framework to increase the public valuing of parks and the environment and to promote population mental health. However, data collection ceased at the end of 2017.

The support and promotion of mental health within the Health sector was acknowledged as a current gap in health policy, but the findings indicated that the *HPHP Policy* and the *HPHP Action Plan*, had served to open up a policy space for mental health promotion. Discussion about the use of intersectoral practice supported the understanding that such mechanisms were integral to opening doors to new knowledges and possibilities for mental health promotion. Concern about the shaping of these possibilities was discussed and the need to manage the relational and systemic channels of influence was identified. However, despite the complexity associated with the intersectoral mechanisms, the HPHP Policy presents a range of strategies with potential to promote population mental health. Further, the *HPHP Policy and the Action Plan* have been valued at political, executive and strategic levels and represent positive developments in progressing policy and practice relative to mental health promotion.

CHAPTER 6 BUILT ENVIRONMENT SECTOR

Overview

This chapter presents the research findings from the analysis of policies drawn from the Built Environment sector which includes the Department of Planning, Transport and Infrastructure (DPTI), Housing SA and Renewal SA. Following the content analysis of available policy, 6 policies were selected as relevant to the research subject matter, that is relevant to mental health, the social determinants of health and population-based approaches. These 6 policy documents were analysed using Bacchi's methods to examine the problematisations, assumptions and silences inherent in the documents, as in the previous two chapters. Following this analysis, three policies were identified as having the potential to promote population mental health: the *30-year Plan for Greater Adelaide*, the *Housing Strategy for South Australia* and the *MOU between DPTI and DH&A*. These results are discussed in the first section (6.2).

The second section of the chapter (6.3) presents the results of the strategic level interviews conducted with policy actors and academics associated with the identified policies and the work of the Built Environment sector. The results confirmed that the policy considered most likely to enable population mental health was the *30-year Plan for Greater Adelaide*. Strategic interviews regarding this policy demonstrated it was currently being implemented across the sector and viewed as central to the work of the sector. From these strategic interviews, further analysis has enabled insights into the current positioning of mental health within the plan and its relationship to current departmental goals, culture and practice.

The third section of the chapter (6.4) outlines the nested case study, on the *Bowden redevelopment* which was identified in the analysis as an exemplar of the policy and practice articulated in *the 30-year Plan.* Interviews at both strategic and operational levels were supplemented by the analysis of specific Bowden related documents, on site meetings and observations and attendance to a Built Environment workshop, all of which were used to identify themes and answer the research questions.

6.1 Document Analysis

The six policies analysed in this section are predominately concerned with built environment form and function, housing and the construction of transport infrastructure, effectively the built environments (which include both physical and social elements) in which people live their lives.

Such policies – in a sector other than Health – have significant implications for health and health equity but these implications may not be explicitly recognised in policy discourse. The research methodology employed enables these implications to be identified and scrutinised.

As in the previous findings chapters, the same process of analysis has been applied to understand the construction of the problem being addressed in each policy examined and to further scrutinise the policy to reveal the underlying assumptions and silences in relation to mental health and psychological wellbeing. Again, analysis is guided by the following questions:

1. What is represented as a problem in the selected Built Environment sector policy and how does mental health fit with that problem representation?
2. What assumptions regarding mental health underlie this representation in the policy?
3. What was left unaddressed in the policy examined and where are the silences regarding mental health?

Each policy is introduced prior to analysis and a summary table, detailing the Built Environment sector policies analysed and the results of the three stages of research, is initially presented.

Urban planning sector	**Document analysis**					**Interview analysis**	**Interview and document analysis**
	Stage 2 Research					**Stage 3 Research**	**Stage 4 Research**
Year	Document	Problem representation	Policy consistent with a social view of health	Critical scrutiny identifies the consideration of mental health in the document	Policies for 2nd stage research	Evidence of policy to practice actively promoting mental health for all	Case Study
2013-2016	1.Road Safety Action Plan	Need to increase safety of those using roads			NO		
2015	2.Renewing our Urban future: Unlocking South Australia's potential	Need to address urban sprawl by improving areas characterised by densification, mixed uses and non-vehicle transport options.			NO		
2014	3.Planning Reform – A driver of economic growth	Need to drive economic growth by limiting urban sprawl and renew older urban areas.			NO		
2015	4.MOU – DH&A and DPTI	Need to support processes that enable the urban planning and health sectors to work in collaboration.			YES	NO	
2013-2018	5.The Housing strategy for South Australia: Building a Stronger South Australia	Economic imperative to change approaches to developing, providing and maintaining state housing options.			YES	NO	
2010-2040	6.The 30-year plan for Greater Adelaide	Urban planning and development principles governing development in the Greater Adelaide area.			YES	YES	YES
Total = 6 policies							**Case study selected = 1**

Table 6.1 Summary of the Built Environment sector policies, research stages and results.

Green – great extent Amber – some extent Red – little extent

Road Safety Action Plan 2013-2016

This plan details an action plan to invest in safer roads; create safer communities and neighbourhoods; encourage safer behaviours; continue with improving the licencing system; continue to use modern technologies and to better inform communities with regards to road safety. Conveyed in the document is a strong awareness of roads as structures that serve cars, cycling and pedestrians. Referencing a large and diverse stakeholder contribution to the development of the plan, key actions include a range of structural, legislative, educative and technological responses to improving road safety. Examples of key actions include the development and design of road infrastructure to provide cycling alternatives; the development of 'sharing the road' education campaigns; the consideration of licencing issues for novice, Aboriginal and older drivers and installing point to point speed detection systems.

The problem being addressed in this plan, concerns the creation of environments, laws and legal processes and behaviours that support people to be safe on roads. Health is not overtly discussed in this document; however, the document proposes strategies for the development of roads and transport infrastructure that have the potential to support health. The focus on access to and use of both public and active transport in the document is reflective of a central theme of built environment policy, which will be seen in other DPTI documents yet to be discussed. Critical scrutiny of the document identifies an understanding of transport as a social determinant of health. Roads are represented as infrastructure for the movement of both vehicles and people. Potential benefits of road infrastructure for health are mostly recognised in terms of the links between infrastructure, active transport and physical health, but also in relationship to facilitating social connection. Active transport is a common theme in much of the sector's policy, including this policy which refers to active transport as walking, cycling or use of public transport. The design and development of road infrastructure that supports 'vibrant, healthy and connected communities' (p.3) is reflected on in the following statement, although a link to mental health is absent.

> *People friendly streets and safer roads are characterised by lower vehicle travel speeds, pleasant and convenient routes, and facilities and infrastructure that particularly consider the needs of children and older people. Such environments will encourage safer and more active travel options…* (p.8).

Two urban development resources, the '*Streets for People Compendium'* and '*Living Neighbourhoods'* are referenced, both key documents in the design of 'people friendly' streets, a central aim of the *30-year plan for Greater Adelaide*, yet to be discussed. Reconceptualising streets and roads as places for people first and then vehicles, is a consistent theme in this strategy.

> *As a community we need to continue to work to create a vibrant city and streets that are more people friendly places encouraging cycling and walking* (p.3).

Two strategies relevant to the support of cycling and walking, are referenced in the plan.

These are the *Way to Go strategy*, which supports schools to encourage local school children to walk or cycle to school and the smart phone app *Cycle Instead Journey Planner,* which enables cyclists to choose the safest, most appropriate route for their travel. Both strategies are likely to support both physical and mental health, however, these benefits are not articulated. There is also silence around the psychological trauma and/or mental illness associated with road accidents, either as victim, witness, emergency service personnel or medical or clinical personnel; however, these silences are not of significant concern for my research.

Strategies proposed to reduce road trauma include the need to address the risk related to individual behaviour and the risk related to road infrastructure, technology and quality. As such, these strategies reflect a balanced assumption where road safety is viewed as related to factors such as road quality, road rules and safety belt legislation i.e. the circumstances in which one drives, walks or cycles, in addition to the attitude and capacity one brings to the activity. The following statement identifies a need for education and attention to be directed towards individual behaviour change.

> *Road trauma would be significantly reduced if people obeyed speed limits, didn't drink or take drugs and drive, wore a seatbelt and were not distracted when driving. Everyone is accountable and responsible for their actions on our roads* (p.9).

However, key action areas are also identified in the document that support community-based change such as supporting locals to meet, discuss and progress local traffic solutions in tandem with DPTI and other stakeholders such as councils.

Demonstrating an awareness of issues of equity, the plan presents key actions relevant to the state's Aboriginal communities. Initiatives include addressing the need for structural road improvements in the Anangu Pitjantjatjara Yankunytjatjara lands (APY) and the need for changes in the processes and requirements of the licensing system, which have served as barriers to residents in the APY lands obtaining licences. The culture and social aspects of remote community life in the APY lands have served to decrease the opportunities to access a licence and practice safe driving for community members, increasing the likelihood of accidents, social isolation and driving offences (Jones, Delany & Lawless, 2016). Systemic changes regarding the licencing system and the development of a supportive and culturally appropriate framework have been put in place to support equitable outcomes for Aboriginal communities and people across the State in relation to roads, licences and the use of cars. This action is in part attributable to the HiAP policy and practice (Baum et al. 2014).

Renewing our Urban Future: Unlocking South Australia's potential (August 2015)

This document progresses the agenda of urban development that is central to the Greater Adelaide planning reform, the SA government's economic priorities and Renewal SA. Pre-empting the new planning legislation (anticipated to be released in 2016), the document is a visually engaging document, seeking to progress the new economic and urban living opportunities afforded by the anticipated Planning reform. The focus in the document is on the development of low carbon cities that have medium to high density living options with good transport options and provide urban spaces that enable economic and employment opportunities and healthy lifestyles. Three goals are outlined to achieve this focus: 1. Planning and building mixed-use urban infill areas with improved connection between people and businesses and markets; 2. Supporting the liveability and activation of SA city and regions by attracting investment and 3. Ensuring more emphasis and effort is placed on early engagement regarding urban based strategy, directions, plans and policies.

This document is focused on providing information about the broad concepts relevant to state planning and the *30-year plan for Greater Adelaide Plan*. The problem that is presented in this document is the need to develop well serviced and denser urban environs that are consistent with increased economic opportunities and employment and improved investment for the state. Health and wellbeing are positioned within the policy in a way that is consistent with a social view of health, as outcomes that are primarily achieved by the development of economic options for employment and urban settings that encourage healthy lifestyles. Creation of 'Better places to live, work, invest and spend time' is a catchphrase consistently used in the document. The following quotes demonstrate the combination of urban development and economic needs.

> *People and economies prosper in places where it is easy to do business, be creative and live a healthy lifestyle… We recognise the need to put people at the centre of urban planning and to revitalise communities by creating high quality places that bring people together* (p.2).
>
> *We want all residents to enjoy convenient access to housing, transport, jobs and services in the future, while benefiting from increased local, national and global scale private sector investment in our state* (p.2).

The strong economic imperatives that characterise this document indicate an overarching policy intent to use urban planning policy to drive increased economic opportunities for the SA population. Building urban environs that attract interest and investment is a priority in the document.

The reference to 'access to housing, transport, jobs and services' aligns strongly with the social determinants of health; however, the document demonstrates a stronger alignment of health and wellbeing with economic and employment options, as opposed to the social and environmental aspects of the built environment.

In this sense, the document demonstrates a weighting of the economic imperative as opposed to the social, which prioritises economically based solutions. Equity of access to these economic based solutions is not discussed in the document.

Recognition of the need for public open space within built environments is conveyed in the document and linked to liveability, viewed as an essential element of healthy urban space that needs to be maintained in balance with increased urban infill. Public open space and greenspace are mentioned but not specifically linked to health or mental health.

> *Open space is a key component of a liveable city. As the city grows, existing green space must be protected and better utilised* (p.5).

Liveability is identified in the document as being achieved by ensuring urban areas that offer access to employment, transportation and housing opportunities. The term, liveability is consistently utilised in the Built Environment sector but as will discussed later it has been variously defined. It is also present in the *30-year plan for Greater Adelaide* and the *Planning Reform – A driver for economic growth*.

The conceptualisation of 'health' in the document is primarily one of physical health, which is then linked to being physically active. Potential benefits of urban planning for mental health as such are not mentioned. Recognition of the value of public transport to physical health and environmental sustainability is acknowledged but the social connection that is enabled through the use of public transport and the benefits to both mental and community health (Barton, Thompson et al. 2015) are not.

> *Investment in public transport will be complemented by initiatives to encourage active travel. An increasing understanding of the health benefits for communities and growing concerns about the sustainability of vehicle-based transport means that cycling and walking must start to play a greater role in how we get around* (p.9).

The document acknowledges the need for community involvement and participation in the development process. It discusses improved communication mechanisms to enable the community to 'have a say' in the planning, design and development of the renewed places and spaces in which community members will 'live, work, invest and spend time'. Although 'having a say' is not linked to health and mental health outcomes in the document, it is an approach that is consistent with improved health and mental health outcomes and the recommendations of the CSDH (2008).

> *Communities will play a greater role in determining how their city is planned through involvement at early stages of planning. A new charter of citizen participation will be developed to provide a clear and proactive framework for this public participation* (p.11).

The Housing Strategy for South Australia 2013-2018: Building a Stronger South Australia

The Housing strategy sets out a plan for housing in the state that is inclusive of a number of stakeholders. Different non-government agencies, private owners and renters, commercial enterprises, Renewal SA and Housing SA are collectively seen as providing a range of diverse housing options for the population, both singularly and in partnership. Economic imperatives are articulated for the state and the ability of the housing sector to support those imperatives is stated. The development of new housing projects, the redevelopment of older urban spaces and strategies to enable home ownership are all seen as supportive of both housing and economic outcomes. Three goals are articulated in the strategy: Increase housing choice and diversity; create places where people want to be; and change the way housing services are delivered.

The problem represented in the *Housing Strategy* is one of needing to change the way state government, the private sector and NGO bodies provide housing options and services to the SA population. Changing national housing frameworks, the increased involvement of NGOs in the sector and the state's economic difficulties have all set the context in which the strategies employed by the State's housing bodies (Housing SA and Renewal SA) are being discussed and addressed in this document. Safe and appropriate housing is recognised as a significant social determinant of health in the document and health and mental health are presented as outcomes associated with a social view of health as shown in the following statement.

> *The way we develop our housing, communities and public spaces underpins the health and wellbeing of the people who live there, their sense of connection and the ease with which their needs can be met. It promotes a sense of vibrancy, a place of activity and interest and a place to meet and be with others* (p.16).

The statement also acknowledges the need to consider not only housing but the social context and sense of community, important factors underlying health and mental health.

As in the previous document, however, critical scrutiny of the *Housing Strategy* indicates a strong economic imperative and while the social value of providing housing is acknowledged, there is an economic imperative to develop housing as a means to generate economic activity. Given this imperative, the incentive to prioritise housing solutions that involve inner urban construction is evident and alternative housing solutions such as social housing, subsidised housing or housing cooperatives are backgrounded.

> *As part of our plan to Build a Stronger South Australia, we will encourage new urban forms in the inner city and create places where people will want to live. Importantly, this will also enhance activity in a sector that drives our economy* (p.6).

As such the plan relates to both Renewal SA and Housing SA, given that projects of urban renewal and redevelopment come under the auspices of Renewal SA since 2013.

Attention to issues of access and equity in the provision of housing feature strongly in the document. Significant reference is made to homelessness, housing priorities in Aboriginal communities, disadvantage, the ageing population and those with disabilities, indicating a need to consider the specific housing challenges that these groups face.

> *The voices of people living with disability, new arrivals, Aboriginal people, the homeless, women, young people and older people must be heard to deliver the housing choice and services they require* (p.9).

However, while issues concerning affordability, tenancy sustainability and the need for specific programmes to increase housing access to identified disadvantaged groups are acknowledged, the main strategies proposed are to enable finance and access, as opposed to addressing the causes for housing inequity. That is, disadvantage is viewed as an attribute of people, not as a complex issue reflective of the interplay of structural, social and personal factors.

Minimal reference is made to mental illness or domestic violence which often serve as precursors to homelessness or their association with a range of social issues, such as community and family breakdown or drug and alcohol use. Having said this, the term 'disadvantage' is consistently featured in the *Housing Strategy*, aligned with 'complex needs' which could be serving as an umbrella term for social and/or psychological issues.

> *For many disadvantaged people, providing a secure housing option is only part of the overall solution; support is also required. For people with complex needs, providers will connect them to the support and professional resources they need to sustain their tenancy* (p.18).

Planning Reform – A driver of economic growth - Policy paper (February 2014)

This document is part of a group of DPTI policy documents that provide information relevant to the new planning legislation and planning for urban renewal and economic growth. Multiple use, medium/high density development with accessible services and public and active transport options are featured as key planning reforms. The document aligns with the Renewing our urban future document and both relate to the 30-year Plan for Greater Adelaide. Three agendas are articulated: 1. Setting limits for urban sprawl; 2. Setting an agenda for urban renewal; & 3. Using planning reform to drive economic growth and jobs.

This paper progresses an agenda for urban renewal and economic growth similar to the *Renewing our urban future* paper. The problem represented in this paper concerns the need to change planning and development practices from greenfield to urban infill development and in doing so create economic opportunities. The paper outlines population health improvements related to urban redevelopment, demonstrating an understanding of health that is consistent with the social view of health; however, again the relationship between health and wellbeing and improved economic and employment opportunities dominates over the social and environmental aspects of the built environment.

Strong arguments are made on the goal of limiting urban sprawl, namely that urban infill yields higher economic benefits than greenfield development, and urban infill decreases transport costs. Statistical analysis to support this argument is presented in this document which provides evidence of the long-term costs associated with greenfield developments, and the need to plan for urban living that is transport orientated is argued from an economic perspective. There is no consideration of the needs of those living on the urban fringe, who are generally poorer that those who live in urban centre. Reference to the *30-year Plan* in made in the document.

> *The 30-Year Plan identifies the need for new statutory mechanisms to support the roll-out of transit-oriented development at key nodes such as the Bowden urban village being undertaken by the Renewal SA* (p.6).

However, the problem being addressed in this paper is framed in such a way that neither the social or environmental aspects of the built environment nor health or mental health are significantly considered. Thus, the potential health and mental health benefits associated with the proposed urban in-fill reforms are silent in the document. The singular reference to health in the document refers to how planning reform will support physical health and environmental sustainability.

> *Over time, the city and inner metropolitan area will be redeveloped, allowing for significantly more people. Through their use as walking and cycling trails the Park Lands can reduce the pressure on our roads and public transport; by including more facilities for organised and informal sport and exercise, they can improve our health; and by fulfilling their role as the cooling and cleansing green lungs of our city they can become even more important as changing climate impacts are felt* (p.7).

The social benefits from living in a state where the government aims to "provide opportunities for denser, healthier and more liveable urban projects through greater infill opportunities and renewal of existing suburbs" (p.10) are not articulated. There is an overriding assumption conveyed in the document that such projects will deliver economic opportunities for residents and close access to transport, employment and housing options. As such, social and environmental aspects are overlooked. Thus, although a social view of health is present in the document, it is heavily weighted towards the economic end of the socioeconomic spectrum and demonstrates inattention to economic or health inequity.

The related concept of liveability features in the document and a statement about Adelaide being known as one of the world's most liveable cities is made, presented as an accolade that is attributable to government planning practice.

> *Adelaide is consistently rated as among the world's most liveable cities. This hasn't come about by accident* (p.2).

The 30-year Plan for Greater Adelaide (2010- 2040)

The 30-year Plan for Greater Adelaide is a major government document that articulates the current planning objectives and processes. It acknowledges the roles of related policies and sectors in the implementation of the plan. Centred around the concepts of mixed land use, medium density housing and public transport hubs, the document outlines goals and strategies to achieve sustainable urban development. Three key objectives are identified in the plan: maintaining and improving liveability and increasing competitiveness; driving sustainability; and environmental protection and resilience to climate change.

The *30-year Plan* is a comprehensive and large document, with a specific section on health and wellbeing. The problem that is presented in this document is that the current housing, infrastructure and transport systems in Adelaide are ill equipped to sustainably support future population needs. The *30-year Plan* outlines proposed solutions which focus on future urban development that is based on a social view of health and characterised by sustainability, liveability and health.

Critical scrutiny of the document indicates that the framing of the problem being addressed in the *30-year Plan* acknowledges and recognises the need to consider health and mental health. Both the main body of the document and the subsection relating to health and wellbeing demonstrate this recognition, indicating the integration of health into the *Plan* generally. It is suggested that this integration is reflective of the historical and ongoing collaboration between the Health and Built Environment sectors, which I discuss later in this section.

> *Ensure health and wellbeing requirements are incorporated into Structure plans* (p.101).

Referencing both obesity and depression as 'epidemics', the policy's proposed approaches to these issues include the development of urban spaces to support walkability and social connection.

> *The development of a new urban form for Greater Adelaide will support improvements in community health and wellbeing. There is growing evidence of a link between current health epidemics such as obesity and depression and the built environment* (p.100).

This statement demonstrates the plan's commitment to strategies that are consistent with population-based approaches. Strategy is proposed to support health and mental health but also, to play a role in addressing the social and environmental factors associated with development of depression. The plan is one of the few documents that specifically problematises mental illness (depression) as a condition related, in part, to the circumstances in which one lives and has proposed strategy consistent with that problematisation.

The following statement demonstrates the policy's underlying commitment to creating 'people friendly' urban spaces in which people can both live and work, consistent with a social view of health.

> *Transit-oriented developments comprise mixed-use, higher-density development centred on a major public transport access point. They accommodate residential, high-order retail services and employment activities as well as high quality open space. They will be attractive and walkable places for people to live, work, shop and recreate in an accessible and self-contained community* (p.222).

Reference is made to the recent Bowden development as an exemplar of such development.

> *For example, the former Clipsal site at Bowden, a 10-hectare former industrial site, is now being transformed into a sustainable green village on the Adelaide CBD's doorstep. The Bowden Village will offer rapid transit, energy and water efficient developments, and a broad range of housing choices* (p.61).

To achieve health and mental health outcomes in urban regeneration programmes such as Bowden, the following features are identified: to provide links to adjoining areas to maximise the shared use of services and facilities; to incorporate cultural initiatives, such as public art; to stimulate revitalisation of communities and social cohesion; and to ensure that pedestrian centres are direct, convenient, well-signposted, sheltered and shaded and offer disabled access. These actions articulate a commitment to a social imperative and are underpinned by research referenced in the *30-year Plan* that links people orientated urban development to community safety, social connection and equity, all which have the potential to produce positive mental health outcomes. The translation of research into policy in the document is evident in the statements below.

> *Promote healthy, connected and safe communities by ensuring new and existing suburbs are walkable neighbourhoods that incorporate Crime Prevention Through Environmental Design principles* (p.58).

> *Evidence shows that accessible local facilities (when combined with a safe and attractive street system with an appropriate degree of connectivity) enhance social equity by reducing the need to own a car to get access to services. There is also increased social connection and interaction with benefits for both physical and mental health* (p.100).

> *The policies will create environments that encourage social inclusion, giving people an opportunity to participate in social and economic activities in their community* (p.89).

While social inclusion is discussed as a valued concept, the difficulties in achieving social inclusion in communities characterised by a lack of safety and disadvantage is not mentioned and constitutes a silence. Likewise, the relationship between disadvantaged neighbourhoods and violence and their impact on health and mental health is a silence. It could be argued that this document is not the place to focus on population groups with specific needs, however the plan does demonstrate a significant focus on the needs of the ageing population, indicating a privileging of this population cohort.

The plan recognises and acknowledges Greater Adelaide's first people, the Kaurna, Ngarrindjeri, Ngadjuri and Peramangk nations and articulates a strategy in a section of the plan on Aboriginal Heritage and Culture to *"develop protocols for traditional owners and government to ensure consultation during planning processes*" (p.93). However, the positioning of the Acknowledgement of country in the document, just prior to the page exulting the vision of Colonel Light's first urban plan for the city of Adelaide, suggests the need for a deeper consideration of 'recognition'. There is no reflection on what Light's plan meant at the time for the Kaurna people who were the original inhabitants of Adelaide.

Since the release of this plan, an update was released in 2017, which has not been analysed given it falls outside of the research timeframe. However, brief review of the update indicates that the focus on health and wellbeing has been maintained and extended.

The MOU between Department of Health and Ageing and the Department of Planning, Transport and Infrastructure (DPTI) (2015- 2017)

The MOU between DH&A and DPTI has been drawn up under the Public Partnership agreement articulated in the Public Health Act (2011) establishing DPTI as a partner in the development of programmes to support population health. The MOU provides a mechanism to support discussion pertaining to the health and wellbeing impacts of the planning reform process with view to further develop collaborative plans. The MOU outlines the rationale, objectives and responsibilities associated with this goal.

The problem being presented in this document, is that there is a need to jointly acknowledge, evaluate and discuss the impact of planning processes on health and wellbeing. There is note of the history of intersectoral collaboration between the *Department of Health and Ageing* and the *Department of Planning, Transport and Infrastructure* which was integral to the development of key planning documents, including: the *Transit-Orientated Development Guide*, the *Streets for People Compendium* and the *Healthy by Design Guide*. These documents were additionally developed and supported by other government departments and NGO's including: Heart Foundation, Council for the Ageing and the SA Active Living Coalition which includes local council representation.

As a joint initiative, it is envisaged that the joint work between the sectors will be mutually beneficial. For DPTI, the goal is to enable knowledge of the health outcomes related to planning processes to be articulated and communicated, given, "*this will contribute to increased community acceptance of planning reform recommendations*" (p.2).

The *MOU* demonstrates a strong understanding of the contribution that DPTI can make towards population health, an understanding that is consistent with a social view of health.

> *The health and wellbeing of individuals and population is shaped by broad societal factors that lie outside the influence of the health sector. These determinants include social, economic and physical environment, and individual behaviours and characteristics* (p.2).

Clearly outlining links between planning and health, past achievements relating to the separation of land uses (zoning), sanitation, water and overcrowding are cited, before identifying current health objectives relevant to planning, including the need for quality green spaces.

The statement below clearly identifies elements of the built environment that enable health and mental health and although mental health is not directly referenced, the focus on healthy and safe communities and social interaction in the quote ensures such benefits.

> *More recently, the important role of urban planning and the built environment in creating healthy and sustainable communities has re-emerged. Neighbourhoods that create destinations, facilitate active transport, provide safe and thriving public places for recreation and social interaction — including quality green spaces, and are close to employment, services and amenities, are important in shaping population health and wellbeing* (p.2).

This *MOU* reflects on key objectives that have been present in other Built environment policy, the *30-year plan for Greater Adelaide*, *Renewing our Urban Future* and the *Planning Reform documents.* These policies all emphasise the need for sustainable development that supports economic and employment options.

6.1.1 Document analysis summary

Again, I address the three questions that are guiding my analysis, summarising my findings in regard to policy problemisations, representations and assumptions regarding health and mental health and silences.

What is represented as a problem in the selected Built Environment sector policies analysed and how does health/mental health fit with that problem representation?

The problems addressed in the selected policies include the need to: improve road safety; address urban sprawl; enable economic options and investment through urban development; provide and develop services and systems relative to the provision of housing options; and develop joint platforms for collaboration. There was a consistent theme in the policy analysed of responding to the recent planning reform, focussed on enabling both economic growth and urban development through urban infill and renewal.

All policies that I analysed in this section frame health and wellbeing as outcomes associated with the social view of health, an outcome enabled by access to healthy urban environments, economic opportunities and employment options. The focus on economic growth was a significant theme in the policy analysed, suggesting a stronger weighting of the economic imperative over the social and environmental aspects of the built environment. However, there is consistent recognition and acknowledgement of the relationship between the issues the sector is responsible for and health and wellbeing. This was in part, demonstrated by the *MOU*, although this understanding concerns *DPTI*, and not the sector as a whole.

The central objectives of developing and redeveloping urban areas in the policy examined, support densification, mixed use and public transport which are understood to support population health and mental health. Although mental health is less visible in policy than health, it is strongly and directly acknowledged in the *30-year Plan*, and indirectly referenced in the *Housing Strategy of South Australia* and the *MOU*.

What assumptions lie under that representation?

The sector's representation of health is that the built environment and health and wellbeing are linked. It is assumed that in developing healthy, sustainable and liveable urban environments, population health and wellbeing will benefit. Specifically, *the Road Safety Action Plan* prioritises road safety and connectivity in both a very tangible and social sense; the *MOU* stresses that community participation and response to urban development and redevelopment is important to progress health and wellbeing outcomes; the *Housing strategy* stresses that connection to the community in addition to adequate housing is important to health and mental health; and the *30-year Plan*, *the Planning Reform document* and the *Renewing our urban future document*, all progress urban development that supports economic outcomes, viewed to be important to health and wellbeing.

What is left unproblematised and where are the silences in the dominant discourse?

While the recognition of health and wellbeing is inclusive of both physical and mental health there is a weighting in policy towards physical health. The relationship between the built environment, physical health and walkability, is strongly represented in policy, unlike the relationship between the built environment and mental health, a finding that is consistent with Jackson, Dannenberg and Frumkin (2013). Generally, there is less depth to document references regarding mental health excepting the *30-year Plan* and less depth to document references regarding the relationship between urban form, social processes and mental health.

Socioeconomic inequalities and their association with health inequities are a significant silence in the majority of policy analysed. The social gradient is largely unacknowledged and unaddressed in planning policy although disadvantaged groups are acknowledged in the *Housing Strategy.* The specific housing needs of those who are homeless, Aboriginal communities, the ageing population and those with disabilities, were all identified; however, proposed strategy was largely to provide welfare and financial support as opposed to progressing structural or systemic changes to address inequities. Lack of attention to the less advantaged outer suburbs or to the rural areas are additional silences.

Reference to the Indigenous population is minimal in the majority of the policy in the Built Environment sector, despite native title being awarded to the local Kaurna people (Eacott, 2018). The significant exception to silences concerning Australian and Torres Strait Islander peoples, is the *Road Safety Action Plan*.

In summary, through my application of Bacchi's analysis I identified three policies that are considered the Built Environment policies most likely to enable population mental health and psychological wellbeing: *the Housing Strategy of South Australia, the 30-year Plan for Greater Adelaide* and the *MOU between DH&A and DPTI*. The next section discusses the interview findings regarding these policies.

6.2 Interview Analysis

In this section I report on the findings from the third stage of research which involved interviewing strategic policy actors and academics associated with the three Built Environment policies identified and discussed in the previous section: *the Housing Strategy for South Australia: Building a Stronger South Australia* & *the 30-year Plan for Greater Adelaide* and the *MOU between DH&A and DPTI.* Policy actors were drawn from the three state government organisations that comprise the sector: Department of Planning, Transport and Infrastructure (DPTI), Renewal SA and Housing SA, and additionally included policy actors from the Health sector, given the intersectoral nature of the *MOU*.

This stage of research sought further knowledge and insight into how the three policies identified were potentially enabling of population mental health and whether the policies were significant in driving the work of the sector. Given the historical collaboration with the Health sector, data from Health policy actors has been included when indicated. Data that related to the sector's structure and culture was also sought at this stage of analysis.

The analysis of data from the interviews identified the *30-year Plan for Greater Adelaide* as the Built Environment policy that best demonstrated potential to enable population mental health and psychological wellbeing.

These four themes form the content of this section:

1. The Built Environment is a setting that promotes health and wellbeing
2. The links between urban form and physical and mental health are growing
3. The social determinants of health are recognised in the Built Environment sector
4. Metrics that reflect health and wellbeing outcomes are needed

I now discuss these themes in detail.

6.2.1. The built environment is a setting that promotes health and wellbeing

The role of the Built Environment sector in supporting population health and wellbeing was well recognised by interviewees, supporting the finding from the document analysis.

> *It's useful to have documents (referring to the Transit Orientated Design, Healthy by Design and Streets for People documents) which shows the evidence about why health and planning are working together but I think that argument - this is what our DPTI colleagues tell us, that the argument's already been made…people know the benefits about why a supportive built environment will positively impact health and wellbeing* (Health Policy Actor, 2016, #29).

> *There are elements of the built environment that can either positively or negatively impact health, I think there is a good awareness of that… Uni SA has a planning for healthy cities course as a compulsory subject for all of their planners, so I'd say there's a rising awareness (in the planning profession)* (Built Environment Policy Actor, 2016, #32).

The following statement further highlights specific elements of the built environment that contribute to the development of a healthy built environment.

> *…there is certainly no doubt that people are seeing good public spaces, connectivity, you know, public transport access, walking as an absolute must for a good development* (Built Environment Policy Actor, 2016, #28).

Reflecting on the different drivers for urban development operating in the sector, the following interviewee makes the point that, despite the different drivers (economic or health related) in the sector, health related outcomes can still be achieved.

> *I recognise the different language and the different motivations but if it all results in the same kind of outcome frankly I don't care. I can sit in a discussion with developers where they talk about walkable neighbourhoods and new urbanism but get that it's really about marketing …but it still provides a good environment* (Built Environment Policy Actor, 2017, #26).

This statement refers to the broader context, in which urban development and renewal is serving to drive economic growth in the state, as articulated in the *Planning Reform* and *Renewing our Urban Future* documents. My analysis indicated that the problem representation in these documents was consistent with the creation of economic opportunities through urban development and the previous statement demonstrates acknowledgement of that. The interviewee adopts a pragmatic position, engaging with the economically driven agenda to achieve good things for the built environment and for population health.

In eliciting responses in relation to mental health, interviewees frequently required prompting, that is, asking specifically about mental health. The majority of interviewees implied 'physical health' when mentioning 'health', which was viewed as being enabled by public and active transport and walkable environments. When prompted, the majority of interviewees also acknowledged that what is good for physical health is also good for mental health. As stated in the previous section, acknowledgement of the significance of the connections between the built environment and social interaction and mental health, although present in the data, was less pronounced. However, urban planning policy actor 'champions' were identified who understood the significance of these connections. The following quotes demonstrate this understanding.

> *I think people recognise that healthy neighbourhoods and the extent that that influences people's own mental health, is about good design and good planning. I think that's a part of the way we think about stuff now… a safe environment for people to walk and feel comfortable and get people out and about in their local neighbourhood, …elements that sort of help people's sort of mental health and wellbeing.* … (Built Environment Policy Actor, 2017, #32).

> *…there's the bigger picture, planning…How do people move between places and all those sorts of things? Then it's the who's using these places and what opportunities are there for social interaction and what values are communicated in the design of places and spaces and the connections between them and how easy and accessible - and I see all of those things having a role to play in mental health* (Built Environment Policy Actor, 2016, #11).

The second quote expresses the nuances of how the different built elements can convey values, enhancing or desisting a sense of welcoming and acceptance in the built environment.

However, the same interviewee states that the connections between built environments, social processes and mental health are not generally well understood across the sector. The second quote likewise indicates that practice that considers social issues is not commonplace.

> *I think health and wellbeing in a physical and social sense are thought about, but I don't think mental health is specifically considered or thought about… Connectedness and I mean I understand that there can be a mental health benefit from that, but I don't think anybody would've specifically thought that* (Built Environment Policy Actor, 2016, #11).

> *I suspect people would find the whole sociability aspect of that to be [waffly]. I think they'd see it a bit 'we're not here to do that. The planning system isn't here to deal with people's social issues' sort of thing. I think there'd still be a bit of an attitude around that* (Built Environment Policy Actor, 2016, #5).

Interestingly, the same two interviewees also observed that in failing to value the importance of social processes to mental health or to value mental and physical health equally, the sector essentially replicates the valuing of health from within the health system (Built Environment Policy Actors, 2016, #5 & #11). Given the findings relating to the dominance of the biomedical model in the Health sector, these observations have some validity. Further information regarding the imbalance in the consideration of physical and mental health within the urban planning sector is offered in the next section.

6.2.2. The links between urban form and physical and mental health are growing

The objectives identified as central to varying extents in the Built Environment policies, excepting the *Road Safety Action Plan*, included the need to: increase densification, develop transit orientated urban areas, increase areas of mixed-use, support economic and employment options and reduce car use. The health benefits associated with these objectives were consistently discussed by the majority of interviewees, however regardless of the following quote, it was physical health that was most often cited.

> *…more mixed-use areas so you're more likely to have local shops and houses close together …creating a sort of a walkable, less car (orientated) environment where you've also got public space for people to be able to meet and congregate. There's a real correlation between people actually having somewhere to walk to and their walking levels… AND… if you put in some open space it has lots of positive impacts ranging from economic benefits, social benefits, environmental benefits, mental health benefits* (Built Environment Policy Actor, 2017, #32).

The central message in the sector is that creating a compact urban form and enabling public transport infrastructure will address urban sprawl, enabling walkability and health. The above quote extends the understanding, by discussing how zoning for mixed-use areas maximises the likelihood of walking, enabling a range of benefits, including social and mental health benefits.

However, despite the focus on reducing car use which was evident in the scrutiny of both the policy documents and the interviews, a number of participants expressed concern about genuine commitment to this goal, citing current road infrastructure building projects, which were perceived by the following interviewee to having a negative impact on local communities.

> *…with the South Road redevelopment, putting bridges up and dividing communities, it's terrible…other places in the world are pulling down stuff down like that and we're putting them up* (Built Environment Policy Actor, 2016, #11).

Two interviewees (Built Environment Policy Actors, #32 & #33) further suggested that commitment to reducing car use requires a significant and concerted approach on a number of different levels, such as investing in public transport, programmes or subsidies that support public transport use, access to shared transport schemes and public engagement (Giles-Corti, Foster, Shilton & Falconer, 2010; Barton, 2016). That is, approaches are needed that support a cultural shift from a car centric community to one where the majority of urban transport is car free and energy efficient. Importantly, the sector has pursued a number of these approaches such as a tram extension to Bowden, the *Way to Go* programme supporting walking to school, and public transport subsidies for retirees. However, the demand for improved road infrastructure continues, driven in part by community expectations and by perceived economic imperatives to improve and further develop road transport (Miller & Orchard, 2014).

Equating the marked influx of cars into neighbourhoods in the 1960's and the creation of road infrastructure with a demise in population health and health in planning, the following comment indicates that this started to change in the 1990's. This history gives context to the finding that the urban planning sector favours a focus on physical health and walkability, as discussed in the previous section, over mental health and wellbeing.

> *I think in the 1990s they started to re-engage the whole idea that built environment influenced health, they wanted expertise in characterising the built environment for their research around walking behaviour and that walking behaviour then being associated with a raft of chronic disease outcomes, obesity, type two diabetes, high blood pressure…so that's essentially where we started; about 2000 we started… Presently a lot of the built environment influence on planning has actually stemmed from that walkability work…*(Academic, 2016, #10).

Acknowledging the translation of the past 18 years of research regarding the centrality of walkability in urban planning approaches, the same interviewee considers that there is now a changing emphasis in urban planning, shifting from 'walking and physical health' to 'open space and wellbeing'.

> *I think about what's happening (now) in Planning…we think about our open space, our whole urban landscape, as a way of improving people's wellbeing and it's positive and it's certainly happening…I think the idea of wellbeing is starting to filter through* (Academic, 2016, #10).

Such a shift is viewed as enabling a broader consideration of the built environment as a 'whole urban form', that is, a setting, and a broader consideration of health as wellbeing, which is inclusive of physical, mental and social health. As such, it is proposed that the increased focus on wellbeing is increasing the policy space for a more holistic interpretation of healthy urban planning (Arthurson, Lawless & Hammet, 2016).

This theme is extended in the following comments, in which the relationship between place and people is considered, bringing into view the significance of social interaction and community connection in the development of a healthy urban form.

> *…so starting to think about the public realm and the car and the roads in a different way… why it's there in the first place and how does it maintain community… it seems to me that we're seeing a real shift back away from what everyone used to hate, which was the small strip shopping and those small main street type places, to being people wanting to be conscious about being local and having connection in community and interaction in a place* (Built Environment Policy Actor, 2017 #33).

> *…if you link that (the quality of the built environment) back to health and wellbeing and mental health then that idea of place and belonging becomes a lot stronger* (Built Environment Policy Actor, 2016, #11).

> *…people that are more likely to be getting to know their neighbourhoods and their neighbours and are less likely to feel isolated which obviously is helpful to mental health* (Built Environment Policy Actor, 2017, #32).

These statements make reference to a valuing of the role of the built environment in enabling local interaction and community connection. References to a sense of community and a sense of place by these interviewees, directly relates to the relationship between the built environment and social interaction and mental health.

Consideration of the urban environment as a 'setting', that is also inclusive of greenspace was discussed by interviewees, who viewed access to greenspace as related to both physical and mental health. The following quote refers to the importance of contact with nature, noting the challenges associated with prioritising greenspace in an urban environment, where one of the central planning priorities is to increase density, essential to supporting public transport use and efficiency.

> *…connection with nature is very important…having mental health outcomes for the community, I know that's being increasingly recognised…it certainly is in a lot of our strategic documents but, you know, there's still a lot of work still to be done in terms of prioritising it* (Built Environment Policy Actor, 2017, #32).

6.2.3. The social determinants of health are recognised in the Built Environment sector

The interview data demonstrated that interviewees from the sector held different views and understandings of the social determinants of health. There was acknowledgement of the need to support access to healthy urban settings for all and the need to work on a population level and there was acknowledgement of the need to support discrete groups struggling with disadvantage i.e. those experiencing financial and/or social difficulties and specifically older persons, with disabilities or from aboriginal communities or rural areas. Of the defined groups referred to across the sector, the most commonly referenced group was the aged population, as is discussed later.

The diminished health outcomes associated with low socioeconomic position was recognised in the data, however, reference to the social gradient or health inequities were minimal, although a number of interviewees, specifically from Housing SA, demonstrated knowledge of both the social gradient and the need for practice to address health inequities.

The following quotes suggest that action that addresses the social determinants of health or health equity, is potentially relevant to the work of the sector, but possibly considered 'out of scope', in regard to current sector objectives. The first interviewee also expresses concern about who is doing this work.

> *A community that has regard for - respects diversity and inclusiveness, you know, to us has to be a part of that equation and so whose role is that*? (Built Environment Policy Actor, 2017, #26).

> *The discussion on the social determinants of health has not much intruded into the housing area…whereas (referring to the NGO sector) are constantly experimenting with what you'd call the social determinants of health* (Built Environment Policy Actor, 2016, #2).

This following quote discusses the current limited ability of Housing SA to work proactively or even reactively, to address the social determinants of health.

> *…a lot of our work is band aid work. You know we are keeping the lid on things and sometimes we don't. You know, we have people burning down properties, all those terrible things that happen in a society where the most disadvantaged aren't responded to* (Built Environment Policy Actor, 2017, #22).

As previously stated, the recognition of the needs of defined disadvantaged groups and the non-recognition of the social gradient, means that where action is taken, it is more likely to be targeted, as opposed to universal. Recognition of this limited approach is illustrated in the following comment which references a policy response to assist with financing to overcome the problem of housing affordability, viewed largely as an individual issue. The interviewee acknowledges the positive intention of a policy that requires 15% of housing developed to be considered affordable, but expresses cynicism at the policy response, which is undermined by market forces and fails to address the structural barriers to housing affordability.

> *…you can get a house priced less than $350,000 by making it small, so you can do a one-bedroom unit, potentially, which would be less than $350,000 and that's classed as doing your affordability bit for government* (Academic, 2016, #6).

The same interviewee furthers the theme discussing housing in current built environment projects, including the Built environment nested case study, the Bowden redevelopment.

> *The new sort of master planned communities like at either Bowden or places…should have facilities there but they are not targeting - they're targeting generally the wealthy; there isn't much affordable or social housing there* (Academic, 2016, #6).

Given this situation, it could be suggested that financial ability is effectively acting as a 'gate' to new developments such as Bowden, possibly skewing the population demographics, minimising urban diversity, inclusiveness and social sustainability in areas close to the city.

Coming from another perspective the work of the sector was observed by one interviewee, as failing to consider the links between the built environment and health in country areas.

> *At the moment we just seem to be completely focused on what happens in the capital cities, yet we know that a lot of our poor health outcomes are not in capital cities…there's a disproportionate burden on non-capital cities and we don't seem in any way interested in actually addressing that* (Academic, 2016, #10).

This observation raises questions about the current objectives of the urban planning agenda and the equity of health gains that are associated with urban planning policy. The problem representation of addressing urban sprawl, which is central to the sector's policies, leads to a focus on the city of Adelaide, not the rural or remote area of the state. Furthermore, the focus on inner urban renewal serves to overlook the outer suburban areas of Adelaide.

The strongest theme that emerged in the data relating to the social determinants of health was the housing needs of the older population, mirroring the strength of the focus on older people in the Health sector, as indicated in Chapter 4. This finding is possibility reflective of Professor Alex Kalache having served as a Thinker in Residence in the state of SA in 2011. Concerns about appropriate housing design, housing options, transport options and social and community connection for the older population were all discussed by interviewees.

> *Ageing for the state, is a demographic kind of bubble that's going through…it was 30 years ago that the Housing Trust built their cottage homes and they were the last kind of initiative of housing forms suited to aged people so we're now looking at apartment living*… (Built Environment Policy Actor, 2017, #26).

> *We see a lot of problems in social housing with people who are disconnected from the neighbourhood. There's a lot of loneliness, squalor, hoarding. To some extent it's greater with older people* (Academic, 2016, #6).

> *All of our demographics are showing, …an incredibly ageing population and there's a whole range of different ways we need to rethink about space and where we live and how we manage that* (Built Environment Policy Actor, 2017, #33).

Five interviewees described the pressing need to rethink housing, public open space and participation in the community to support the health and mental health of the older population. The increased incidence of single person households, social isolation and increased reports of loneliness associated with ageing were common themes (Kelly et al. 2012; Lim, 2018). Intersectoral collaboration was viewed as essential to this goal, that is, collaboration between agencies such as Housing SA, Renewal SA, Office for Design and Architecture SA and SA Health, which is further discussed later in this section.

6.2.4 Metrics that reflect health and wellbeing outcomes are needed

This theme was also discussed in the previous chapter on the Natural Environment sector. Interviewees reported wanting measurement options to allow the links between the work of the sector and health outcomes to be explicit. There was a frustration specifically expressed regarding the lack of measurement of health outcomes in the Built Environment sector and frustration at the perceived lack of interest in these outcomes, from the Health sector. The second quote specifically highlights social and mental health outcomes.

> *…how do you start to measure (health outcomes) and see where you are actually making a difference … what are the measures that make sense of that? I don't think we've got any (measures)* (Built Environment Policy Actor, 2017, #33).

> *I don't know of anything that actual quantifies social connectivity or more, the mental health wellbeing concept* (Built Environment Policy Actor, 2016, #11).

> *I mean again Health's very, very good at mapping. You can spatially map out chronic disease …but then linking that back to what is the planning aspect that correlates to that; that's the missing gap to me. We haven't drawn that link together. We intuitively all know what it is, but we haven't -- what's the data link? What's that metric that will mesh that? Budgets get decided on measurables ultimately* (Built Environment Policy Actor, 2016, #5).

This last quote reflects on the capacity of the Health system to collect health data but the lack of use of that capacity in support of health promotion or illness prevention objectives. The interviewee highlights capacity to 'spatially map out chronic disease', such as is done in the *Social Health Atlas of South Australia*, as a powerful way to highlight the association between the incidence of disease and the social determinants of health however as he/she suggests such action is lacking. The majority of interviewees stressed that the power of the 'metric' matters, effectively viewing the lack of health-based data as serving as an impasse to supporting and validating future collaboration between the Health and the Built Environment sectors, collaboration that could potentially enable mental health promotion.

Coming from another perspective, an alternative measurement obstacle is seen in the disconnection between research and the development of policy. The following quote is interpreted to refer to the gap that exists between researchers wanting to support civic progress by informing policy and policy makers wanting access to research that enables civic progress but is sensitive to current policy problemisations, assumptions and context.

We couldn't publish this in a journal…that's not translatable to the planner. He doesn't read that paper and go 'ah, there we go; there's the evidence I needed'. Whilst we talk about policy relevance, we've somehow got this sort of yawning gap between the way research is done in universities and the way it's needed for policy relevance. Now I haven't seen any real steps to overcome that in my time... (Academic, 2016, #10).

6.2.5 Analysis Summary of the thematic data from the interviews and selection of the nested case study

This previous section has identified the themes that have emerged from the interview analysis of policy actors and academics in strategic roles within the built environment sector. There was consistency in the document and interview data concerning the policy problematisations and assumptions. The current sector objectives concerning urban form were consistently referred to by policy actors, as objectives that relate to improved population health outcomes. The link between the built environment, urban form and health and to a lesser extent mental health, was strongly endorsed in the sector. However, the growing emphasis on wellbeing, and recognition of the need to consider the 'whole urban form' i.e. buildings, social processes, public open space and greenspace as relevant to health outcomes, has potential to raise the profile of mental health within the sector. The fact that interviewees would like to find a way to evaluate and promulgate mental health outcomes associated with the work of the sector is most encouraging.

Three policies were forwarded from 6.1 as potential case studies: The *MOU between DH&A and DPTI,* the *Housing Strategy for South Australia: Building a Stronger South Australia* and the *30-year plan for Greater Adelaide.* Data from the interviews confirmed that the *MOU between DH&A and DPTI,* was not considered an active policy at the time of research (#5, #9, #11). Likewise, data confirmed that the *Housing Strategy for South Australia* was considered out of date, and that the *Housing SA Blueprint* (2013-2018) (South Australian Government, 2013) associated with the Department for Communities and Social Inclusion was the document that was guiding the work of the agency (#6, #22, #26). The decreased role of Housing SA and the increased role of NGO's in the provision of housing services (#2 & #6) additionally confirmed decreased agency capacity.

The *30-year Plan* proved to be an active policy that currently serves as the key document for the state's urban development. Further, the plan directly proposes strategy to improve population health and mental health, indicating that it is highly relevant to the research purpose and has therefore been selected as the policy exemplar for the Built Environment. *The Bowden redevelopment* was identified as applying the principles of the *30-year Plan* and was subsequently selected as the subject for the nested case study in this sector.

6.3 Nested Case Study analysis– Bowden Redevelopment

The *Bowden redevelopment* was selected as the case study from the Built Environment sector, drawn as a practical example of policy implementation from the policy exemplar, the *30-year Plan for Greater Adelaide (2010-2040).* A map of the redevelopment followed by photos taken of the area can be found below in which the proximity to the city, parklands, public transport and other key features can be ascertained.

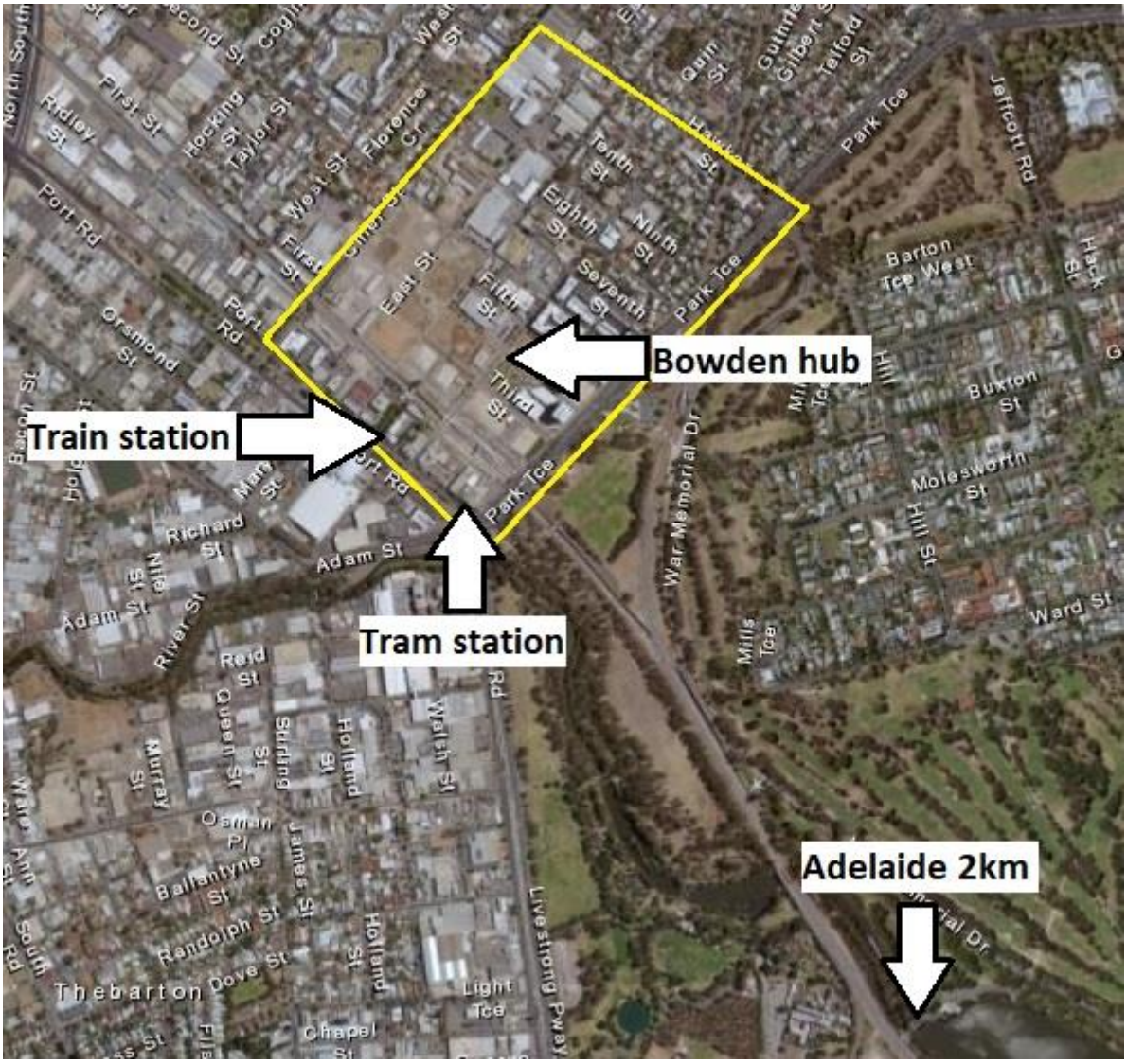

Figure 6.1 Map of the Bowden redevelopment

Figure 6.2 Emu Park, Seventh St. Bowden

Figure 6.3 Bowden Hub, retail and public open space (from the north)

Figure 6.4 Bowden Hub, retail and public open space (from the south)

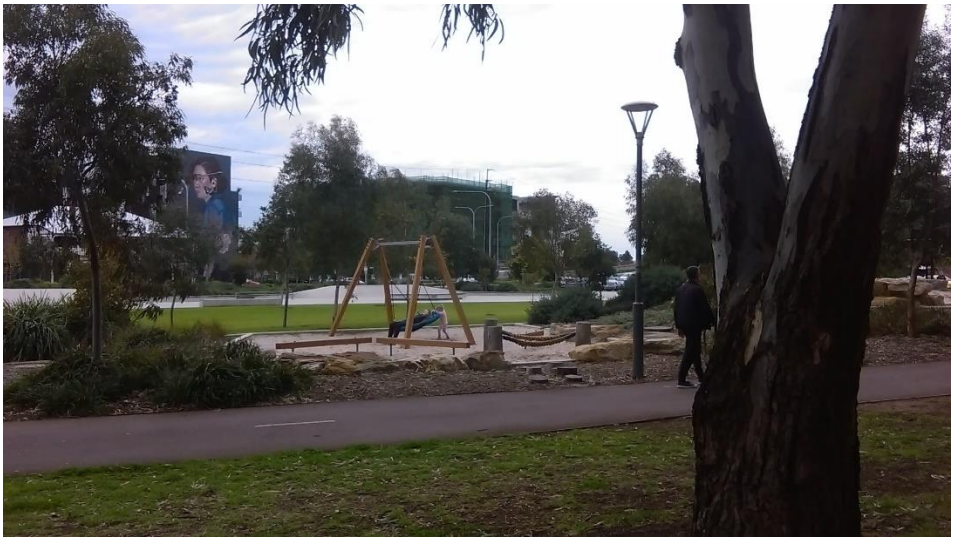

Figure 6.5 Bowden playground, walking track, basketball courts and community garden in adjacent parklands (Park Terrace)

Figure 6.6 Bowden train station

Figure 6.7 Public open space integrated into residential area (under development)

This section presents the themes that have emerged from the analysis of data relating to the case study and a summary of these findings. This data includes strategic and operational interviews (13 participants), documents disseminated by the Built Environment sector relative to Bowden, other web-based information and notes from site observations (Appendix G).

There are three key themes that emerged from this level of analysis, which I discuss in this section.

1. Urban redevelopment at Bowden focuses on economic, social and environmental outcomes in support of health
2. The Bowden redevelopment has benefitted from past and present intersectoral collaboration
3. The concepts of wellbeing, liveability and placemaking facilitate a broader focus on mental health

6.3.1 Urban redevelopment at Bowden focuses on economic, social and environmental outcomes in support of health and mental health

The findings indicated that the Bowden redevelopment was understood to be a unique development that was to serve as an exemplar for future urban planning in Adelaide. Initially a brownfield site, Bowden was seen as a demonstration project that embodied the objectives of the *30-year Plan*. Both comments below illustrate this understanding, while also articulating that the redevelopment at Bowden is about people, their living and working environment and their health.

> *Bowden is the state government's first higher density urban infill project located 2.5 km from Adelaide's CBD. Bowden strongly reflects our commitment to creating a new urban form. It shows how putting humans at the centre of design can create places where people are drawn to live, work and recreate* Renewal SA. (2018) Bowden. Retrieved from https://renewalsa.sa.gov.au/our-projects/).

> *Well we've, being government, got an objective or really an expectation on us that we lead the development industry, so I see this project (Bowden) as providing examples to other private sector developers on how to do place making, how to master plan and how to achieve higher levels of sustainability and quality and liveability and healthy outcomes for people* (Built Environment Policy Actor, 2017, #27).

Interviewees discussed the potential economic, social and environmental benefits of the urban planning and development that has taken place at Bowden as is evident in the following statements.

Relating to the economic benefits

> *That was sort of the government demonstrating that if you took underutilised land and managed it in a particular way you could get quite significant quality and density close to the city… demonstrating that different style of housing and form can be done in a way that is well designed… now seeing replicated by a number of the others (developers/developments) …* (Built Environment Policy Actor, 2017, #33)

Relating to the social benefits

> *I think Plant Four (public open space with greenspace, eating area and shopping area) has been a real success story for the project with the amount of people that are talking about it and coming to it and the things that it's achieved for the project so far and it's really only one year old. I think that's the thing that probably stands out most for Bowden at the moment, which is great because it's really the hub of everything. It's right in the centre of the community…* (Built Environment Policy Actor, 2017, #27).

Relating to the environmental benefits

> *…having a policy, for instance, on carbon neutrality or zero carbon or carbon neutral Adelaide, what that does is allow governments to go "Well, that's our policy"…so they can do things like Bowden which says, "In order to do that (reduce the carbon footprint and pursue environmental benefits) we're going to demonstrate how'…*(Built Environment Policy Actor, 2017, #28).

The commitment to an equal valuing of the economic, environmental and social outcomes achieved at Bowden was initially demonstrated by the adoption of the far-reaching *One Planet Living* guidelines (Hancock et al. 2017) to development (#28). The One Planet Living framework employed (Bioregional, 2019) consists of ten principles of development including: health and happiness; equity and local economy, culture and community; land use and wildlife; sustainable water; local and sustainable food; sustainable materials; sustainable transport; zero waste; zero carbon for use by regions to support healthy and sustainable living.

These principles provide a development framework that counters the narrow economic imperative found in the key Built Environment policies, *Renewing Our Urban Future* and *Planning reform* documents. The difficulties encountered in adopting such an evaluative framework, however, were present in the following statement.

> *Some people would say that's not what we should've been on about because it's about return on investment of government money, but we had a - we started to think within what we were doing, the triple bottom line approach, that economic/environmental/social outcomes was how we should be driving our development* (Built Environment Policy Actor, 2017, #28).

However, the following comment highlights the difficulties encountered which led to a revision of the commitment to the One Planet Living principles (Bioregional, 2019) to an alternative evaluative framework, with a reduced focus mainly on achieving sustainability, Green Star (Green Building Council Australia, 2015).

> *…to a certain extent, we've achieved some of those (One Planet principles) but it's - some of them are very, very difficult to achieve…so we've gone down the path of green star. The green star for buildings is one thing and each building here must achieve a minimum five-star design and…for the whole project, with the Bowden development itself we've gone for a green star communities rating, which is different to just the building, it's the whole project* (Built Environment Policy Actor, 2017, #27).

In working with the triple bottom line approach, it was anticipated that the health and wellbeing outcomes associated with the project would be acknowledged.

> *Our role was to embed health principles and practices in our developments and Bowden was one of those which became a bit of a lighthouse project in terms of showing the relationship between health and development* (Built Environment Policy Actor, 2017, #28).

The same interviewee suggests that while health outcomes were not initially considered a major driver in the Bowden redevelopment, the importance of the built environment as a setting that can be planned to support population health was increasingly realised as the project progressed.

> *Was health a driver? - I'm not sure it was necessarily one of their big drivers early on. I think towards the back end of it though amenity, connectivity, recreational spaces, health and movement (active/public transport), it has certainly risen up* (Built Environment Policy Actor, 2017, #28).

To further explain the links between health and the urban redevelopment, the following quotes in relation to amenities, social connectivity, recreational space and active transport have been drawn from the data. These quotes demonstrate the relationship between the physical and social elements of the urban environment and the physical, mental and community health outcomes they support. This is concrete evidence of how the Bowden redevelopment is prioritising aspects of development that have the potential to enable health and mental health.

Amenities

Examples of how Bowden is establishing a retail precinct that has a balanced market and wellbeing ethos

> *Plant Four is really now becoming a very well-established community hub in the area where people are meeting…The tenants that operate Plant Four have a very good philosophy around healthy living. All of the other tenants around the outside of Plant Four in some way or another are connected to organic and healthy food options*… (Built Environment Policy Actor, 2017, #27).

Examples of how Bowden has prioritised urban based alternative transport options to car travel

> *Get around by tram, bus or train — Port Adelaide, Semaphore, the city and Glenelg are all a short trip away. Also try a car-sharing service or cycle instead…In the future, an integrated transport hub will make Bowden even more connected.* Bowden. (2019). Retrieved from https://lifemoreinteresting.com.au/bowden-life/amenities/

Social Connectivity

Examples of how Bowden prioritises urban forms and processes that enable social interaction and mental health

> *What I really love about this area is that they're trying to build community here*… (Resident quote taken from wall of Bowden real estate selling office, 2017).

> *Blooming balconies – free apartment gardening seminars; Plant 4 Gourmet bus to Clare; Bowden Flicks – free outdoor screening at Bowden Park; Park Terrace Community garden* (Flyers/Online newsletters/Social media event listings, 2017).

> *I think (improved mental health) comes partly with the physical health side of things. The community garden is a pursuit for people to relax and unwind and communicate and relate to their community. We've also got a place making program here where we encourage arts* (Built Environment Policy Actor, 2017, #27).

> *We're going to have certain design features in the public realm that promote interactivity between people and therefore that follow design standards for public furniture or streetscapes, or whatever, (this is) going to be factored into the rules that we set* (Built Environment Policy Actor, 2016, #5).

Recreational spaces

Examples of how Bowden is prioritising land and greenspace in the development for formal and informal recreation

> *…being really clear about pedestrians as being very equal on the hierarchy between, you know, vehicles, walking and bikes, I think that is helping to create that sense of health and wellbeing* (Built Environment Policy Actor, 2017, #28).

> *There's a basketball, tennis court, children's play space, pétanque. There's the community garden which was a separate project that we managed and then there's also a skate park* (Built Environment Policy Actor, 2017, #27).

Active Transport

Examples of how the urban planning at Bowden enables active transport

> *We've also incorporated a lot of other cycling infrastructure features in most of the public realm. Extra bike parking. We've got bicycle maintenance stations at two locations. On top of that we've got a set of urban design guidelines where we require all of the developers here to incorporate cycling facilities in the apartment developments that they deliver* (Built Environment Policy Actor, 2017, #27).

6.3.2 The Bowden redevelopment has benefitted from past and present intersectoral collaboration

The majority of interviewees referred to a history of intersectoral work between the Built Environment and Health sectors that was having a direct and indirect impact on the Bowden redevelopment. There was acknowledgement of the many stakeholders who engage with the Built Environment sector, given the breadth of their mandate, however, engagement with the Health sector was a common and positive theme.

> *I think back to sort of the original 30-year plan, you know, which is five years old now, I think the health in all group and the health planning people and our land use people have made a very strong connection and I think they've had a good working relationship* (Built Environment Policy Actor, 2017, #33).

> *There's lots of great work that's already happened in the past… that can be built upon and I guess through the Health in All Policies work that's happened previously we've got these strong partnerships that we formed with people in the planning sector and the urban design space that we're building on* (Health Policy Actor, 2017, #29).

Three interviewees (Built Environment and Health Policy Actors, #5, #32, #29) made reference the previous deployment of a Health sector position to the DPTI workplace to support intersectoral work processes and outcomes. This was viewed as an influential and formative initiative, that promoted a deeper consideration of health in the state's planning processes then, with continuing effects now.

> *SA Health funded a position at DPTI for three years from 2009 until 2012 which looked at embedding health and wellbeing through the planning system. That then stopped being funded but DPTI's largely kept on doing that sort of stuff* (Built Environment Policy Actor, 2017, #32).

The loss of funding for the position was considered unfortunate by the same interviewees. The following quote captures the common concern held by interviewees, that in the absence of a formalised process and institutional authorisation, that shared knowledges and relationships across the sectors will diminish with predictable results.

> *I feel that probably some of that consciousness of the need to continue having these links has been frayed over time…. I don't know if it's as institutionalised, that relationship, as it could be. Partially that's because the health funding -- the arrangement we have with the health in planning funding arrangement, that's changed so we don't do that anymore so now it's based upon officer goodwill and connection* (Built Environment Policy Actor, 2016, #5).

As a corollary to this, current collaborative work specific to Bowden was not evident in the data, although it was anticipated that the update of the *30-year Plan*, which was due for release in 2017 would provide a renewed opportunity for collaboration (Health Sector Policy Actor, #29). Despite this, interviewees made frequent reference to past intersectoral work that continues to directly inform the Bowden development. Three documents developed through intersectoral collaboration were specifically considered highly instrumental in the Bowden redevelopment by interviewees: The *Healthy by Design Guidelines* (Heart Foundation, 2012), *The Streets for People Compendium* (South Australian Government, 2012) and The *Transit Orientated Developments Guide* (South Australian Government, 2010).

1. The *Healthy by Design Guidelines* (Heart Foundation, 2012) were applied at Bowden and Bowden Park (see map) is a central and integrated public open space adjacent the hub, which incorporates healthy design features indicated by the guide including connected pathways to support walkability, scootering or skating, water fountains, playground, bike parking, sheltered and treed areas, water play areas and BBQ and picnic spaces.

   Designed to draw people through and encourage them to linger, Bowden Park is a place of relaxation, social connection and recreation. This access to public open space allows residents and visitors to reconnect with nature, undertake physical activity or simply relax outdoors (Heart Foundation, 2018).

2. The principles and practices recommended in the *Streets for People Compendium* (South Australian Government, 2012) were also applied at Bowden. Streets were viewed as places for people to sit, walk and cycle, in addition to places to drive. The development prioritised the need to develop a pedestrian environment that encourages shared use. In part this is achieved through the use of traffic slowing, quality footpaths, green thoroughfares, street furniture and street art, all of which feature at Bowden.

3. The *Transit Orientated Developments Guide* (South Australian Government, 2010) nominated 12 sites in Adelaide as sites for transit orientated development and 3 of those sites were redevelopments: Bowden Village, Lochiel Park and Tonsley. Bowden village has been designed to incorporate a renewed train station and has proximity to train and tram travel, on a route that was extended as part of the Bowden redevelopment. Renewed development of the western parklands has additionally established a safe and attractive greenway through the western parklands into Adelaide to support active transport via walking or cycling for local residents.

6.3.3 Wellbeing, liveability and placemaking facilitate recognition of the link between the built environment and mental health

The concepts of wellbeing, liveability and placemaking are central to the Bowden redevelopment as is evidenced in the Renewal SA document, *Placemaking in Bowden* (South Australian Government, 2019).

> *For Bowden to succeed, we all need to understand the 'hows and whys of placemaking'. Placemaking builds community good will, it gives investors and businesses confidence, it enables innovative solutions and it creates places that people love and want to be* (p.6).

In this statement, placemaking is framed as supporting the triple bottom line that was discussed in the previous section. The association between placemaking and investment and innovation relate strongly to economic outcomes however social and environmental outcomes (to a lesser extent) also feature. The following statement from the same document, clarifies an inclusive interpretation of the word 'placemaking' used in relation to Bowden (South Australian Government, 2019).

> *Placemaking is a holistic, multi-disciplinary approach that incorporates and influences other traditional areas of place development, including master planning, urban design, social and economic development, community engagement, retail planning, arts and culture and sustainable development. It involves understanding the culture and qualities of a place, the wisdom of its community and the power of collaboration to achieve a shared vision* (p.6).

This definition enables placemaking to encompass place, people and the relationship between them. That is, the physical urban infrastructure and the social, economic and community activities that are enabled through interaction with the infrastructure. The term was used consistently by the majority of interviewees in relation to Bowden. The following statements illustrate an understanding of placemaking that aligns with the above definition, the second quote linking that interaction to benefits for health and mental health.

> *Place making is about how does a place work. What's the interaction of the design of a place, the physical dimensions of a place, the public realm and how people engage with a place?... Bowden you see as a place where there's a huge emphasis on that* (Built Environment Policy Actor, 2017, #26).

> *…place making (in Bowden) is about places for people, so at the end of the day it's not about bricks and mortar; it's about where people go. It's about providing places for people to relax, for people to play, for people to feel safe* (Built Environment Policy Actor, 2017, #28).

In these quotes, placemaking is seen to support a *sense of place* and a *sense of community*, with significant benefits for health and mental health. The creation of a *sense of community* at Bowden referenced in 6.2.1., is highlighted as a feature of Bowden by interviewees, in related government documents and in advertising information. Critical analysis of how placemaking functions in the community, however, gives rise to concerns about the link between placemaking, urban revitalisation, marketing and social inequity. This was raised in the interview data, albeit, not by interviewees associated with Bowden.

> *My sense is that the placemaking talk is generally hot air and doesn't go very deep and if it does go deep, they're actually thinking about master planning a community plan, zones, roads, transport corridors...so there's very, very little attention paid to community building* (NGO/Academic, 2016, #6).

Despite this, there is data that attests to the importance of the theme of community at Bowden, and its link to mental health which was explicit in interviews and documents. The following quote demonstrates a clear link between community and mental health.

> *Big focus on need to support the sense of community (in Bowden) there and that's been quite successful …if you look at mental health…they have a sense of ownership and the way that they operate…where they are actually part of something… I would say it is part of the community development plan that they had* (Health Policy Actor, 2017, #28).

> *…but if people feel like they're part of something or there's a broader connection in community then, you know, hopefully in some way that makes a difference (to mental health)* (Built Environment Policy Actor, 2017, #33).

The downloadable *Placemaking in Bowden* document (South Australian Government, 2019) also articulates the importance of community to mental health, and discusses community development, identifying the need for 'bottom up' and 'top down' processes. The first statement relates to forming neighbourhoods, the second comment to the role of businesses and community groups in the development of community.

> *For residents…Neighbourhoods are shaped by the actions of those who live and work in them. It works best as a home grown, organic process* (p 13).

> *For businesses and community groups… You can play an important role in creating more worthwhile experiences that will both draw people to Bowden and encourage those already living and working there to linger longer* (p.14).

Two interviewees referred to two group processes supporting community participation and involvement. Firstly, the Bowden Reference group was formed to enable residents and local business owners to have a say on how the area proceeds. Group members were reported to include representatives of community groups, organisations, individual community members from other parts of Bowden and council representatives. However, the need for the increased involvement of 'everyday residents' in this group was suggested in a state government report on Bowden (Better Together, 2018). Two key issues were identified in this report.

Firstly, concerns about what and whose views were being represented at Bowden were raised in this case study. Secondly, the following comment relates to a local arts group which again conveys an awareness of the important of sense of community to wellbeing.

> *All those things I think tend to help people relate to the community and take ownership of it and then become more at one with their local - with the place that they're in…and have a sense of ownership and wellbeing as a result of it* (Built Environment Policy Actor, 2017, #27).

Attention to community is additionally a key factor in the Bowden development advertising material, suggesting that developers understand that 'being a part of a community' or 'being a part of something bigger' is an aspect of life that people are seeking. The data suggests that a significant number of young professionals and resourced retirees (Built Environment Policy Actor, #27) had taken residence at Bowden, implying a lack of community diversity, compromised by the lack of housing affordability, however the fact that developers use the concept of community connection to support the marketing of their housing product is noteworthy. In a sense, it acknowledges and progresses an important aspect of health and wellbeing that is most beneficial to mental health.

The concept of liveability was also discussed by the majority of interviewees as a concept that relates to Bowden. Differing concepts of liveability were identified and highlighted by interviewees but generally it was understood to be a multifactorial concept, that has currency not only in planning but in health. As a concept it potentially offers opportunities to support a focus on healthy settings. The following two quotes reflect on how the concept of liveability can be used to effect change; the second quote, identifying the possibility for the concept to effect health change.

> *I think what we are doing in planning, is focusing on how you make these catchphrases about liveability, about healthy neighbourhoods into practical, real things that we can change…* (Built Environment Policy Actor, 2017, #33).

> *…increasingly one of the ways of selling health to the powers that be, that I've found a few times I've got traction with, is linking it to liveability… I think the concept could probably help make that a stronger connection* (Built Environment Policy Actor, 2016, #11).

This statement conveys the interviewee's understanding that the concept of liveability has validity and status within the Built Environment sector and further that where actions are viewed to enable liveability, they are viewed as relevant to the work of the sector. In supporting the link between urban planning, liveability and health and mental health, the interviewee hopes to enable health and mental to become more visible and acknowledged within the sector.

The documents studied in the case study, also consistently referenced liveability, including the *30-year plan*, from which the case study is drawn. It is a term that additionally features in the *Renewing Our Urban Future* and *Planning Reform* documents.

The *30-year Plan* identifies, 'Maintaining and improving liveability', as the first of the three major objectives, listing the following four components as relevant to this objective (p.12).

- People spend less time in cars and have more time for leisure
- Greater Adelaide has a vibrant arts, cultural and sporting life.
- The best elements of the past and present are evident in urban design and form.
- Housing and the cost of living are affordable.

The Green Building Council of Australia identifies that a development that demonstrates liveability is concerned with the delivery of safe, accessible and culturally rich community with a high level of amenity, activity, and inclusiveness (Green Building Council of Australia, 2015). The concept is paired with economic prosperity, governance, environment and innovation.

The Charles Sturt Council, which is the local government body that presides over the area in which Bowden is situated, have developed a document regarding liveability. The document states that liveability relates to the extent to which a place meets the needs of the residents who live there, citing housing affordability and choice, public transport and traffic management, recreational and cultural opportunities, quality of streetscapes and architecture and land use planning and community safety as central to liveability (City of Charles Sturt, 2016).

In presenting these different definitions, I wish to reinforce how different interpretations of liveability may lead to different actions and outcomes. Illustrating this point, Badland et al. (2014) found 233 indicators of liveability, pointing out that of these, some have the potential to contribute to health and wellbeing and further, that some again, have the potential to contribute to health through the social determinants of health. Having said that, any of the conceptualisations of liveability discussed above are consistent with a focus on the setting in which people grow, live, work and age, and in creating healthy settings, liveability and population health and mental health are enhanced. This focus on the setting and the ability of the Built Environment sector to effect change at this level is reflected in this brief and final quote.

> *I think the collective and how you bring that together…in some ways that's where I think we (DPTI) can do the best* (Built Environment Policy Actor, #33).

6.3.4 Summary of the nested case study

This section has highlighted the case study for the Built environment sector. Three themes have emerged through analysis of the interviews and related supplementary material.

Firstly, as a master planned community development, the Bowden development has exemplified medium density living, the development of mixed-use areas including quality public open space, access to public transport and access to quality greenspace. These are key objectives of the *30-Year plan.* The promotion of mental health was not a central driver in the development; however, the research establishes the links between mental health and psychological wellbeing and living in a community which focuses on economic, social and environmental outcomes which Bowden has attempted to achieve. Concerns regarding housing affordability and lack of community diversity however, suggest that economic outcomes were prioritised over social outcomes and the benefits of living at Bowden were not accessible to all, which means health and mental health inequities remain unaddressed.

Secondly, the data indicated that past intersectoral processes and work has informed the development at Bowden, in ways that have supported health and wellbeing, however, policy actors indicated that these processes are currently not endorsed to the same extent as previously.

Finally, the evidence suggests that the concept of wellbeing has currency in the sector and invites a broader consideration of mental health. Further, the Bowden redevelopment has applied the concepts of liveability and placemaking, both which have potential to draw out the relationships between the conditions in which people live and mental health and psychological wellbeing.

CHAPTER 7 DISCUSSION

Overview

In this final chapter, I draw conclusions from the findings reported in chapters 4, 5 and 6 and further elaborate on the current capacity of health and public policy to promote mental health and psychological wellbeing in the state of South Australia. As chapters 4-6 have identified and discussed, there was no policy exemplar or case study identified for the Health sector but a policy exemplar and a case study for both non-health sectors were identified. The Natural Environment's *HPHP-Making Contact with Nature Second Nature Strategy (HPHP Policy)* and the *HPHP-Realising the Mental Health Benefits of Contact with Nature Action Plan (HPHP Action Plan)* and the Built Environment's *30-year Plan for Greater Adelaide* and the *Bowden Redevelopment* have been identified and discussed in Chapters 5 and 6 respectively.

Further, I answer my three research questions and synthesise my findings across the sectors and across the stages of research to enable recommendations to be made about the paths most likely to progress population mental health. The chapter is structured according to the three research questions which I now repeat, and I finish with limitations of my research, concluding comments and recommendations.

1. To what extent is mental health and psychological wellbeing considered within the policy of the three sectors (the Health, Natural Environment and Built Environment sectors) and how do the policy framings construct responsibility for mental health and psychological wellbeing?
2. How is population mental health and psychological wellbeing represented in the policy of the three sectors?
3. What enables and disables the best exemplars of policy and policy implementation (the nested case studies) and how can these findings inform policy and practice concerning mental health and psychological wellbeing?

Prior to the discussion I present a table summarising the findings from the three sectors.

Summary of Findings	Policies analysed	Policy analysis themes	Policy selection	Case study exemplars and themes
Health Sector	Prosperity for Longevity Aboriginal Health Care Eat Well be Active Strategy State Public Health Plan Mental Health and Wellbeing Policy SA Suicide Prevention Strategy	Dominant focus on individuals, illness and treatment Dominance of the biomedical model Dominance of clinical approaches Revisions to Public Health governance and responsibilities Metrics and budgetary requirements shaping health models	**No Policy selected**	
Natural Environment Sector	Healthy Parks – Healthy People Aboriginal Reconciliation Action Plan	The public valuing of parks The natural environment is a setting that promotes wellbeing, health and mental health Direct and indirect policy impacts mental health Connection to country is essential for Aboriginal & Torres Strait Islander health and mental health Need for metrics to reflect health outcomes	**Healthy Parks-Healthy people – Making Contact with Nature, Second Nature (HPHP Policy)**	**Realising the mental health benefits of contact with nature (HPHP Action Plan)** HPHP Policy and the case study are valued but under resourced initiatives Intersectoral structures and processes enabled HPHP Action Plan Opening policy space in the Health sector for mental health promotion through the development of the HPHP Action Plan Health sector influence potentially shaping case study possibilities into probabilities
Built Environment Sector	30-year Plan for Greater Adelaide MOU between DPTI and DH&A SA Housing Strategy	The Built environment is a setting that can promote wellbeing, health and mental health The links between urban form and physical and mental health are growing The social determinants of health are recognised within the sector Need for metrics to reflect health outcomes	**30-year Plan for Greater Adelaide**	**Bowden Redevelopment** Urban redevelopment at Bowden focuses on economic, social and environment outcomes The Bowden redevelopment has benefitted from intersectoral collaboration The concepts of wellbeing, liveability and placemaking facilitate a broader focus on mental health

Table 7.1 Summary of Finding

7.1 The consideration and framing of mental health in policy

It is understood that the Health sector has an important role in guiding the intersectoral partnerships that are essential to address the economic, social and political factors that impact health and psychological wellbeing (Kickbusch & Buckett, 2010). To do this effectively the Health sector needs to both hold and progress problematisations of health and mental health that are consistent with promotional practice. However, analysis has revealed that the Health sector largely fails to do this. The failure of both health and mental health policy and the sector to strategize and implement practice that supports health and mental health is highly significant given the centrality of the Health sector's role in guiding the work of other sectors. It is for this reason then, that health and mental health policy is considered at the beginning of this chapter.

7.1.1 The framing of mental health in Health policy

Mental health and psychological wellbeing are not evident in the majority of health policy

As stated, the *SA Public Health Plan* and the *SA Suicide Prevention Strategy,* which are discussed further into the chapter, developed policy and goals to address health and mental health; however, the majority of policies analysed were largely focussed on the development of strategy that addressed individual illness and mental illness. This is true of the following policies: *SA Health Care Plan*; *Health Service Framework for Older people*; *Chronic Disease Action Plan*; *SA Framework for Veterans*; *Alcohol and Other Drugs Strategy; Youth Mental Health and System of Care*; *Mental Health Guideline: Pathways to care*; *Aboriginal Health Care Policy;* and *Mental Health and Wellbeing*.

My findings indicated that the majority of health policies progress goals to address illness and mental illness by providing clinical services and individual treatment. These policies propose to 'enable health, mental health and wellbeing', by addressing illness and mental illness through the provision of medical or clinical treatment, which is viewed as the agent of change. Policies largely fail to acknowledge mental health and psychological wellbeing as a separate construct to mental illness, that is, a state of wellbeing, that can be supported and strengthened by enabling equal and equitable access to the social and structural determinants of health (CSDH, 2008) and by enabling healthy settings (Allen et al., 2014).

Further, by applying Bacchi's approach to Health sector's policies, I found that mental health was frequently conflated with or substituted for mental illness. Documents were titled mental health, whereas the content concerned mental illness. This is true of the *Mental Health and Wellbeing Policy*; *Mental Health Guideline: Pathways to Care Policy* and the *Youth Mental Health and System of Care* documents, all of which are discussed in more detail later in this section.

The consistent focus on mental illness in health policy and the dominant representation of mental illness, as a medical, psychiatric or psychological condition, leaves little opportunity for consideration of mental illness as a social construct or consideration of the impact of sociological phenomena such as violence, discrimination and loneliness on both physical and mental health.

Discussion of mental health as a state of psychological wellbeing, as defined by the WHO, is largely absent in policy, severely limiting the development of strategy that progresses mental health (read health). Likewise, my analysis of the *Alcohol and other Drugs Strategy,* discussed in Chapter 4, revealed that implicit in this policy, was the representation of alcohol and drug use as a biomedical (addiction) and criminal problem. Therefore, proposed strategies included treatment, surveillance and management. Strategies involving social or structural actions to address alcohol or drug use issues in the community were largely absent or not prioritised.

These issues of representation are considered further when I answer my second research question on the representation of mental health when I use Bacchi's theory on the power of problem representation in determining policy responses.

From my analysis of policy, I concluded that Health sector policy generally, excepting the *SA Public Health Plan* and the *SA Suicide Prevention Strategy,* fails to recognise the limitations of medical or clinical treatment in improving population health or mental health outcomes. My findings reflect the teachings of Rose, who stresses that medical or clinical treatments and high-risk prevention efforts can be appropriate and helpful for those individuals concerned, however they "quite fail to tackle the underlying reasons for there being a problem in the first place" (1989, p.410). In respect to this, clinical treatment fails to address the causes of incidence of illness or mental illness; rather it enables *recovery* and in the case of increasing age, disability and/or disorder, it enables *adjustment*.

The elevation of the biomedical model over the social view of health

My findings revealed that the biomedical model of health and mental health is dominant in all but four of the fourteen Health policies examined, that is: the *SA Public Health Plan*, the *Dental Health Promotion and Practice Guideline*, the *Prosperity for Longevity Plan* and the *SA Suicide Prevention Strategy.* These policies acknowledge the value of the biomedical model but primarily draw on a social view of health; the *Prosperity for Longevity Plan* weighting a social view of health significantly towards economic participation which is viewed as integral to healthy ageing (Oster et al. 2016). In all other policies the biomedical model is dominant, including the policy most central to mental health, the *Mental Health and Wellbeing Policy.* This policy strongly acknowledges the value of the social view of health in progressing mental health outcomes but data from the interviews confirmed the policy failed to progress strategies to address the SDH. This was also found in the *Aboriginal Health Care Plan*.

Interviewees added that where the biomedical model is dominant, health approaches associated with clinical and professional groups, health care providers, pharmaceutical organisations and specific disease and illness interest groups are privileged. They considered that those policy actors in the sector who held with a 'health' agenda as opposed to a 'health care' agenda, were marginalised by the present focus on individuals, illness and treatment. This meant failure to action health or mental health promotion and suggests a reinterpretation of health promotion in ways that suit their perceived institutional constraints (Smith, 2014) and coping with reduced resources and capacity, as is discussed in more detail later in the section.

Moreover, interviews with key health policy actors indicated a significant gap between stated policy objectives and implemented policy, in the majority of policy.

Interviewees consistently communicated that despite policy containing broader goals, implemented strategies were more likely to be focused on health care, clinical responses and service delivery for those groups identified as already subject to a chronic physical or mental illness, for example:

- *Suicide Prevention Policy* and the delivering of Mental Health First Aid (Health Sector Interviewee, #16)
- *Eat Well Be Active Strategy* and discontinuation of the strategy in favour of chronic disease management (Health Sector Interviewee, #12)
- *Aboriginal Health Care* and the prioritisation of individual medical management for chronic disease over community led and based initiatives (Health Sector Interviewee, #17)
- *Mental Health and Wellbeing* and the emphasis on the stepped model of care for those with mental illness (Health Sector Interviewee, #19)
- *Prosperity for Longevity* and the emphasis on elder rights, elder abuse and advanced care directives (Health Sector Interviewee, #14)

These actions are not unimportant however they strongly indicate how the dominance of the biomedical model has served to narrow health policy responses. These findings confirm the presence of 'lifestyle drift', in which health problems are acknowledged as socially based issues requiring structural approaches but the strategies employed 'drift' to narrow in on individualised biomedical or behavioural responses (Popay, Whitehall & Hunter, 2010; Baum & Fisher, 2014). Marmot and Allen (2014) further confirm 'lifestyle drift' and the 'overconcentration of health care' as significant barriers to action targeting the SDH. Baum, Laris et al. (2013) concur, emphasising how health policy is crowded out by health care policy. Labonte (2016) informs us of another barrier, that of *innovation*, where the application of technology is prioritised as a solution to health problems. This was evident in the *SA Health Care Plan* where clinical excellence, individual care and innovative technology is emphasised. It is also evident in the Natural Environment sector where policy to reduce the impact of climate change relies on innovation and technology and fails to progress strategy that address the role of the current economic imperative or human behaviour in continued environmental degradation (Hes and Du Pleiss, 2014, Hes, 2017).

The lack of strategy targeting the SDH revealed by my findings, reinforces the current research detailing the lack of and/or limited strategy targeting the social determinants of health in Australia (Hurley et al. 2010; Baum, Laris et al. 2013; Fisher, Baum, MacDougall, Newman & McDermott, 2016). Fisher et al. (2016) reported the barriers to actioning the SDH to include: the complexity of SDH policy, the dominance of medical power and paradigms, and weak advocacy for action that targets the SDH. Conversely, policy from the Natural and Built Environment sectors is not directly subject to the dominance of medical power or health care demand, although as will be discussed, the Natural Environment case study demonstrates the long arm of influence extended by medical privilege (Germov, 2014).

Importantly, however, the social view of health is integral to the *Public Health Plan* and the *SA Suicide Prevention Strategy* (despite the reference above to Mental Health First Aid). Both policies propose strategies relevant to social determinants of mental health, identifying social inclusion, stronger communities and intersectoral action as integral to improved mental health outcomes (Jane -Llopis et al. 2005; Friedli, 2009; Fisher & Baum, 2010; Allen et al. 2014). Further, interviewees reported that these strategies were, in part, being put into practice. Prior to discussing both these policies however, I review the findings in relation to the specific mental health policies examined.

7.1.2 The framing of mental health in Mental Health policy

The overt clinical focus in mental health policy

Critical scrutiny of the *Mental Health and Wellbeing Policy*, *Youth Mental Health-System of Care* and the *Mental Health Guideline-Pathway to Care* revealed a consistent focus on individual illness, clinical treatment, and medical systems of care. Interview data confirmed this finding. Mental health (read health) was not evident in these policies, rather it is a silence, as it was in *The Alcohol and Other Drugs Strategy* and the *Veterans Framework*. The *Mental Health and Wellbeing* policy, appears to offer policy space for mental health as a positive construct, however, interrogation of the language used in this policy reveals that 'recovery' and 'promotion' are consistently linked as paired processes associated with the delivery of the *stepped model of care,* for those with mental illness. In this context, the notion of promotion has been distorted and contracted (Smith, 2014), that is, the ideas about how to 'do promotion' are shaped to fit with a health model that prioritises individuals, the biomedical model and a clinical focus. Further, as stated the policy also appears to offer policy space for the social determinants of mental health but then distances itself from the SDH, stating this to be the responsibility of the welfare sector. It is the SA Public Health Plan and the SA Suicide Prevention Strategy that offer alternatives to this illness focus, which is discussed in detail further into the section.

The consistent reference to the '*stepped model of care'*, in all mental health policies examined, confirms that the central focus of current mental health policy is the implementation of mental health (read illness) service reform, which despite its potential benefits to those with mental illness, fails to action mental health promotion. This is contrary to the state's target (at the time) to '*Improve psychological wellbeing'* as articulated in the SA Strategic Plan (2011)[5], which failed to be referenced in the *Mental Health and Wellbeing Policy* but interestingly was referenced by the Built Environment sector in the *30-year Plan*. It is also contrary to the recommendations of the *Australian National Review of Mental Health Programmes and Services (2014)*, completed by *the National Mental Health Commission.*

As detailed in Chapter 2, the *National Mental Health Commission* (2014) reported that the current approaches to addressing the incidence and burden of mental illness, being predominately drawn from the medical and pharmacological treatment paradigms, were failing and that system change enabling a focus on promotion and prevention is required in addition to service reform. The current emphasis on mental health service reform in the *Mental Health and Wellbeing Policy* examined concerns regarding an improved model of care but not the paradigm restructure which was called for by the National Mental Health Commission (2014).

South Australian state policy and practice has failed to adopt the Commission's recommendations and failed to respond to the national criticism regarding the overreliance in mental health services on treatment approaches (Meadows & Bobevski, 2011; Jorm & Reavley, 2012; Jorm, 2018). Additionally, it has failed to respond to the need for policy and strategy to prioritise the social determinants of mental health (CSDH, 2008; Friedli, 2009; Allen et al., 2014) and failed to respond to the need for population health approaches to promote mental health (Rose, 2001; Brunner and Marmot, 2011). This failure is also evidenced federally where significant investment in individual clinical treatment, through the *Better Outcomes* scheme continues, despite evaluation that articulates the failure of the scheme to achieve improved mental health outcomes for all (Allen and Jackson, 2011; Rosenburg, Mendoza & Russell, 2012; Jorm, 2018). In this respect the individual remains the dominant subject of Australian health policy on mental health (Hurley et al. 2010).

Policy and practice that affects population mental health by prioritising social connection and inclusion, acceptance of diversity and support of community safety through the use of upstream, universal and intersectoral approaches (Hermann et al. 2004; Barry, 2007; WHO, 2014b) is largely absent in the Health sector, with, the exception being the *SA Public Health Plan* and the *SA Suicide Prevention Strategy* which I now discuss.

[5] The SA Strategic Plan, initiated in 2004 provided a state-wide framework for a sustainable development agenda that incorporated alternative success indicators to economic. Inclusive of community and environmental factors, the plan, developed 100 targets that included goals relevant to: health, education, employment, renewable energy and community safety (State Strategic Plan, 2011)

Mental health is evident in the Public Health and Suicide Prevention policies but unsupported in the sector

Both the *SA Public Health Plan* and the *SA Suicide Prevention Strategy* are policies in which mental health is evident and presented as both an individual and a social construct. Both policies provide policy framings that consider how an individual's context impacts their mental health, recognising the impact of the social determinants of health and the fact that many of the determinants are out of the individual's control. Articulating goals that work at a structural and community level, both policies recognise that health and mental health are not solely the responsibility of the individual but that some responsibility must fall to the whole of society, including our systems of government. However, the findings from Chapter 4 indicate that the legislative, structural and management changes over the last 10 years in the Health sector have negatively impacted the potential of both these policies to promote mental health, action the social determinants of mental health and guide the work of the sector. It is for these reasons, that neither the *SA Public Health Plan* nor the *SA Suicide Prevention Strategy Policy* was identified as a policy exemplar; however, I specifically discuss both in this section, given their significance to the research, starting with the *SA Public Health Plan*.

Highlighting the links between social isolation, loneliness and mental health, the *SA Public Health Plan*, articulates implementation strategies, such as progressing practice that supports community-based levels of social connection and inclusion, known to improve population mental health (Evans, 2003; Corcoran and Marshall, 2016; Barton, 2016). Addressing causes as opposed to symptoms, the plan seeks to improve population mental health, highlighting the need to address the social factors and inequalities implicated in the development of mental disorders (WHO, 2014b). The *SA Public Health Plan* presents strategies that are consistent with arguments that stress the need for mental health to become a much higher priority for public health (Parham, 2007; Wahlbeck, 2015; Hancock, 2018).

However, the downgrading of the State Government's role in public health, post 2011, evident through the shifting of public health responsibilities to local government, *Primary Health Networks* and *Public Health Partnerships* has served to distance the *SA Public Health Plan* from the Health sector. Further, two decisions made at the same time: the decision to combine previously separate clinical and public health roles at the executive level in the sector, merging the Chief Public Health Officer and Chief Medical Officer roles and the Executive Director of Mental Health and State Chief Psychiatrist (Siebert, 2017) roles must raise concern about the valuing of public health in the sector.

Interviewees questioned the shifting of public health responsibilities outside of the sector but also expressed hope about the possibilities for health promotion that this might also provide. They explained that councils were worried about 'cost shifting' but were also well positioned to effect community-based health promotion work, as is consistent with the *Strengthen community action* strategy of the Ottawa Charter (1986) and Healthy Cities (1988).

However, interviewees also expressed concern that neither local governments nor *Primary Health Networks* had a developed public health knowledge base from which to work, especially in relation in population mental health and that progress was slow. Additionally, although *Public Health Partnerships* has such a knowledge base, their resources were also reported to be very limited, impacting their ability to provide leadership, support or funding in support of the *SA Public Health Plan.* This reality challenges the hope that was expressed by some interviewees as to the opportunity for increased health promotion opportunities, as was suggested by Baum et al. (2017).

Working with both the biomedical model and the social view of health, the *SA Suicide Prevention Strategy,* also highlighted the links between social inclusion and mental health, progressing public health approaches that enabled intersectoral practice and community participation, while also highlighting the need to provide services and treatment for individuals at risk of self-harm. However, the interview analysis in Chapter 4 showed that the problem being addressed in the *Suicide Prevention Strategy* had shifted to a narrower focus and that current strategy was focussed on reducing the incidence of suicide by rethinking clinical services, providing mental health first aid and post suicide intervention services. The evidence indicated that Health sector resources directed towards progressing the intersectoral practice and support of community participation and collaboration had significantly been reduced post the McCann Review (2012). That is, the practice Parham (2007) considers essential to reducing the incidence of self-harm and suicide. She stressed the need for a public health approach to reduce the incidence of suicide and promote mental health, warning, that "Without the ongoing input of public health, it would be easy for the mental health sector to return to a predominantly medical paradigm…" (p.175).

These findings indicate the lack of support for mental health promotion in the sector. My findings support conclusions drawn by Littlejohns (2016) who found that the 'building blocks' necessary for the sector to effect health promotion had largely been removed over a 10-year period, and that the lack of health promotion governance, financing and workforce, must result in health promotion policy failure. Significantly, my interviewees expressed distress at the withdrawal of the state's direct influence over public health, surmising that in locating the work associated with the state's public health policy outside the Health sector, the public health approach loses ground internally and is unable to offer a counterweight to the dominance of the biomedical model. It is suggested that it is exactly this dynamic, which threatened the full implementation of the *SA Suicide Prevention Plan*.

The sense of frustration and resignation from Health sector policy actors attempting to focus on health, as opposed to health care and health promotion as opposed to clinical responses was a significant finding of this research. Policy actors clearly understood the evidence regarding the SDH and the need to act on social factors in order to promote health and mental health, prevent illness and reduce health and mental health inequities. However, they also clearly felt unable to act on this understanding within the context of Health sector policy suggesting that the dominant representations regarding mental health (read illness) were being determined elsewhere.

Demoralised policy actors relayed the reduced, if not removed mandate to practice health promotion stating the likelihood that promotion would be substituted for targeted prevention work orientated towards individual screening, monitoring and education (Smith, 2014), a finding that aligns with Jolley et al. (2014) and Littlejohns, Baum, Lawless & Freeman (2019).

As the application of Bacchi's approach reveals, the *SA Suicide Prevention Strategy*, has been developed to address the rising incidence of suicide in SA, which as highlighted in Chapter 2, is a concern for all but a confronting concern in relation to Aboriginal and Torres Strait Islanders.

The key indicators associated with the policy understandably link to reduced suicide rates, not increased levels of psychological wellbeing. Thus, it is paradoxical, perhaps, that some of the best examples of Health sector strategies to support population mental health and address mental health inequalities and inequities are present only when mental illness and the extreme outcomes of mental illness are acknowledged. This finding suggests that Health sector engagement in mental health is only activated when associated with diagnostic frameworks, a finding that is related to the prevailing representation of mental health within the Health sector as a disordered internal state as is discussed in the next section.

The use of diagnostic frameworks in mental health has long been acknowledged as problematic, serving to establish a definitive and defendable scope of practice but also serving to enable the medicalisation of ordinary life, the expansion of psychiatric diagnosis and the increased utilisation of psychotropic drugs to those previously considered healthy (Frances, 2013). Interviewees explained the different aspects of the dilemmas created with the use of diagnostic frameworks. The impact of the diagnostic framework on mental health stigma; the neglect of those in psychological distress until a diagnosis is made; the problematic linking of diagnosis to the ability to access a service; and the inadequacy of promoting individual help seeking, were all common themes raised by interviewees. However, of most significance for the interviewees, was that current strategy failed to prioritise the need to attend to the social issues underlying presentations of mental illness, that is, the adverse impacts of experiences of social and economic disadvantage, trauma, abuse and neglect. Interviewees considered that in predominantly attending to diagnosis as opposed to the social and environmental context underlying diagnosis, social issues were medicalised, and mental health inequities failed to be addressed. Further, the biomedical model's dominance was perpetuated in a vicious cycle that consistently distanced "social determinants type solutions" (Health Sector Interviewee, #15). In relation to this, Francis (2013) warns:

> *…the mislabelling of everyday problems as mental illness has shocking implications for individuals and society; stigmatising a healthy person as mentally ill leads to unnecessary, harmful medications, the narrowing of horizons, misallocation of medical resources and the draining of the budgets of families and the nation* (p.14).

Collectively the findings suggest that both the *SA Public Health Plan* and the *SA Suicide Prevention Strategy* are significantly compromised in their ability to contribute towards mental health promotion. Both have been rendered less effective through the removal of the building blocks necessary to health promotion practice and impacted by a raft of legislative, structural and management decisions within the sector.

Unlike the *Primary Prevention Plan* which was withdrawn, the *SA Public Health Plan* has effectively been outsourced and the *SA Suicide Prevention Strategy* has been limited to strategies that are short term, remedial (not addressing the social determinants of mental health or mental health inequalities) and have no real chance of reducing the scale of the problem. This finding concurs with Littlejohns (2016) who found an, "abdication of reorienting health services towards health promotion by the state" (p.138). As stated in the opening paragraph this finding has implications not only for the delivery of state health services but for the delivery of healthy public policy.

7.1.3 The framing of mental health in the non-Health sectors

Mental health and psychological wellbeing are evident in the Natural Environment and Built Environment sectors

Significantly, it is within the Natural Environment and Built Environment sectors examined in this thesis that we see mental health (read health) and psychological wellbeing considered, in some of the policies. Policies in both sectors demonstrated recognition of the link between health and mental health and the natural and built environments (Hancock, 2000; Evans, 2003; Maller et al. 2006; Sainsbury, Harris & Wise, 2011), however, this recognition was not evident in most policies in either sector. Analysis revealed that recognition was best afforded in the policy exemplars: *30-year plan for Greater Adelaide* and the *Healthy Parks, Healthy People- Making Contact with Nature, Second Nature* policy from which the nested case studies are drawn. In these policies both sectors demonstrated responsibility for contributing to population health and mental health. Both documents additionally frame policy that explicitly targets mental health. Specifically, both policies:

- Contain strategy that is consistent with the aims of the *Ottawa Charter* (1986); the *Healthy Cities* movement (1998) and *Health in all Policies* (2006).
- Are considered 'healthy public policy', where the distal determinants of mental health, presented in the Dahlgren and Whitehead (1991) and Barton and Grant (2006) socioecological models discussed in Chapter 3, have been actioned within the confines and capacities of the sector.
- Directly reference and discuss mental health and psychological wellbeing and develop strategy indicative of upstream approaches which have the potential to improve population mental health.

- Consider mental health outcomes for both individuals and communities, as is consistent with the Community Wellbeing model presented in Chapter 1.

However, it is important not to overemphasise this finding, given that only 4 of the 13 Natural and Built Environment policies examined (*SA Housing Strategy*, *MOU between DPTI & DH&A, 30-year Plan* from the Built Environment sector and *Healthy Parks Healthy People Strategy* from the Natural Environment sector) were considered exemplars of 'healthy public policy'.

Given this result, it is concluded that current practice is a significant way from the Health sector goal of *Health in ALL Policies*. The fact that the *SA Housing Strategy* and the *MOU between DPTI & Health* were both considered inactive by policy actors at the time of interviewing, serves to further strengthen this conclusion.

As stated, mental health and psychological wellbeing are evident in the *30-year Plan*. The plan discussed mental health as a situated and relational concept, a psychological state impacted on by the quality of context and environment. The plan identified a number of strategies that aligned with the *South Australian Strategic Plan* (Retracted in June 2018), including the goal of *Improving psychological wellbeing,* explicitly stating the importance of providing safe urban settings, public open space and greenspace for recreational activity and social interaction, to improve population mental health outcomes. As highlighted in the literature review, the relationship between the built environment and physical health has had greater recognition in both research and policy than mental health (Kelly et al. 2012; Jackson, Dannenberg & Frumkin, 2013) but the *30-year plan* stands as an exception to this by directly linking the urban environment to both mental health and mental illness. This is a significant finding. The *30-year Plan* acknowledges a responsibility in addressing the "current epidemics of obesity and depression" (p.100). The use of this phrase clearly endorses a role for the sector in progressing population-based approaches to health, mental health and mental illness.

Likewise, mental health and psychological wellbeing are evident in the *HPHP policy.* The policy is framed to address health and wellbeing from a socioecological perspective, acknowledging the links between the health of people and the health of the environment, specifically highlighting the significance of those links for Indigenous Australians (Rose, 1996; Garnett & Sithole, 2008; Kingsley, Townsend, Phillips & Aldous, 2009). The policy articulates both population and individual approaches to support mental health, promoting the idea of greenspace, not only as a park or reserve, but as open public space that is integrated into the built environment. The extent to which mental health is directly considered in the *Healthy Parks, Healthy People Strategy - Making Contact with Nature, Second Nature* policy is again a significant finding, standing in direct contrast to the Health sector, which has neither a health nor mental health promotion policy.

Importantly however, the *HPHP Policy* has been enabled by *Public Health Partnerships,* which is discussed further in the third section of this chapter.

More generally, analysis indicates a consistent use of the term *wellbeing* in the framing of policy in both sectors was also evident. *Wellbeing* was used as a broad concept covering both physical and psychological health and individual and community wellbeing. Additionally, positive wellbeing was linked to economic, social and environmental factors, to varying extents as will be discussed.

Atkinson (2013) discusses the increased use of the term wellbeing in public policy as progressive, suggesting that despite criticism of the concept for its ambiguity and lack of conceptual clarity (Dodge, Daly, Huyton & Sanders, 2012; Henriques, Kleinman & Asselin, 2014), it is exactly this ambiguity that serves to invite different perspectives and supports the involvement of different disciplines and intersectoral partnerships. This has proved to be the case especially in the Built Environment sector, where policy actors consistently referenced wellbeing as a broad and varied concept and an outcome related to aspects of the urban environment that relate to liveability, including access to the social determinants of health. This is consistent with Badland et al. (2014) who reported a growing policy interest in urban liveability and its relationship to health and social outcomes.

Failure to discuss mental health in the *SA Climate Change Strategy (2015-2050) – Towards a low carbon economy* was a notable silence, given population wellbeing, health and mental health is significantly threatened by the continued focus on economic growth and the possibility of ecological collapse, related to the inadequacy of current responses to ameliorate climate change impacts (McMichael, Woodruff & Hales, 2006; Friel, Marmot, McMichael, Kjellstrom & Vagero, 2007). This silence hints at the findings from the Built Environment case study, discussed later in the third section of this chapter, in which economic development goals were positioned above environmental and social goals, despite the employment of measures which framed all three goals as integral to sustainable development.

Further evidence of the recognition of a need to progress population mental health in both the Natural and Built Environment sectors is demonstrated by the findings that relate to the expressed desire for metrics to capture the health outcomes achieved through the implementation of their policy. It is an interesting finding that policy actors in both sectors expressed the view that if such outcomes were assessed and results disseminated, greater acknowledgement and valuing of these outcomes from government would ensue. Policy actors held the view that decisions regarding the funding of intersectoral work to support health outcomes would be valued if quantitative results could be compiled. They expressed disappointment and to some extent, befuddlement, that neither their sector nor the Health sector demonstrated interest in gaining or using such data.

In summary, this section answered the first research question discussing the extent of consideration of mental health in policy from the three sectors under examination.

Mental health was minimally considered in the Health sector, where illness and mental illness are the dominant subjects of policy, privileging the biomedical model and the use of diagnostic frameworks. Importantly, however the Health sector does assume responsibility for the delivery of clinical treatment and services for those with mental illness and the Transforming Health initiative, and the new hospital has arguably strengthened a commitment to the provision of improved quality healthcare.

Within the Natural and Built Environment sectors the extent of consideration of mental health is also relatively unconsidered, as indicated by the small number of policies initially selected for analysis and the smaller number of policies that progressed to the second stage of research. However, as the findings indicated the *HPHP- Making Contact with Nature Second Nature* and the *30-year plan for Greater Adelaide* were found to purposefully and directly take responsibility for contributing to developing healthy settings that support access to the natural and built environment elements that support
mental health.

7.2 The representation of mental health in the three sectors

This section answers the second research question by summarising the analysis of data relevant to the representation of mental health and the assumptions underpinning them, in the sectors under examination. It is the application of Bacchi's methods as discussed in Chapter 3 that allow the opportunity to examine and articulate the implicit understandings that are conveyed in policy. Examination of these assumptions enables insight into why policies propose certain strategies and solutions and fail to recognise others. Bacchi's approach serves to "allow for a critical appraisal of the ways in which government policies and the representations of particular problems, in specific contexts, impact on people's realities" (Pantazis, 2016, p. 5) and in my clinical scenario in Chapter 1, I sought to illustrate why such analysis matters. The scenario illustrates how government (health) policies and clinical practice guidelines via the application of clinical and diagnostic frameworks impacted Steve and his Mum's realities. In relation to this Burr (2003) states, "Applying techniques of assessment and categorisation, the biomedical model can have a significant impact by imposing a "framework to people's everyday experience of themselves and their lives, their subjectivity…" (p.73).

I start by making that point that mental health (read health) is largely unrepresented in policy. Nowhere in the Health sector policies are there goals or strategies consistent with the WHO definition of mental health. Instead, the dominant representation of mental health is as an absence of disease.

Further the dominant focus in health policy is on mental illness, despite references to mental health, illustrating the pervasiveness of discourse that substitutes the phrase mental health for mental illness.

I discuss the prevailing representations of mental health (read illness) implicit in Health sector policy as revealed through Bacchi's analysis of both the policy and the interviews before discussing the alternative representations revealed in the non-Health sectors.

Three key representations of mental health (read illness) are central to Health sector policy and practice and these are discussed. These representations are not uniform and consistent across the sector, policy and practice. Importantly, it is not suggested that the representations do not offer a particular set of knowledges and techniques which are helpful and serve to support recovery from illness and a return to health. However, as prevailing representations they also serve to occlude alternative representations, as the findings from the Health sector interviewees demonstrated.

Firstly, the representation of mental illness in Health sector policy is predominately as an internalised and disordered psychiatric, psychological or neurological state which is a binary (either you are ill or not) and a static state (requiring clinical and pharmacological treatment to progress recovery). Individuals largely, fail to be a subject of policy until illness is acknowledged. Significantly, graduated levels of mental health status depicted on a spectrum from poor mental health to excellent mental health i.e. 'illness, languishing, wellness, flourishing' (Ryff, 1989; Keyes, 2002, 2007; Seligman, 2011) are largely absent in health policy, yet, significantly, these concepts were consistently discussed by interviewees. The fallacy of only recognising illness once a diagnosis or state of crisis is reached, was highlighted by the majority of policy actors, one policy actor equating the situation to one of waiting for blood lead levels to rise to a defined criterion before acting. These findings replicated the main theme to emerge from the 1800 submissions received by the *National Mental Health Commission* (2014), which was that meaningful help was not available until after a person had deteriorated to the point of crisis, making neither economic nor humanitarian sense.

Secondly, the representation of mental illness as individual pathology in policy fails to value the extent to which social, economic and environmental factors impact mental health. "Too often lost is the full biopsychosocial systemic understanding of individual patients in their life context" (Raven & Parry, 2012, p. 512). Socioeconomic inequalities predispose people to the development of mental illness, meaning that those who are most disadvantaged are at most risk. As stated, the failure of policy to address social inequalities (Fisher & Baum, 2010) was a significant of source of frustration for interviewees, who variously stressed needs to: contextualise mental health issues; acknowledge the social gradient and the impact of social position on health (Brunner & Marmot, 2011) and position mental health as a concept relevant not only to individuals but to families and communities (Friedli, 2009).

A significant number of interviewees stressed that without addressing these factors, government fails patients, who in all probability, return to the same circumstances, that made them sick (Corburn, 2015).

In failing to enact strategy that addresses the structural inequalities associated with mental illness, many in our communities continue to struggle with gaining access to the social determinants of health, allowing disadvantage to translate across multiple generations, further entrenching health inequity (Friedli, 2009).

Thirdly, the representation of mental illness as being located in the brain and/or mind separate to other physical health issues has resulted in health policies that fail to fully acknowledge links between psychology and biology.

Research that links psychology and biology continues to provide evidence of how chronic toxic stress affects a range of health issues (Friedli, 2009; Corburn, 2015) and is a key mediator of social impacts on mental health (Fisher & Baum, 2010). Prolonged exposure to stress has been linked to the development of cardiovascular and immune system health problems (Wilkinson & Marmot, 2003) and to depression and anxiety (Hermann et al. 2004), which fail to be recognised, acknowledged or responded to, given this representation. I would particularly like to highlight the chronic stress associated with loneliness. Loneliness as a health risk factor is a significant silence in current policy despite research indicating that loneliness is a rising public health issue in Australia (Kelly et al. 2012; Kelly & Donegan, 2015; Lim, 2018) and as a risk factor has a similar health impact to high blood pressure, lack of exercise, obesity, or smoking (Cacioppo, Hawkley, Norman & Berntson, 2011). This finding hints at the privileging of physical health over mental health in the discipline of public health, which Hancock (2018) and Patel et al. (2018) report as having neglected mental health.

In contrast, the representation of mental health (read health) in both the Built Environment and Natural Environment sectors, is as an outcome influenced by the conditions in which people live; an outcome that relates to health and the broader concept of wellbeing, as discussed in Chapter 1.

The Built Environment represented mental health (read health) as a part of both health and wellbeing. Mental health was viewed to be an outcome related to the quality of the urban settings in which we grow, live, work and age; and as an outcome related to physical activity and, to a lesser extent, social interaction in the neighbourhood. Community safety, adequate housing, road connectivity and walkability were concepts that were referenced in policy and cited by policy actors as central to population health and wellbeing (Barton et al. 2015; Giles-Corti et al. 2016). These concepts relate to both the physical and social elements of urban infrastructure, elements that policies and policy actors assumed a level of responsibility for and in doing so demonstrated an understanding that mental health is not only about the individual but about living conditions (Sainsbury et al. 2011).

Policy actors reinforced this understanding by discussing the health and mental health benefits of having access to lower income housing options, age appropriate housing and safe and connected neighbourhoods.

Mental health was also represented as an outcome related to individual behaviour i.e. walking but policy actors constantly iterated that in creating a walkable urban environment, both physical and mental health could be improved. The concept of walkability was consistently referred to in policy and by policy actors who represented mental health (and physical health) as an outcome associated with walking and green environments but also with incidental social interaction (Sugiyama et al. 2008; Kaczynski & Glover, 2012). As indicated in Chapter 6, however, despite quotes to the contrary, policy actors stressed that the representation of mental health as a social issue was less established in the sector.

Likewise, the Natural Environment represented mental health (read health) as a part of health and wellbeing. Representation of mental health in the Natural Environment sector is as a component of health aligned with physical, social, spiritual and cultural aspects of health. In part this representation is reflective of an understanding and valuing within the sector of the deep relationships and interconnectedness between nature and humans as described in literature on deep ecology (Naess, 1973) and biophilia (Wilson, 1984). Both these influences strengthen the representation of mental health in the sector as a relational and situational phenomenon (Atkinson, 2013) a health outcome related to the environments, both built and natural, in which people grow, live, work and age (Ottawa Charter for Health Promotion, 1986).

Interestingly, the findings indicated that the representation of mental health as a relational and situational phenomenon in the Natural Environment sector, extends beyond the idea that contact with nature is positive for mental health, to also recognise such contact as potentially beneficial for mental illness. Consequently, contact with nature can be seen to both enhance mental health (Maller et al. 2006) and remediate mental illness (Pryor, Townsend, Maller & Field, 2006). References from policy actors to green prescriptions, ecotherapy, mindfulness walks and forest bathing were confirmatory of remedial practices that support individual mental health and illness. While the research strongly supports the benefits associated with these practices (Kaplan & Kaplan, 1989; Korpela at al., 2001; Wolsko & Lindberg, 2013) the dilemma is that this representation links easily to individual treatment with the attendant biomedical assumptions. As such, this risks attention being focussed on individual not population approaches (Lewis & Townsend, 2015) which is discussed further in the following section.

In summary, the Health sector's dominant focus on mental illness, largely, precludes a representation of mental health (read health), as is consistent with the findings regarding health policy framing.

The Built Environment and Natural Environment sectors however, consider mental health and represent it as a component of health and wellbeing, however, there were only four policies where these representations are present in policy and only two of these were considered current by policy actors: the *30-year Plan* and the He*althy Parks, Healthy People- Making Contact with Nature, second Nature Policy*.

These are exemplary of 'healthy public policies', however, the way that mental health and illness are represented in these sectors still leads to significant limitations in the kinds of approaches that are prioritised and implemented. Kickbusch and Buckett (2010) stressed a range of sector-based governance issues that can threaten the successful implementation of such policies, which I discuss in this next section as one of the disablers to the implementation of policy that supports population mental health.

7.3 What helps and hinders policy and practice that progresses population mental health?

Overview

In summary, the bad news delivered by the research findings thus far, is that the action on the social determinants of mental health is significantly impacted by the current framing of most health policy given it predominately concerns individuals, illness and treatment. The representation of mental health as illness and illness as related to individual pathology underlies that framing. Collectively, they are illustrative of what is discussed by Baum (2019) as biomedical individualisation. This represents significant missed opportunities to progress population mental health by the Health sector. It fails to respond to the National Mental Health Review (2014) which detailed recommendations for a whole-of-system reform "shifting funding to more efficient and effective upstream supports and services" (p.5, National Mental Health Programmes and Services Summary, 2014) to both promote mental health and address the incidence of mental illness.

The good news delivered by the research findings, is that both the Natural and the Built Environment sectors have constructed policy that acknowledges a role in contributing towards both health and mental health. In the policy exemplars and the case studies, both sectors have demonstrated responsibility for developing and actioning healthy public policy that has the potential to promote population mental health. They do this by actioning the social, economic and environmental determinants of mental health that lie within their policy domain. However, neither sector has applied this approach consistently or comprehensively, as is needed to progress a *Health in All Policies* approach (Kickbusch and Buckett, 2010). Evidence from the research indicates that despite the successes of the case studies: *HPHP – Realising the mental health benefits of contact with nature* and the *Bowden redevelopment*, there is difficulty in justifying and embedding health as a legitimate goal of the majority of policy in both the Natural and Built Environment sectors.

In this final section I consider the key themes discussed in the preceding sections, regarding policy framing and problem representations in all three sectors and the two policy exemplars and instances of policy implementation, the nested case studies. Both case studies provide examples of how the broader discourse discussed in each policy exemplar has been enacted. Firstly, I use the evidence from the findings to discuss the diversity and complexity of factors that have enabled or disabled action to promote population mental health. Secondly, I outline the implications of these findings for policy and practice.

Four significant factors relevant to the promotion of mental health are discussed in this section.

As I discuss these factors, it becomes evident that under certain conditions what might otherwise be an enabler can operate as a disabler, and where this is the case, I discuss both, acknowledging the complexity that exists between phenomena and context.

7.3.1 Enablers - Wellbeing and Liveability and Intersectoral collaboration

7.3.1.1. Wellbeing and Liveability

The concept of wellbeing was referenced in both policy exemplars and in many other policies analysed. Reference to wellbeing in policy variously related to access to the social determinants of health, the health of a community, as a composite term combining physical and mental health or as a term equivalent to holistic health. In using this term broadly, policy is enabled to focus on the individual, the collective and the systems that all interact to support health. Supporting a systems approach, Atkinson (2013) discusses the benefits of wellbeing as an open concept asserting that it supports the framing of policy that works with context, interactions and processes which can be applied individually but also collectively. Viewing wellbeing as an outcome related to the situational and relational, Atkinson states, "*Shifting the focus from individual acquisition and foregrounding relationality and place offers new ways to understand wellbeing…"* (2013, p.138) and further positions wellbeing as central to the built environment.

This focus on locating wellbeing within a relational and situational context as opposed to an individual context is evident in both the policy exemplars and case studies of the non-Health sectors and is highly significant to mental health. In the *30-year plan* and in the *Bowden redevelopment* there is a focus on the importance of *sense of place* and *sense of community* to mental health (Francis et al. 2012; Anderson & Baldwin, 2017). In the *HPHP – Making Contact with Nature Second Nature* and *HPHP – Realising the Mental Health Benefits of Contact with Nature*, there is a focus on the importance of *relationship with the environment* for mental health (Townsend & Weerasuriya, 2010).

The enabling impact of wellbeing is highly significant in the broad based *HPHP policy*, which is recognised here as a significant public mental health approach, prioritising contact with nature for both individuals and communities (Maller et al. 2006; Townsend et al. 2015). The findings revealed that the broader discourse in the policy was implemented in the nested case study and in the initiative the *Five ways to Wellbeing.* All strategies focused on people's relationship with nature through various physical, social and psychological pathways emphasising and validating the need for access to urban based greenery, nature playgrounds, parks and reserves to support health and mental health and the case study specifically focussed on the relationship between contact with nature and mental health. The policy and case study reference the continuum of mental health, shifting away from the binary thinking and closed categories associated with the representation of mental health in the Health sector. This enables the *HPHP-policy* and the *HPHP-case study* to assume a role in both preventing and ameliorating mental illness and in promoting positive mental health, health and wellbeing.

The *HPHP-policy* also stressed the reciprocity of such a relationship, that is, the strategy supports the wellbeing of people *and* the environment. It is hoped that by supporting an increased valuing of the environment, the outstanding need to better value ecosystem biodiversity and integrity will be enabled, benefitting the long-term health and wellbeing of all (Hartig et al. 2007; Lewis & Townsend, 2015). The problematisation presented in the *HPHP-policy* is consistent with representation of health and mental health in the Natural Environment sector, linking human health to the global ecosystem as conveyed in Barton and Grant's (2006) settlement map. However, as other policy analysis in Chapter 5, has indicated, this representation is not consistent in the policy portfolio i.e. the *NRM Plan* and the *SA Climate Strategy*.

Policy analysis also indicated that the range of proposed strategies in the *HPHP policy* are yet to be fully realised, despite their significant potential benefit for population and mental health. As an exemplar, the third strategy in the policy*, Promoting the Cultural Value of Country for Aboriginal Health and Wellbeing* which has much to offer the health and mental health of Indigenous people through the reconnection of kin, country and culture (O'Brien & Rigney, 2006; Garnett & Sithole, 2008; Kingsley, Townsend et al. 2009) has not been enacted. This strategy provides solutions that are designed to support the healing of Indigenous people and communities and additionally support a greater appreciation of the importance of connection to place for all. Again, this strategy supports mental health through relational processes that support a *sense of community* and *sense of place*.

It is of significance that it is a Natural Environment sector policy that presents an alternative to the illness-based prevention and treatment programmes offered by the Health sector's *Aboriginal Health Care Plan, Alcohol and other Drugs Strategy* and the *Mental Health and Wellbeing Policy.* which propose targeted treatment interventions to address the high incidence of chronic and mental illness for the Indigenous population.

The enabling impact of the concept of wellbeing in the *30-year Plan* is also highly significant. The findings from 6.3.2, indicated that the sector is in the process of conceptually shifting from an understanding that links the urban environment, walkability and physical health to an understanding that links the urban environment, walkability and social interaction and wellbeing (understood as encompassing mental health). In developing built environments that are equally concerned with material infrastructure and social processes, health and mental health are enabled (Rice & Hancock, 2011). Despite social connection being increasingly supported by digital technology and networks, "… for many people, place-based social networks remain critical to their sense of identity, social support and mental health" (Barton, 2016, p.100). This finding indicates the importance of developing neighbourhoods in which people can frequent healthy places and spaces in which they can feel safe and socially connected.

In combination with wellbeing, the concepts of liveability and placemaking have emerged strongly in the data and the findings suggest that these concepts will potentially enable a bigger emphasis on mental health (read health). These linked concepts have the capacity to embed the consideration of health and wellbeing as integral to urban planning and to support a relational and situational view of health. Liveability particularly stands out in the policy exemplars as a concept that has both currency and validity.

In the *HPHP-Policy*, the strategy: *Green infrastructure in Urban settings* presents opportunity to work jointly with the Built Environment sector to improve the quality, quantity and accessibly of a range of greenspaces in urban areas. This strategy additionally links to the concept of liveability and references the objectives of the *30-year plan*, clearly identifying liveability as a joint goal, stating, "We will work jointly to explore policies and programmes that reduce vehicle use, increase active transport, enhancing the liveability of Adelaide" (p. 37).

The first of three objectives in the *30-year Plan* is to *Maintain and increase liveability*, which is monitored annually. Referencing the need for a liveable city to have efficient transport, access to greenspace, options for employment and recreation, sustainable development, low pollution and noise exposure and housing affordability, the policy exemplar is consistent with many of the physical aspects of a healthy city (WHO, 1986; Barton et al. 2015; Barton 2017) but not the processes as will be discussed. The broader discourse proposed by the *30-year Plan* then has not been fully realised in the case study, despite significant achievements particularly in relation to economic and environmental outcomes. It is argued later in this section that the overbearing economic priorities have challenged the ability to achieve social outcomes and health equity at Bowden. Both social equity and cultural vitality, two of the four essential components necessary for community wellbeing, as indicated by the Community model of wellbeing, illustrated in Chapter 1, have not been prioritised in the development at Bowden.

The concept of placemaking also emerged as a significant enabler of health and mental health in the *Bowden redevelopment* by enabling a *sense of place and community*. Placemaking did not feature in the *30-year Plan* suggesting it to be an approach that is applied discriminately (i.e. not equitably) as is later discussed. A concept most associated with urban or city renewal projects as opposed to urban areas more generally, placemaking at Bowden has been recognised nationally as providing an example of thoughtful and effective action that can connect people by enhancing the social and recreational fabric of the city (Heart Foundation, 2018). Despite the recognition of this project and its outcomes for improved health and quality of life, it needs to be acknowledged that the Bowden town square was a commercially driven project presumably linked not only to the quality of the development but to the potential for profit. That is, not a community-based activity promoting participation in community and civic life. However, the council supported street painting and the local community garden are examples of placemaking that have real and ongoing potential to enable mental health by supporting a *sense of place* and *sense of community*.

Such activities also support participation in local decision making, enabling residents to have some level of control over their immediate environs and community direction which is in itself positive for health (CSDH, 2008; Marmot et al. 2012).

In summary, Atkinson (2013) suggests that a broad understanding of wellbeing, "offers a conceptual unifier across different sectors…" (p. 139), and reference to wellbeing in all sectors and in the policy exemplars would suggest this to be so. My research suggests that a broader understanding of liveability does the same. Because liveability is a concept that has currency in a range of different sectors, it thereby lends itself to intersectoral partnerships that can potentially support place-based social outcomes and wellbeing (Badland et al. 2014). Badland et al. state, 'If planners use a liveability framework based on the social determinants of health, healthy and liveable communities will be developed" (2014, p.70).

In the following section I discuss intersectoral collaboration. The findings show that intersectoral collaboration, supported by the Public Health Partnership initiative has supported a policy focus on health and mental health in both *30-year Plan* and *HPHP-Policy*.

7.3.1.2 Intersectoral Collaboration

Intersectoral collaboration is discussed here as an enabler of policy and policy action progressing health and mental health and in this research the focus has primarily been between the Health sector, and each of the Built Environment and Natural environment sectors, although all sectors are implicated as potential enablers.

Intersectoral collaboration played a significant role in facilitating both the policy exemplars and the case studies but there are significant factors threatening the continued viability of this practice as reported by policy actors in all three sectors examined in my research. Additionally, in relation to the *HPHP case study*, intersectoral collaboration was viewed to have both enabled and limited outcomes as will also be discussed in this section.

Overwhelmingly, the importance of intersectoral processes to supporting health and mental health promotion was highlighted by all policy actors interviewed. These processes were considered necessary to address the SDH, although it was noted that some policy actors failed to discuss health inequities as was also found by van Eyk, Harris et al. (2017).

Two processes were identified as pertinent to collaboration: a historical building of shared understandings and trust over time; and engagement with the Public Health partnership mechanisms. In relation to the *30-year Plan* and the *Bowden redevelopment* both have benefitted from historical collaboration processes and collaboration with *PHP*. In relation to the *HPHP policy – Making Contact with Nature, Second Nature* and the *HPHP case study -Realising the Mental Health Benefits of Contact with Nature,* the enabler was collaboration with *PHP*.

Interviewees stressed the importance of intersectoral processes to instituting healthy public policy, understanding the role of the Health sector to be one of stewardship, that is, offering guidance to other sectors regarding the ability to affect the SDH and generate healthy public policy (Sturgeon, 2007; Kickbusch & Buckett, 2010). Concern was expressed in the interviews about the fragility and viability of intersectoral collaboration generally, and interestingly, specific concern was expressed by Natural Environment and Health sector interviewees regarding the *HPHP policy* and the *HPHP case study*, despite endorsement at both a political and executive government level, as noted in 5.3.1. Policy actors understood the *HPHP policy* to be vulnerable as it presented a policy framing that was consistent with health promotion, not healthcare. Also, policy actors understood that withdrawal of authorisation for collaborative practice was highly possible, given intersectoral processes were not embedded institutionally in either department.

Policy actors from the Built Environment and Health sectors, also expressed concern, although the *30-year Plan* as a foundational policy document was not at risk of withdrawal. Their concern related to securing continued commitment to intersectoral practice so as to maintain the focus on health in the Built Environment sector, a commitment that was well demonstrated by the decision to use a triple bottom line approach at the *Bowden redevelopment*. Policy actors referred to the *Health in Planning (2009-2012)* project (Arthurson et al. 2016) and the benefits that followed from the work including the production of three pivotal healthy urban planning documents detailed in 6.3.2. They stressed that the now diminishing intersectoral relationships established at that time were integral to the health and mental health focus in the *30-year plan* and had produced documents and processes that had informed the *Bowden redevelopment.*

Further, they reported a reduced opportunity to revitalise intersectoral work which reinforced concern about current government commitment to intersectoral practice. This is despite the literature that stresses the necessity and benefits of intersectoral approaches to address social inequalities and reduce health inequities (Hancock, 2000; Corburn, 2015). Corburn (2015) makes the point that when governments make a commitment to intersectoral practice much can be done at a place-based level to promote health.

Reflecting on the current lack of leadership, authorisation and mandate for intersectoral work, interviewees felt unsure about the possibility of new collaborative opportunities. This finding is consistent with Littlejohns et al. (2019) who reported that the leadership, governance and resources associated with health promotion, including intersectoral practice, had been significantly reduced i.e. '*abandoned*' in the Health sector by 2013, the year following the McCann review which recommended cuts to health promotion. Interview data confirmed this, as is noted in 4.2.1. It is also consistent with Jolley et al. (2014), Baum, Laris et al. 2013 and Fisher et al. (2016). Yet, despite this, the Public Health Partnerships mechanisms supported the development of the *HPHP Policy and case study*, enabling a policy space for mental health promotion, where previously there was none.

The findings indicated (5.3.2) that the considerable progression of intersectoral work practice focussed on *HPHP*, from 2015-2017, enabled a continued and sustained focus from the initial *MOU* through to the development and implementation of policy, a policy that continues to be current. International and national focus on Natureplay and *HPHP*, particularly from the state of Victoria (Townsend et al. 2015); and political endorsement at the time was also considered helpful by policy actors in opening policy windows (Kingdon, 2011). However, the findings have indicated that just as the Public Health partnership mechanism acted as an enabler, it has also acted to influence and limit strategy selection from the broader policy. In selecting the *Making contact with nature, second nature* strategy (1 of 7 strategies) a space for mental health promotion was opened up but it appears to have quickly become associated with individual mental health (read illness) demand. That is, the strategy has been enlisted by the Department of Health and the Mental Health Commission to 'help' individuals with mental illness, including those at suicidal risk. An outcome consistent with lifestyle drift (Popay, Whitehead & Hunter, 2010).

This outcome also appears to have weakened the ability of the Natural Environment staff to contribute whereas alternative *HPHP* strategies would have invited more intersectoral collaboration. Strategies such as the previously discussed *Promoting the cultural value of country for Aboriginal Health and Wellbeing* and *Green Infrastructure in Urban Settings,* but also *Community Health and Wellbeing in a Changing Climate*, *Childhood development in nature,* and *Biodiversity, Conservation and Health* were overlooked in the selection of a strategy and are yet to be implemented.

For all sectors, the sense of positive energy expressed by policy actors engaged in any intersectoral work, not only for those associated with the policy exemplars and case studies but for those working on small joint projects to progress policy for alternative housing options, safe neighbourhoods or social inclusion was significant, as this is was viewed as work that sought to *make things better*.

That is, intersectoral practice is not only enabling of policy but is enabling of policy actors and their investment and commitment to health promotion practice. For those in the Health sector, this was highly significant given the power of biomedical individualism within the sector and the marginalisation of population health approaches. As discussed however, the constant concern regarding the authorisation of intersectoral collaboration and security of funding tempered this energy, as did noted staff reductions in the Health Promotion and *PHP* teams, highlighted previously by Littlejohns (2016). Of note, was the difficulty for some non-Health interviewees in understanding the overarching dominance of the clinical focus in the Health sector and its implication for the underfunding of non-clinical work within the sector, which on occasion introduced significant tension, and at times anger at what some non-Health interviewees perceived as a failure of the Health sector to act proactively, which could be perceived as an accurate appraisal. Where this dynamic was evident, the maintenance of effective intersectoral relationships was difficult.

As an aside, in June 2019, the Public Health Partnership webpage had been removed from the Health sector website, no doubt raising further doubt for concerned policy actors over the continued viability. If the mechanism is removed this action would remove the mandate for future intersectoral work and further separate the only Health sector mechanism that utilises a public health framework, further privileging the biomedical and clinical models active in the sector. The ability of the Health sector, to work collaboratively and guide healthy public policy and practice would be significantly impaired if this mechanism were to be removed. Again, this would also be contrary to the recommendations of *the National Mental Health Commission* (2014).

In summary, intersectoral collaboration has played a significant role in the development and implementation of healthy public policy, including the *30-year plan* and the *HPHP-policy*. Intersectoral collaboration was viewed as highly significant in opening a policy space for mental health promotion but equally this policy space was subject to influences which limited the range of policy response. Interviewees were generally strong advocates of the intersectoral practice enabled by the *PHP* team and the previous *Health in All Policies* Unit, acknowledging this as an effective mechanism which is needed to address the determinants of mental health that lie outside of the domain of Health policy (Patel, 2015; Wahlbeck, 2015; Hancock, 2018). Interviewees largely understood that given the current healthcare focus demonstrated in Health sector policy framings, intersectoral practice was at risk, citing concerns about leadership, governance and resources.

7.3.2 Disablers - Absence of social outcome and wellbeing measurements and Economic priorities

7.3.2.1 Absence of social outcome and wellbeing measurements

Not having access to indicators of improved social outcomes or wellbeing, which were associated with policy and practice in both the non-Health sectors, was viewed by a significant number of policy actors as a disabler. The interviews indicated that both the Natural and the Built Environment sector actors understood that within their policy portfolio, there was selected practice contributing to improved health and wellbeing outcomes but that this commonly failed to be recognised or acknowledged, either by executives in their sector or the Health sector. Policy actors understood some means of measuring health outcomes to be necessary, given the present pervasive work culture that demands measurements to validate time and resources (Muller, 2018). Policy actors expressed frustration with this situation and with what they perceived to be a lack of interest in healthy public policy from the Health sector, perceiving that the Health sector 'should' be interested in how selected Natural or Built Environment policy has contributed to improved population health outcomes. However, as discussed, the healthcare focus in the Health sector and the concern regarding the *PHP* must raise questions about how committed the sector is to the development of healthy public policy and whole-of-government approaches to addressing the SDH and health inequity (Fisher et al. 2016) or to measuring relevant outcomes.

Natural and Built Environment policy actors proposed that social and wellbeing indicators are needed to raise the profile of improved health outcomes (Badland et al. 2014; Baum, 2019) and further that Health sector guidance and support is needed to help with this. However, this is also an issue for the Health sector who largely fail to measure improved health or mental health (read health) indicators but as interviewees indicated would infer improved health or mental health from a reduction in illness i.e. decreased numbers of people with diabetes complications or self-harm. Additionally, given the sector's focus on individuals, illness and treatment, indicators are more likely to relate to individual as opposed to population outcomes. There is however, methodology, that can measure improvements in wellbeing associated with the development of a sense of place and/or sense of community (Baldwin, 2005; Anderson & Baldwin, Corburn & Bhatia, 2007). Such measurements would enable the benefits associated with regular access to local landscapes (Korpela et al. 2001; Townsend, Henderson-Wilson, Ramikissoon &Weerasuriya, 2018) to prove their value to the population, including the older population, given the restorative benefits span the generations (Scopelleti & Giuliani, 2004). The question of whether urban based research which focusses on wellbeing would then be used to inform policy remains, but if it was, then it would potentially lead to improvements in the proximity and quality of parks for all (Sturm & Cohen, 2014), in part addressing health inequities (Astell Burt et al.2014).

Interestingly, social outcomes and community wellbeing indicators were referenced in the *30-year Plan*, initially developed at a time when the *S.A. Strategic Plan* was active. Ministers were required to present plans addressing relevant targets and stewardship of this task was provided by the Health sector's *Health in All Policies* unit (Kickbusch & Buckett, 2010). This process enabled a system of accountability, a regulatory system that focussed sectors and politicians on the outstanding need to govern for health (Baum, 2019) but this process has now been withdrawn.

Baum (2019) notes the outstanding need to highlight social and wellbeing outcomes such as improved population health or health equity rather than GDP as a measure of social progress and community health, separate to individual health outcomes. Alternatives such as Health Impact Assessments or Equity Focussed Health Impact assessments (Harris & Spickett, 2011; Corburn, 2015); the use of the UN Sustainable Development Goal's (Labonte, 2016; van Eyk, Harris, et al. 2017) or Liveability indicators (Badland et al. 2014) all offer under-utilised alternatives, which could potentially serve to highlight the relationships between policy, settings and mental health.

Given that the findings have indicated the concept of liveability has currency and validity in both the Natural Environment and Built Environment sectors, linking measurement to liveability indicators may serve to support to support a collective focus on wellbeing, health and mental health. Badland, et al. (2014) identify the potential of liveability indicators to shift the focus to the urban and environmental contexts which determine the health and wellbeing of the population. She stresses however, the need for liveability measures to be consistent with a social view of health.

More broadly progressing the consistent use of a liveability indicator may support the development of shared understandings, goals and strategies relating to the SDH, not only across sectors, but inter-governmentally (CSDH, 2008). This has pertinency for SA given that the *SA Public Health Plan* is in part being enacted by local councils, who arguably have the best capacity to identify community-based issues, their precursors, influences and effects and hopefully solutions (Corburn, 2015).

7.3.2.2 Economic Priorities

Economic priorities were conveyed in policy documents, particularly within the Built Environment sector policy and by policy actors. In this section I discuss these findings in relation to the growing influence of neoliberal values and policy practices in Australian public policy since the 1980s, and in particular two aspects of this: pressure on public policy to contribute to economic growth and to reduce public spending. The Health sector also experiences pressure to reduce public spending but additionally, practice within the sector has been ideologically influenced by the strength of individual values inherent to neoliberal economic approaches which have served to reinforce and privilege a biomedical view of health.

Three interwoven themes have emerged in the data which are discussed in this section: 1. How the Health sector has increasingly been constructed as responsible for the provision of healthcare not health; 2. How economic priorities have served to delay and withdraw policy that supports population health; and 3. How all sectors are seen to have a role to contribute to economic growth and reduce spending.

These three features of policy are all likely to impact population health. In relation to this Hancock (1999) stressed that economic growth is a profound threat to population health and more recently, Labonte & Stuckler (2016) articulated the need for economic reform (economic regulation, rejection of austerity measures, progressive taxation and a shift to a green economy) to reduce inequalities and improve population health. That is, in continuing to invest in a neoliberal economic framework that prioritises economic growth and development, social and environmental outcomes are backgrounded. This has significant impact on planetary and human health (Hes, 2016) generally and in relation to my research, mental health and psychological wellbeing, given the increasing socio-cultural expectations to be independent, to achieve and to cope despite economic recessions and austerity measures (Stavropoulos, 2008; Henderson, 2012; Curl and Kearns, 2015).

Individualism, one of the central tenets of a neoliberal economic framework supports a sociocultural value where "…*each individual is held responsible and accountable for his or her own actions and wellbeing"* (Harvey, 2007, p.65). Given this understanding, the individual focus enables the application of the biomedical model which is favoured because: a) it does not challenge the power of the medical profession; and b) it does not raise 'uncomfortable' issues about socioeconomic inequality or the impacts of large corporations on health, such as in the food industry (Baum & Fisher, 2014) or the pharmaceutical industry in relation to mental health (Raven & Parry, 2012). The individualism of neoliberal theory offers little space to support a view that acknowledges the impact of economic, social and environmental factors on health as is illustrated in socioecological models. It is unsurprising therefore, given the political and economic context, that health policy that addresses the SDH and health equity or progresses population health and mental health is significantly challenged or absent as found in my research, and as other authors have noted (Labonte, 2016; Baum & Freeman, 2016).

The findings from the Health sector reflect the dominance of individualism, the biomedical model and clinical approaches which conflate to form a triumvirate that has proved resistant to policy and practice that supports a focus on the SDH, health equity or health promotion. Collectively, the concepts have combined to enable policy and practice within the Health sector that focusses on medical and behavioural interventions to address diagnosed individual health issues.

Given the sector's focus on the health of older people (*Health Service Framework for Older People*; *Chronic Disease Action Plan* & and *Prosperity for Longevity*) this manifests in action addressing individual chronic illness (Baum & Fisher, 2014) but not socially based issues such as isolation, loneliness and depression (Kelly & Donegan, 2015) suggesting that the dominant clinical focus is acting as a barrier to addressing the sociological phenomena underlying health issues.

Kelly et al (2012) report that the development of Australian cities has contributed to a loss of social connection and a rising incidence of loneliness for Australians (Lim, 2018), especially affecting the mental health of older people, single parents and those living in single person households. As my findings from the representation of mental health in the Health sector revealed however, policy has responded to physiological health risk factors (hypertension, obesity, diabetes), but loneliness as a psychological and sociological risk factor was not considered. Its absence in policy relevant to the health of older people was most noted. Significantly, in both the *SA Public Health Plan* and the *SA Suicide Prevention strategy*, loneliness and social isolation are recognised as a significant risk to population mental health but strategy developed to support community-based action enabling social connection and inclusion has failed to be progressed by the sector; a strategy not consistent with the triumvirate. That is, community-based practice seeking to impact social factors and health equity is not aligned with the prevailing individualising discourse within the sector (Fisher et al. 2016).

The need to reduce spending in the Health sector is another economic priority consistent with a neoliberal economic framework and policy actors well understood the contradiction between committing to the biomedical model with rising medical, pathological, radiological and pharmacological technologies and treatments, and the need to reduce spending. The findings from Health sector policy actors reported reduced, rationed and delayed policy responses as a strategy to manage healthcare demand, which can only increase given improved life expectancy. Given the current neoliberal economic framework solutions to this dilemma include increased privatisation of the health system which threatens population health outcomes and increases health inequities (Baum, 2015; Labonte, 2016; Labonte & Stuckler, 2016; Raphael, 2017).

The Natural and Built Environment sectors offer alternatives to the dominance of the triumvirate of individualism, biomedical model and clinical approaches as the findings reveal, as both sectors frame policy that links mental health (read health) to the relational and situational contexts in which people live their lives. However, both sectors are also subject to the broader macroeconomic framework and demands to contribute to economic growth.

Within the Built Environment sector and specifically *DPTI* and *Renewal SA* there is a focus on supporting economic growth through infrastructure development. The *30-year Plan, Renewing Our Urban Future: Unlocking South Australia's Potential* and the *Planning Reform-A Driver of Economic Growth* all overtly present goals relevant to growing the state economy.

Analysis of the *Housing Strategy for SA* likewise reveals that while the stated goal is to improve access to housing options, it is considered that this will best be achieved by using the market to further development and increase supply. Within the Natural Environment sector policies also emphasise a need to contribute to the state economy albeit less overtly given that the traditional role of the sector is to conserve and protect.

It is important to acknowledge that the focus on economic growth does not preclude policies from enabling health and mental health, as the literature on co-benefits indicates (van Eyk et al. 2017). It is equally important to acknowledge the significance of economic stability and financial security to wellbeing, health and mental health (Marmot & Bell, 2012).

The Bowden redevelopment case study articulated two key goals: 1. To demonstrate urban redevelopment according to the principles and practices of the *30-year Plan;* and 2. To contribute to state economic growth and employment, like much of the Built Environment sector policy. Given this pre-requisite for the *Bowden redevelopment* it is to be expected that economic goals feature, but additionally the development has demonstrated a focus on liveability and sustainability as is consistent with the principles and practices of the *30-year Plan.* As stated, many of the physical features are consistent with a *Healthy City,* however a *Healthy City*, additionally values social inclusion and equity and the participation of residents in place-based decision-making, enabling a sense of agency over local factors impacting health and wellbeing (Hancock, 2000). The case study findings indicated that commitment to a *One Planet* living framework which included an equity goal was discontinued, the definition of liveability associated with the Greenstar accreditation failed to make reference the social determinants of health, attempts to support housing affordability were limited and a report regarding Bowden by *SA Better Together* indicated a need for improved community participation. It is argued therefore, that the Bowden redevelopment did not adequately attend to social inclusion and health equity, which has served to limit the benefits of the health promoting features of the neighbourhood to those with higher social and economic resources who can afford to live there. In this sense, it failed to bridge social capital.

This interpretation is consistent with the *Grattan Institute* report on 'Social Cities', which confirmed that development in Australian cities achieves economic outcomes first, then environmental and lastly social (Kelly et al., 2012). They state, "*Our understanding of the human dimensions of cities lags behind our understanding of economic and environmental issues…In planning, building and redeveloping our cities, we consistently consider such factors as financial cost, economic productivity and environmental footprint. The social impact of projects however is rarely given equivalent emphasis"* (p.49). They suggest that for Australian cities, environmental and social goals are only implemented if these objectives do not hinder growth and that where environmental objectives are pursued, they partially serve the economic imperative.

The market demand for housing and urban environments that are environmentally sustainable is demonstrated by the popularity of Bowden but there is no perceived market for social sustainability, although interestingly, the advertising material associated with the *Bowden redevelopment*, would suggest that there is a market for living in places where you can be a part of a community i.e. *Bowden is a neighbourhood where the good old days are back* (Renewal SA, 2019).

This finding raises a question about whether, instead of government sectors, it is commercial developers responding to the research that indicates that Australian cities need urban development that supports social connection (Kelly et al. 2012).

The findings indicated that the *HPHP-policy* and *HPHP-case study* were highly valued by policy actors as discussed in 5.3.1, yet had inadequate resourcing limiting the full implementation of the policy and additionally the ability to widely disseminate the *HPHP-case study* and the Five Ways to wellbeing initiative. Given the lack of resources and the selection of a strategy primarily enacted at the individual level, opportunity for community and population-based practice was backgrounded. Speculatively, if the strategy were adopted more broadly by the Built Environment sector, other Public Health partners such as education or disseminated to workplaces or local councils it could potentially offer significant benefits to population mental health, support pro-environmental behaviours and address equity issues in terms of access to quality greenspace and green public open space. Lewis and Townsend (2015) stress that it is these cross sectoral universal applications of policies such as the *HPHP policy*, that are needed for both population health and ecological health to be enabled.

For example, the Five ways to wellbeing initiative could of been applied to the Bowden development. Development could have been reviewed for its capacity to develop prosocial places (*Connect*); prioritise access to third places for cooperative community activity (*Give*); develop attractive, engaging and stimulating environments that direct attention away from internal preoccupations and worries (*Take notice* and *Keep learning*); and develop areas that facilitate physical activity (*Be Active*) (Corcoran & Marshall, 2016). In progressing the *Five ways to wellbeing* initiative at a community or population based level, neighbourhoods are potentially enabled to have equal access to quality greenspace (Mitchell & Popham, 2007; Francis, Wood et al. 2012) green streetscapes (van Dillen, de Vries et al. 2013) and local microfeatures in public open spaces (Anderson & Baldwin, 2017; Cattell, Dines et al. 2008). Such outcomes will in turn, support social connection. The involvement of local councils in the initiative would enable increased engagement with local residents resulting in opportunity for community participation and over time increases in *sense of community* and *sense of place.*

When discussing planning for equity in built environments, Barton (2017) stresses that "*Urban planning is not about favouring one group of the population over another but attempting to create places that can accommodate and provide for all the different needs that people have*" (p. 114).

Built environments can't address the causes of poverty and disadvantage but Barton goes on to say that, "*Built environment policies ameliorate or exacerbate income differentials through their impact on employment, housing and movement*" (p.116), which means that Bowden, with its emphasis on economic regeneration, medium density housing and public transport, is well positioned to ameliorate these inequities but this potential has been significantly compromised by failure to achieve housing or accommodation affordability in the area.

The *30-year plan* and the *Bowden redevelopment* both address housing affordability, however, the strategy implemented has failed, as indicated by the skewed demographic of residents. The measures to support affordability (a requirement of 15% affordable housing in the development) were viewed as failing in practice because they translated into 'less' housing i.e. less rooms, less bathrooms, no or only one allocated car space and decreased proximity to amenities and services; moderately more affordable to people in the middle income bracket, but not accessible to those on lower incomes. The result is that the redevelopment is currently failing to support an inclusive and diverse community, preventing low income earners and families from having equal and equitable access to living in the area with its noted health benefits and access to the city (Harvey, 2008). The added disadvantage is that in failing to afford purchasing a home, those on lower incomes fail to benefit from the accumulation of capital resources associated with home ownership (Corburn, 2009).

The corollary of failing to ensure a range of affordable housing options in developments like Bowden, with access to jobs and transport, is that new housing that is somewhat more affordable for people on lower incomes (for purchase or private rental) "*gets built in areas with poor access to jobs, exacerbating the growing social and economic divide"* (Kelly et al. 2012, p.163) and failing to arrest health and mental health inequities. This outcome is not compatible with the broader agenda of the *30-year Plan*, which aims to progress a more systemic, city wide approach to urban development across the Greater Adelaide area. This outcome it is suggested, reflects the dominance of the economic priority at Bowden, despite commitment at both the policy and planning level to value economic, social and environmental outcomes i.e. the commitment to a triple bottom line. This finding aligns with Cole et al. (2017) who question that ability to achieve equity in such developments, stating, "The submission of urban planning and social policy to market-orientated regulatory processes is preventing policy interventions from effectively promoting health and environmental equity" (p.394).

This submission is illustrated in the housing affordability issue but also in the failure to acknowledge the history of the area. From my observation of the area, it is the industrial history of the area that remains evident and celebrated but not the social history or recognition of the land as Kaurna land, and the development illustrates what Eckenwiler (2018) discusses as non-inclusive placemaking.

This again reflects the economic priority that underlies the development focus, which has served to enable the development of a sustainable and healthy urban environment but failed to foster a socially inclusive and diverse community. Commitment to achieving social outcomes would have enabled viable housing options for low income earners, like that provided by the *Hindmarsh Housing Cooperative* who support equitable accommodation options i.e. rent calculated relative to income, which interestingly is immediately adjacent to the Bowden redevelopment. Commitment to achieving social outcomes would have also regarded the ongoing history of local Kaurna people in the area who have cultural and spiritual connections with the River Torrens area.
Telfer & Malone (2012) identified the continuing link to the Hindmarsh-River Torrens area, *Karraundongga*, an area where communities continue to meet along the river although the majority of the riverside area has now been developed as greenspace for Bowden residents. It is from this area that the following photograph below was taken.

Figure 7.1 Photo taken from the adjacent parklands (Park Terrace)

The access to and use of the Hindmarsh-River Torrens area/*Karraundongga*, relates strongly to the following statement from Kaurna elder, Uncle Lewis O'Brien, "In most cases it is non-Indigenous individuals and organisations that have the human, financial resources and power to contribute effectively to strategies of sharing space" (O'Brien & Rigney, 2006, p.28). The finding highlights both social and environmental injustice for the local Kaurna people and the continuing and linked nature of these injustices. Again, the implementation of the *Promoting the Cultural Value of Country for Aboriginal Health and Wellbeing* strategy from the *HPHP Policy* has much to offer the outstanding need for an increased valuing of relationship to country for Indigenous Australians which could support a shift in the unfair power dynamic (O'Brien & Rigney, 2006).

The findings from the Natural Environment sector, indicate it is the sector most cognisant of the need to support environmental justice in relation to land access and rights for Aboriginal people.

A complex issue in urban areas, Jackson et al. (2017) discuss Indigenous rights in urban planning, stressing the profoundly detrimental impact (including health and mental health) of past planning processes on Aboriginal people and communities, highlighting the importance of redressing this wrong by working towards both rural/regional and urban land justice now. They advocate for a genuine and just relationship between planning bodies and Indigenous Australians.

In summary both the Natural Environment and Built environment case studies have provided data relevant to how policy and practice can support population health and mental health.

The Built Environment sector has provided a template for urban planning that considers mental health, but the identified challenges will be to shift from healthy 'boutique' urban environments to healthy urban environments for all. The Natural Environment sector has provided policy and practice that reinforces the need to attend to the relationship between ecological and environment health and health of people to maintain mental health. The identified challenge will be to maintain a focus on the relational and situational aspect of mental health.

7.4 Policy and Practice Implications

In this section I identify three state-based goals that relate to how the examined sectors can further progress population mental health and psychological wellbeing. I discuss how these applied goals relate directly to the research findings regarding policy framing, representation of mental health and enabling practice. I acknowledge the current promising work identified in the sectors examined but stress that expanded roles and responsibilities are needed to effectively promote population mental health and psychological wellbeing.

Firstly, I *highlight* the research implications more generally.

Health sector

Healthy public policy or HiAP approaches, as broad-based measures to improve population health and mental health are enabled by intersectoral practices and processes which are necessary to support collaborative work to address the social and structural determinants of health. These processes need to be characterised by authority, governance and resources both inside and outside the Health sector. Health sectors have an important role in governing for health and mental health.

All sectors discussed the *Public Health Partnerships* as a valuable mechanism in supporting intersectoral practice. The fact that both policy exemplars have benefitted from historical and/or current *PHP* mechanisms is a powerful statement about its value to the development of healthy public policy. It is essential therefore that the *PHP* team and processes continue to be authorised and supported within the Health sector.

It is further recommended that *PHP* be expanded to enable new initiatives to be developed and disseminated and to provide knowledge and technical support relevant to the development and progression of those initiatives. Given the current gap in the sector regarding mental health promotion it is recommended that future collaborations are focussed on this outstanding need. Finally, re-establishing a Chief Public Health Officer would provide leadership for an increased focus on population health and mental health within the sector by addressing the social factors that impact mental health and mental health inequities.

Natural Environment sector

Policy with an underlying representation of mental health as an outcome associated with the social view of health enables a shift from the dominant thinking of mental illness as primarily an internal disorder to mental health as a state of wellbeing, that is linked to relational and situational factors. The natural environment offers opportunities to support the mental health of all and healthy public policy that maximises opportunity to access greenspace and live and work in urban environments with integrated greenspace will support population mental health. Such practice enables a focus on settings as opposed to individuals.

The policy exemplar *Healthy Parks, Healthy People-Making Contact with Nature, Second Nature* offers seven strategies and it is recommended that all seven strategies are implemented. All seven strategies offer opportunities to progress equitable access to greenspace and nature with significant health and mental health benefits for all the population including local residents, school children and Indigenous Australians. The sectors could work jointly with local governments given their increased public health responsibilities, with stewardship support from the *PHP* team. A further recommendation is that the *HPHP - Case study*, *Realising the Mental Health Benefits of Contact with Nature* and the *Five Ways to Wellbeing* initiative be continued and expanded into local governments and schools.

The representation of mental health within the Natural Environment sector is consistent with a holistic and relational understanding of health and mental health, enabling the framing of policy that is settings based and therefore enabling of promotional practice. Dissemination of this understanding more broadly would support the health of both people and the environment. The benefit of this representation of health and mental health for the wellbeing of Aboriginal and Torres Strait islanders cannot be understated and it is recommended that the third *HPHP-Policy* strategy, *Promoting the Cultural Value of Country for Aboriginal Health and Wellbeing* be urgently implemented.

Built Environment sector

Wellbeing and liveability are concepts that are inclusive of health and mental health and have currency and validity in the Built Environment sector, in addition to a range of sectors proving opportunity for intersectoral practice that maximises healthy and equitable urban development.

Broader measures of social and economic progress than the GDP are needed to progress population health and environmental sustainability. The use of wellbeing indicators and selective liveability indicators may provide alternative options.

The growing focus on wellbeing and its relationship to urban liveability in the Built Environment sector has been found to be a significant enabler of healthy and sustainable urban development. In relation to this, it is recommended that the links between mental health and the physical (places and spaces) and social aspects of the urban environment (social connection, community safety and community participation) be strengthened. Liveability indicators that reference the social determinants of health and mental health and link to socioecological models of health may further support these links. However, the use of liveability indicators that focus on economic and prosperity outcomes may serve to reinforce social and health inequalities and inequities.

Bowden has demonstrated a development that has significant urban features that support health and wellbeing and the *30-year Plan* outlines aims to progress these features equitably over time across the Greater Adelaide area. I stress that disadvantaged areas are in more immediate need of such development and it is recommended that disadvantaged areas be prioritised as this will in part, address health and mental health inequities. The use of the *Five Ways to Wellbeing* initiative through *DPTI*, *Housing SA*, *Renewal SA* and the *Office for Design and Architecture SA* would consistently allow mental health to be a focus in urban planning. Involvement and collaboration with local governments in this planning is essential.

These recommendations are made in the awareness that the research has indicated that all sectors are disabled by the struggle to accommodate their goals and their budgets, given the economic priorities on contributing to the economy and reducing spending. Comment on this is out of scope of this research, however, it is important to note that despite the punishing constraints of the economic framework, the limited policy framings and the preoccupation with biomedical individualism, the findings indicated that policy actors across all sectors sought to activate healthy public policy where possible. This is an observation but an important one.

There was an acute awareness from the majority of policy actors of the rising incidence of mental health issues across the population and a desire to contribute to helping to make things better, especially for those who have less and who are affected by social ills.

An excerpt from an Arundhati Roy essay, The Cost of Living, in *My Seditious Heart* was used here to further reinforce the importance of the contributions of policy actors but has been removed due to copyright restrictions. Available online from: https://poet4justicedotwordpressdotcom.wordpress.com/2012/11/25/to-love-to-be/

7.5 Research limitations

My research has examined mental health and psychological wellbeing in the policy and practice of three sectors and is consistent with the understanding that mental health and psychological wellbeing is impacted by policy from a range of sectors. This has enabled a comprehensive review of diverse policy from the selected sectors but much unexamined policy exists in other sectors, which are also positioned to enable healthy public policy. Drawing on South Australian policy over a specified time period I secured a manageable and discrete set of policies for research but I also became increasingly aware of the dynamic nature of policy and the departments and sectors that develop and practice policy, given a significant number of policies researched have now been changed, succeeded or discontinued. State review processes and a state election over the period of research served to further highlight the political context in which policy and policy processes operate. Given the dynamic nature of policy and the political process there are limits on the ability to reflect on and/or apply research understandings. Having said that, the two policy exemplars and the case studies examined in detail in the research are ongoing, supporting research currency and applicability.

In presenting both specific and general research implications I highlight my acknowledgement that the research findings relate to a specific place and time allowing for more explicit implications to be drawn locally, however, more general implications which linked to the published literature were also made.

Additionally, the research is limited to state policy and while local government and federal influences and policies are acknowledged, they were excluded from the research serving to ensure manageability of data, but also serving to limit the insight gained from the examination of broader systemic influences.

Finally, interviewing academics provided an alternative voice to that of policy actors however it is also acknowledged that stakeholders outside of the state government would have also offered further perspectives i.e. the voice of the community and/or local government. However, the boundaries set for my research served its aims well, a four- stage research design has made for a progressive analysis of state policy and practice from multiple sources.

7.6 Concluding Comment

In the opening pages of this thesis I detailed the story of a client and his family needing increased access to: 1. Adequate housing, a safe, connected and walkable neighbourhood, access to greenspace and access to schools and amenities; 2. Intergenerational and family based social and emotional supports; and 3. Individually focussed clinical therapy, in that order.

The Health system responded to the third need, by providing a service that enabled the use of a diagnostic framework and access to clinical therapy. This was a potentially helpful response but an incomplete one and not one without iatrogenic risk. It was from this clinical experience that the goals of my research developed. How do we enable a focus in mental health policy and practice that shifts the emphasis from the individual to the community; from illness to health; and from intervention to promotion?

My findings revealed two state government policies which demonstrated potential to promote mental health and psychological wellbeing, policies outside of the Health sector. Both policies, the *HPHP-Making Contact with Nature Second Nature* from the Natural Environment sector and the *30-year Plan* from the Built Environment sector were explicitly concerned with mental health. The framing of strategy in these policies constructed responsibility for the development of settings that promote mental health. As such these policy exemplars signalled that where policy represents mental health as an outcome related to social, economic and natural environmental factors; and where the framing of policy acknowledges responsibility for contributing to population mental health, strategy is developed with potential to promote population mental health.

The two instances of practice associated with the policies: the *HPHP-Realising the mental health benefits of contact with nature* and the *Bowden redevelopment* presented opportunities to further examine what helps to progress practice the supports population mental health.

The *Bowden redevelopment case study* utilised planning whereby residents had access to transport, local services and activities, employment opportunities, sustainable housing and quality greenspace, essentially many of the features of a *Healthy City*. Growing interest in the broader concept of wellbeing in policy and practice was found to enable a focus on health that was inclusive of mental health. Likewise, liveability brought into focus those aspects of the built environment that support wellbeing and the need to consider health as an outcome related to the relationship between people and place and space. Intersectoral collaboration was noted as a significant enabler. A *sense of community* and a *sense of place* were discussed as important to mental health and were supported by considered placemaking at Bowden. However, failure to focus on adequate housing affordability and social equity was found to be a barrier to progressing population mental health.

The *Healthy Parks, Healthy People case study* supported mental health through contact with nature. Psychological restoration, emotional regulation and mindfulness were specifically supported by the

Five Ways to wellbeing initiative. An initiative that can be enacted at an individual, community and/or population level, the *Five ways to wellbeing* initiative was initially associated with action to enable mental health and support those with mental illness. The opening of a policy window for mental health promotion was highly significant but supporting the *Five ways to wellbeing* at a population level and a full implementation of the *HPHP-policy* are yet to be achieved. Intersectoral processes were assessed to be both enabling and to some extent disabling, given the influence of a Health sector, currently characterised by individuals, illness and clinical treatment.

Disablers included the inability to value and measure social and wellbeing indicators and the growing influence of economic priorities, which were viewed to have impaired the capacity to achieve social outcomes at Bowden and the ability to fully implement *HPHP-Making Contact with Nature, Second Nature.* It was suggested that the individualism inherent to neoliberalism was aligned with the individualised, biomedical and clinical focus in Health sector policy.

The Health sector largely progressed policy to address mental illness despite reference to mental health, and the sector had largely withdrawn from the primary prevention or public health work that offers strategy to promote both health and mental health. No policy exemplar was able to be selected from the Health sector and consequently, there was no case study.

Both selected policy exemplars continue as active policy and it is hoped that there will be a shift towards an increased focus on social equity at Bowden; a population-based application of the *Five Ways to wellbeing* and a full implementation of the *HPHP-Policy*. It is recommended that further research progress the literature regarding the links between measures of liveability, social indicators and wellbeing and the urban environment. The use of Health Impact Assessments could potentially draw attention to the links between the urban environment and mental health, which would better inform urban planning policies to support mental health and mental health equity.

In addition to adding to the literature base, such research would also offer opportunities for intersectoral collaboration and collectively strengthen a focus on mental health and psychological wellbeing across a range of government sectors. Ideally this would also involve local councils given their increased public health responsibilities regarding the implementation of the *SA Public Health Plan*.

It is also recommended that further research progress the literature base regarding the Healthy Parks, Healthy People initiative as an important for population and ecological health. Ensuring equitable quality greenspace and biodiversity in all urban environments is necessary to promote population mental health. Integrated and biodiverse rich environments are important to the health of people, animals and plant communities, and research that adds to the literature regarding the inextricable nature of the relationship between ecological health and human health is urgently needed to disrupt the dominance of economic priorities.

In summary, this research contributes new insights to the existing literature by teasing apart how mental health is problematised within the three sectors and what the implications of this are for shaping the responses proposed and pursued in the policies. Bacchi's *What's the problem represented to be approach?* has not previously been applied to questions of mental health in policy. In utilising Bacchi's approach it is specifically hoped that the research contributes to a more realistic understanding of the limits of the biomedical model in enabling mental health and addressing mental illness, allowing socioecological models of health to be better valued and utilised in policy in all sectors. Doing this will have widespread benefits for the mental health of everyone and especially for those living in disadvantaged circumstances.

APPENDICES

Appendix A: List of Policies Analysed

SECTOR	POLICIES ANALYSED
HEALTH (14)	SA Health Care Plan (2009-2018)
	Health Service Framework for Older People (2009-2016)
	Chronic Disease Action Plan for SA (2009-2018)
	SA Framework for Veterans Health Care (2012-2016)
	Alcohol and Other Drugs Strategy (2011-2016)
	Youth Mental Health and System of Care Framework (2012)
	Mental Health Guideline - Pathways to Care Policy (2014-2019)
	Health Promotion Practice Guidelines - SA Dental (2012-2015)
	Prosperity and Longevity – SA's Ageing Plan, Our Vision (2014-2019)
	Aboriginal Health Care Plan (2010-2015)
	Eat Well Be Active Strategy (2011-2016)
	SA: A Better Place to Live – Promoting and protecting our community's health and wellbeing (2013)
	SA Mental Health and Wellbeing Policy (2010-2015)
	SA Suicide Prevention Strategy (2012-2016)
NATURAL ENVIRONMENT (7)	Natural Resources Management Plan – Our Place, Our Future (2012-2017)
	Water for Good – Ensuring our water future to 2050 (2009-2050)
	SA Climate Change Strategy – Towards a low carbon economy (2012-2050)
	Aboriginal Reconciliation Action Plan (2013-2014)
	DEWNR Corporate Plan (2014-2015)
	People and Parks Strategy - A Visitor Strategy for South Australia's National Parks, Marine Parks and Reserves (2012)
	Healthy Parks Healthy People MOU & TOR (2013-2015)

BUILT ENVIRONMENT (6)	Road Safety Action Plan (2013-2016)
	Renewing Our Urban Future: Unlocking South Australia's potential (2015)
	Planning Reform – A Driver of Economic Growth (2014)
	MOU between the Department of Health and Ageing and the Department of Planning, Transport and Infrastructure (2013-2015)
	The Housing Strategy for South Australia: Building a Stronger South Australia (2013-2018)
	30-year Plan for Greater Adelaide (2010-2040)
TOTAL	**27 Policies**

Appendix B: Nvivo coding framework

Nvivo Coding Nodes		
Primary Nodes	**Secondary nodes**	**Subcategories**
References health		
References mental health		
References mental illness		
Policy representation	*Government interpretation of problem*	
	Government perception of appropriate action	
Population cohort focus	*Individual*	
	Whole of Population	
	Specific groups focus	*Disadvantaged, Indigenous, Aged, Disabled*
Assumptions about the stated/implied origin of health problem	*Individual - Biomedical, lack of knowledge, poor behavioural choices*	
	Circumstances/Conditions of living	
	Social, cultural, political, environment impacts	
Paradigms used for health/mental health outcomes	*Promotion*	
	Prevention	
	Treatment	
Approaches for health/mental health outcomes	*Singular approach*	
	Intersectoral approach	*NGO's, other state of national departments, other*
References other policies		
References economic priority		
Convergence of evidence of policy document and interview data (Added at Stage 3)		
Reference made to the case studies - HPHP Mental Health Action Plan or Bowden redevelopment (Added at Stage 4)		

Appendix C: Letter of Introduction

LETTER OF INTRODUCTION

Dear Sir/Madam,

This letter is to introduce Jane Fitzgerald who is a post graduate research student at the Southgate Institute of Health, Society and Equity, in the School of Medicine, Faculty of Medicine, Nursing and Health Sciences at Flinders University.

Jane is undertaking research to examine how policy may work to support and promote population based mental health and psychological wellbeing. Jane's research will lead to the production of a thesis and possibly other publications. Jane will also provide feedback on her findings to participants via a presentation and a written summary.

Jane would like to invite you to assist with this project by agreeing to be involved in an interview. Approximately, one hour of your time, on one occasion would be required. When attending the interview, Jane will produce her student card, which carries a photograph, as proof of identity.

Please be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis or other publications.

You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.
Since Jane intends to make an audio recording of the interview, she will seek your consent, on the attached form, to record the interview and to use the recording or a transcription in preparing the thesis and other publications, on the condition that your name or identity is not revealed. Jane will make the de identified recording available to other researchers i.e. her supervisors on the same conditions but your interview data will never be shown to people outside the research team, or people employed by the SA Government. It may also be necessary to make the recording available to a professional transcriber who has signed a confidential agreement.

Any enquiries you may have concerning this project should be directed to me at the address given above or by telephone on 08 7221 8410 or by fax 08 7221 8424.

Thank you for your attention and assistance.

Yours sincerely

Professor Fran Baum
Matthew Flinders Distinguished Professor
Director, Southgate Institute for Health, Society & Equity
Southgate Institute for Health, Society & Equity
Room 2.05, Health Sciences Building Flinders University Sturt Road | Bedford Park | South Australia 5042

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 7015). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

Appendix D: Research Information Sheet

INFORMATION SHEET

Title: The social determinants of health and psychological wellbeing: Improving the mental health of all through broad based policy and intersectoral action.

Researchers:

Mrs Jane Fitzgerald

Southgate Institute for Health, Society and Equity, School of Medicine, Faculty of Medicine, Nursing and Health Sciences

Flinders University

Ph.: 08 7221 8542

Supervisor(s):

Professor Fran Baum

Southgate Institute for Health, Society and Equity, School of Medicine, Faculty of Medicine, Nursing and Health Sciences

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Dr. Toni Delany

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Flinders University

Ph.: 08 7221 8466

Dr. Matt Fisher

Southgate Institute for Health, Society and Equity, School of Medicine, Faculty of Medicine, Nursing and Health Sciences

Flinders University

Ph.: 08 7221 8463

Description of the study:

This study is part of the project entitled '*The Social Determinants of Health and Psychological Wellbeing: Improving the mental health of all through broad based policy and intersectoral action'.* The project will examine policy action and practice that works to promote and support mental health and psychological wellbeing. It will involve the analysis of current policies at the state level and examine policy and practice that can positively impact population mental health by addressing the social determinants of health.

This project is supported by Flinders University, the Faculty of Medicine, Nursing and Health Sciences, the School of Medicine and the Southgate Institute for Health, Society and Equity.

Purpose of the study:

This project aims to find out to what extent policy considers mental health and psychological wellbeing and further, to what extent that policy facilitates action on the social determinants that supports population based mental health and psychological wellbeing. Specifically, the project will:

- examine policy that relates to health, urban planning, transport and the natural environment for reference to mental health and psychological wellbeing.

- examine specific practices and programmes that result from this policy where they are making a positive impact on population mental health

What will I be asked to do?

You are invited to attend a one-on-one interview with the researcher, who will ask you questions about your understandings about the policy and/or programmes that have been identified as relevant to this study. The interview will take about 60 minutes and with your consent will be recorded using a digital voice recorder. It will then be transcribed (typed up) and stored confidentially as a computer file. Having the interview recorded is voluntary.

What benefit will I gain from being involved in this study?

The sharing of your experiences will support the gathering of evidence to further inform and improve the policy making process and the delivery of future programs that enable and promote population mental health and psychological wellbeing.

Will I be identifiable by being involved in this study?

Your name will be known by the researcher only and the interview data will be stored in a de identified form. Any identifying information will be removed, and the transcribed file stored on a password protected computer that only the researcher (Mrs Jane Fitzgerald) will have access to. The academic research team will have access to the information once it is de identified. Excerpts from the interview may be used in the research and other research publications and although you will be not be identified by name, given the small number of participants and the specific professional roles of participants it is not possible to guarantee anonymity however every effort will be made to do so.

In keeping with ethical requirements data will be stored confidentially for a period of seven years and staff from the South Australian Public service will not have access to the data.

Are there any risks or discomforts if I am involved?

The investigator anticipates few risks from your involvement in this study. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the researcher. Participation is voluntary. If you agree to the interview, you may answer 'no comment' or refuse to answer any questions and you are free to withdraw at any time without effect or consequences.

How do I agree to participate?

A consent form accompanies this information sheet. If you agree to participate please read and sign the form and either just hand it over at the commencement of the interview or you may wish to send it back via email to fitz0225@flinders.edu.au

How will I receive feedback?

Outcomes from the project will be summarised on a one-page document and will be sent to you by the researcher. Additionally, a presentation of the results will be delivered here at the Southgate Institute and participants will be invited to attend. Any publications relating to the research will be made available to participants.

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 7015). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email

Appendix E: Consent Form

CONSENT FORM FOR PARTICIPATION IN RESEARCH
(by interview)

I ……

being over the age of 18 years hereby consent to participate as requested in an interview for the research project: *The social determinants of health and psychological wellbeing – Improving the health of all through broad based policy and intersectoral action*

I have read the information provided.

1. Details of procedures and any risks have been explained to my satisfaction.
2. I agree to audio recording of my information and participation.
3. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
4. I understand that:
    - I may not directly benefit from taking part in this research.
    - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
    - While the information gained in this study will be published as explained, I will not be identified by name. My contribution will be acknowledged by my professional role.
    - Given the small number of participants and the specific professional roles of participants, it may not be possible to guarantee anonymity however it is only the researcher and the research team that will be aware of my participation.
5. I understand that I may request a draft copy of the interview transcript to review and make comment upon prior to its use in the research.

Participant's signature……Date……..

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name……

Researcher's signature……..Date…….

NB: Two signed copies should be obtained.

Appendix F: Interview Schedule for Stage 3 Interviews

Interview Questions for Research Stage 3

Project: The social determinants of mental health and psychological wellbeing: Improving the mental health of all through broad based policy and intersectoral action

SBREC Project Number - 7015

Conditional approval date – 21/8/15

Interview questions will allow for an examination of the selected policy or document, and its references to and acknowledgement of the social determinants of health and psychological wellbeing and mental health.

The interview process will include questions relating to what concepts and/or assumptions underpin the policy focus. Questions may be adapted to be made suitable to each Department in the study. Information gained from the first stage of analysis, that is the analysis of the written policy, may also be used in further refinement of the questions.

QUESTIONS FOR RESEARCH STAGE 3: INTERVIEWS WITH PEOPLE WHO HAVE BEEN INVOLVED IN THE DEVELOPMENT OF A RELEVANT POLICY

1. Can you tell about the xxx policy and what is/was your role in the xxx policy?
2. Why was the xxx policy developed? [prompt for influences from national/state government directives, pressing contemporary issues or concerns or alternative groups/individuals]
3. How did considerations concerning the social determinants of health form part of the discussions during the development of the policy?
4. How did considerations concerning psychological wellbeing and/or mental health form part of the discussions during the development of the policy?
5. What do you understand to be the social factors that potentially influence mental health and psychological wellbeing?
6. In your view, what values or ideologies underpin the discussion of psychological health and/or mental health within this document?
7. In your view were there any issues or actions that you would have liked to have been included and further addressed in this policy?
8. Reading the policy, the following population groups are mentioned in relation to psychological health and/or mental health - why were these groups identified specifically? [If relevant]

9. How does consideration of psychological wellbeing and/or mental health relate to the core business of your department?
10. Do you consider that work resulting from this policy is benefitting from or would benefit from intersectoral collaboration?
11. Thinking about the xxx policy now, how do you think it is progressing?
12. To what extent do you consider that xxx policy is likely to have an impact on psychological wellbeing and/or mental health?

Appendix G: Nested case study supplementary data sources

	Nested Case Study supplementary data sources
Healthy Parks Healthy People	Notes from attendance to the People, Parks & Wellbeing Conference – First action associated with the Health and Environment sectors MOU & TOR and the Healthy Parks, Healthy People policy (August 2015)
	HPHP Discussion paper – Connecting nature and parks to mental health promotion and mental illness prevention strategies in South Australia (March 2017)
	Notes from attendance to the HPHP case studies planning workshop for the Five ways to Wellbeing in Nature campaign (17-8-17)
	Disseminated paperwork related to the launch and additional workshop for the Five Ways to Wellbeing in Nature (6/12/17)
	Disseminated paperwork from an intersectoral meeting (Health and Environment sectors) in which evaluation and research strategies associated with the HPHP were planned (9/1/18)
	Information from the DEWNR and SA Health websites - including the Five ways to wellbeing video (accessed July 2017 - July 2019)
	Web based research and information regarding the Healthy Parks, Healthy People programmes nationally (accessed July 2017 - July 2019).
Bowden Redevelopment	Bowden Placemaking Document (Renewal SA Website) (accessed from March 2017- February 2019)
	Information from the *Charles Sturt local council* website on the development of the Bowden area (accessed March 2017- February 2019)
	Information from *Better Together SA* website on the Bowden redevelopment (accessed Jan 2019)
	Information from *Renewal SA* on the Bowden Redevelopment including the project targets and project progress (accessed March 2017 – July 2019)
	Marketing information on the Bowden redevelopment from Developers (accessed March 2017- July 2019)
	Notes from attendance to a *Healthy Urban Development* seminar presented in SA Public Health week (3/4/17)
	Notes from site visits – including observation of residential areas, community garden, pocket parks, community garden and parklands, real estate centre, Bowden Hub, retail shops & transport hub (accessed over March 2017-December 2018)
	Web based research and information regarding the Bowden redevelopment.

Appendix H: Interview schedule for Research Stage 4 Interviews

Interview Questions for Research Stage 4

Project: The social determinants of mental health and psychological wellbeing: Improving the mental health of all through broad based policy and intersectoral action

SBREC Project Number - 7015

Conditional approval date – 21/8/15

The interview will include questions that allow for an examination of the implemented programme - process, function and outcomes; the relationships between policy and practice; and the supports and barriers to achieving outcomes.

Questions may be adapted to be suitable to the Department and the programme or project selected. Information from the previous stages of analysis may be used in refinement of the questions.

QUESTIONS FOR RESEARCH STAGE 4 - INTERVIEWS WITH PEOPLE WHO HAVE BEEN INVOLVED IN THE IMPLEMENTATION OF THE NESTED CASE STUDY

1. What is your role in [name project/program]?
2. Why was [name project/program] developed?
3. What do you see as positive outcomes/ potentials associated with this programme/project in relation to psychological wellbeing and mental health?
4. Are there other outcomes you would like to mention?
5. Do you consider this programme/project works on an intersectoral level or would benefit from working on an intersectoral level?
6. Do you consider this programme/project has been of benefit to any specific population group?
7. What role do you think the policy that informed this project/programme has had in achieving this outcome?
8. What factors do you think have been either enabling or detracting from the programme/project progress?

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