

**Housing for people  
with a psychiatric disability;  
community empowerment,  
partnerships and politics**

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Submitted in fulfilment of requirements for the Degree

Doctor of Philosophy

Department of Public Health

Faculty of Health Sciences

Flinders University of South Australia 2008

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## **Executive Summary**

This research examined intersectoral relationships and community participation in policy processes across the mental health and housing sectors. The focus was on the development of suitable housing options for people with a psychiatric disability. The study period covered five years of mental health system reform in South Australia (2000-2005). The research found a shortage of housing and support options for people with psychiatric disability and lack of significant strategic policy coordination or ongoing cross-sectoral programmes. The problems faced by people in gaining access to housing and disability support services and the ways in which families provide housing or support in the absence of public services are documented.

This case study used qualitative research methods which were triangulated across four stages: 1) a thematic analysis of national and state policies in the health, housing and disability sectors; 2) participant observation of NGO activity, a thematic analysis of NGO documents, and interviews and focus groups with NGOs; 3) interviews and focus groups with consumer and carer representatives and a thematic analysis of the minutes from state-level groups; 4) interviews with professionals from the health, housing and disability sectors

The housing situation for people with psychiatric disability was explained in terms of a number of key issues in the policy environment;

- The overarching neo-liberal policy context synonymous with a decline in public housing resources and increasing tension between NGOs service provider and advocacy roles.
- The political nature of the local mental health policy context and lack of political commitment to ongoing resources. Broad community stigma reflected in the media and government, affecting ongoing political commitment to mental health and housing and the introduction and progress of housing ‘projects’.
- The slow development of peak NGO and consumer organisations and alliances in South Australia which affected access to policy networks and contributed to the dominance of professional interests within policy

processes.

- The separation of health, housing and disability policy and networks within and across levels of government. This was associated with bilateral agreements (between Australian and state governments) tied to resources within departments, the programme objectives and the goals of bureaucrats.
- The separation of policy networks by sector was also connected to the dominance of bio-medical discourses and interventions and associated professional interests in the health policy sector. Medical discourses on health and disability and ‘consumerist’ discourses on participation also led to social determinants of health such as housing being overlooked within policy processes.
- Governance reform at a state level contributed to organisational instability within departments, causing some problems for cross-sectoral initiatives and protocols.

Kingdon’s (2003) multiple streams analysis of policy helped to explain what missed or reached political agendas within each policy sector of the case study. Kingdon predicts that the unity of policy networks is important for the realization of policy solutions, and the lack of unity in policy sectors was an obstacle to policy agendas on housing for people with a psychiatric disability. However, the way in which problems were being represented (Bacchi 1999) was also important to understanding this policy environment. For example, a medical discourse on disability (Fulcher 1989) tied to the health sector led to a narrow focus on clinical mental health services. Similarly, neo-liberal discourse (Dean 1999) supported private housing solutions and resources or NGOs advocating ‘within sectors’ for the types of services they already provided or wished to provide.

The case study suggested strategies for ‘policy change’ need to address a number of factors across service delivery, policy and political realms. Firstly, better recognition is warranted of the difficulty experienced by many people with psychiatric disability in achieving stable housing, and the need for indicators on housing access and stability for this group. Secondly, processes to address stigma (particularly that perpetuated in the media) will be instrumental for policy change and political

commitment. Thirdly, ongoing cross sectoral advocacy and alliances require development at both a national and state level and support by a political culture which encourages advocacy. Developing processes for working across sectors such as policy learning forums involving both experts and community groups could counter problems arising from professional culture and territories that were documented in this study. Finally, the cross-sectoral development of policy, programmes and accountability mechanisms and the stability of policy networks will be important to ensuring stable housing for people with psychiatric disability.

## **Declaration**

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due references is made in the text.

Signature of Student

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## **Acknowledgements**

I would like to acknowledge the receipt of a National Health & Medical Research Council (NH&MRC) Public Health Postgraduate Scholarship without which completion of the research would have been impossible.

I would also like to gratefully acknowledge the encouragement and advice of my supervisors Professor Fran Baum from the Department of Public Health, Flinders University of South Australia, and Associate Professor Anne Johnson, formerly of the same department. I would also like to thank my supervisor Associate Professor Lionel Orchard from the Department of Politics and International Studies for his invaluable contribution regarding policy theory and background to the housing context. I also wish to acknowledge the advice of Gus Thompson who commented upon chapters towards the latter stages (former Adjunct Lecturer in the Department of Public Health).

Thank you to the people who willingly provided their time and communicated background information, ideas and contacts within the policy and programme environment prior to and at the commencement of this research. I would also like to greatly thank all of the research participants who provided their time and insights in interviews and focus groups, and the organisations who permitted observation of their activities: the Mental Health Coalition of South Australia, Shelter SA and the Community Housing Council of South Australia.

Thanks to all of those friends and family who encouraged me to commence (and recommence!) a PhD and to those who supported me through the PhD experience. I have met some great friends through the Department. Thanks to Jeremy and James at the shop for all of the help with equipment and stationary. Finally, two PhDs seeing completion in one household at the same time and getting married during the process is a real achievement; thank you to Pierre-Alain for the housekeeping, encouragement and support during this time.

## **List of Acronyms**

ABC	Australian Broadcasting Commission
ACF	Advocacy Coalition Framework
AGD	Attorney General's Department
AHM	Australian Health Ministers
AIHW	Australian Institute of Health and Welfare
ANF	Australian Nursing Federation
CDHAC	Commonwealth Department of Health and Aged Care
CDHA	Commonwealth Department of Health and Ageing
CHCSA	Community Housing Council of South Australia
CRA	Commonwealth Rent Assistance
CSDA	Commonwealth State Disability Agreement
CSHA	Commonwealth State Housing Agreement
CSTDA	Commonwealth State Territory Disability Agreement
CoA	Commonwealth of Australia
COAG	Council of Australian Governments
CSOs	Civil Society Organisations
DFC	Department for Families and Communities
DHS	Department of Human Services
DPC	Department of Premier and Cabinet
FACS	Family and Community Services

FHOG	First Home Owners Grant
HREOC	Human Rights and Equal Opportunity Commission
MHCA	Mental Health Council of Australia
MHCSA	Mental Health Coalition of South Australia
NMPH	National Mental Health Plan
NMHS	National Mental Health Strategy
NGO	Non-Government Organisation
OPA	Office of the Public Advocate (South Australia)
PPP	Public Private Partnership
SA	South Australia
SAAP	Supported Accommodation Assistance Scheme
SACOSS	South Australian Council of Social Services
SAHC	South Australian Health Commission
SAHT	South Australian Housing Trust
SAMHS	South Australian Mental Health Services
SIU	Social Inclusion Unit
SCRGSP	Steering committee for the review of government service provision
SDCPSA	Social Development Committee, Parliament of South Australia
WHO	World Health Organisation
UK	United Kingdom
UN	United Nations

# 1 Introduction

## 1.1 Research focus

The first goal of this thesis was to consider the existence and impact of intersectoral collaboration within policy development and programmes aimed at developing appropriate housing outcomes for people with psychiatric disability. The first two related research questions were:

- To what extent have inter-sectoral links between mental health services and the housing sector been developed through the implementation plan of the South Australian Mental Health Reform 2000-2005?
- To what extent have these links been effective in improving housing options for people with a psychiatric disability?

Whilst the primary areas of interest is the intersection between the health and housing sectors, the research has also taken into account policies and research participants from the general disability sector, given that 'psychiatric disability' comes under the jurisdiction of this sector.

A second aim of this thesis was to explore the extent to which people with a psychiatric disability, their families and Non Government Organisations had opportunities to participate within policy and programmes. Both intersectoral and community partnerships were considered at policy and programme (development and implementation) and policy network (policy agenda setting) levels. The third central research question was:

- To what extent have community participation mechanisms<sup>1</sup> contributed to

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<sup>1</sup> 'Community participation mechanisms' is the term used to collectively describe both peak Non Government Organisations (which are sometimes referred to as community service organisations) or consumer/carer member based organisations. This term also encompasses state-level consumer/carer/tenant representative groups or forums operating over the Mental Health Reform period (2000-2005) and established through or by government.

the development of policy or programmes on housing provision for people with a psychiatric disability?

The National Mental Health Plan 2003-2008 resolved to develop 'increased levels of full and meaningful consumer, family and carer participation in policy and in service planning, delivery and evaluation at all levels with evidence of improvement in quality' (AHM 2003, p. 24). However, little was known about intersectoral links and the effectiveness of community participation mechanisms. This research aimed to provide a detailed picture that could guide policy so that it results in more appropriate services for people with a psychiatric disability.

There is an important connection between the study's focus upon 'intersectoral linkages', 'community participation' and 'housing outcomes'. Cross-sectoral networks, processes and structures are important for both policy agenda setting and programmes targeting housing outcomes for people with a psychiatric disability. Community participation should also be considered in terms of intersectoral collaboration, as people's needs are not confined to service sectors. It was also important to maintain a focus upon housing outcomes as it may be possible for public servants to recognise the importance of and engage in both intersectoral policy and community participation processes, whilst having implicit expectations for informal care and housing being provided by families.

## **1.2 Rationale**

Previous research on the housing situation of people with a psychiatric disability has highlighted the importance of both linkages between the mental health, housing and social support sectors, and the need for additional affordable housing and social support services (Thomas & McCormack 1999; Peace & Kell 2001; Reynolds & Inglis 2001; O'Brien et al. 2002; Reynolds et al. 2002a; Reynolds 2002b; Cooper & Verity 2004). Partnerships within and across service sectors and between services and families are important for the prevention of homelessness and housing stability (Crane & Warnes 2000; Reynolds et al. 2002a, O'Brien et al. 2002). Common risks and causes of homelessness include the reluctance of housing and other services to engage in information sharing with each other over clients (Slade 1999; Crane &

Warnes 2000), a factor which can be associated with professional distrust (Glastonbury, in Crane & Warnes 2000). Recommended strategies for effective programme linkages across housing and support services for people with mental illness include improved Commonwealth/state relations, interdepartmental agreements, performance measures for coordination, joint strategies for addressing confidentiality concerns across agencies, improved working relationships and familiarization with each other's services (Reynolds et al. 2002a, 2002b).

One Australian study considered the views of 50 people with a mental illness not living in a combined housing and support service, on the factors that have assisted them to maintain housing stability O'Brien (et al. 2002). The researchers identified that support for individuals with a mental health problem (such as financial, treatment, social support, family and friends), and housing appropriateness and acceptability to residents were important factors for housing stability. Risks to maintaining stability included the cost of maintaining housing and the negative reaction of neighbours, problems related to being unwell (e.g. hospitalisation) and the negative influence of friends, however appropriate risk management strategies could be put in place to reduce such risks (O'Brien et al. 2002). The study concludes that structural barriers (supply of housing and support) may be more challenging for housing stability than the particular challenges of mental illness and disabilities (O'Brien et al. 2002). This point underlines the need for policy change to address resource provision, and provides the impetus for the focus upon policy processes within this study.

New public health approaches have recognised the importance of social determinants of health such as housing, and the achievement of healthy public policy in non health sectors (WHO 1986). In reality, few countries have underpinned their health policy with social determinants frameworks, and often assume an individualist-behaviouralist approach to health. When it comes to intersectoral linkages, focusing on processes and organisational level structures for collaboration in projects (such as Healthy Cities) and programmes have been the main focus for intersectoral action research in public health (Richardson et al. 1989; Stern 1990; Baum 1992; Walker 1992; Delaney 1994; Costongs & Springett 1997; de Leeuw 1999; Walker 2000; van Eyk & Baum 2002; Walker 2002; Walker 2002; Lewis 2005). However, there has

been increasing recognition of the importance of multi-sectoral policy development to tackling health inequities, both at a state and international level (Vega & Irwin 2004). The United Kingdom (UK) has made partnership approaches the central focus of policy (Popay & Williams 1998).

To date there have been few research studies using policy agenda setting theory to consider how 'healthy public policy' may be achieved across sectors. Whilst policy theory has been applied to intersectoral action research (de Leeuw 1999), there has been a call for health promotion to more fully embrace 'political action and inquiry' (de Leeuw 2005, p. 211). Additionally, previous public health studies on intersectoral collaboration and policy change have not explicitly considered the mental health policy context. Policy agenda setting and policy change models were applied here to consider policy agendas across sectors, and the barriers to the supply of appropriate housing for people with a psychiatric disability.

### **1.3 The South Australian context**

Expectations for community participation and cross sectoral integration within policy and services are inherent within Australia's National Mental Health Policy (AHM 1992a). Despite the fact that the Second National Mental Health Plan (AHM 1998) declared 'partnerships in service reform and delivery' as one of its key themes, its evaluators found that 'inter-sectoral collaboration has been evident in some pilot areas, but not developed in a systematic or coordinated way' (Steering committee for the evaluation of the second national mental health plan 2003, p. 24). The evaluation also found that there was more scope for mental health services to establish partnerships with consumers, carers and families. Carer support was particularly lacking at all levels of mental health service delivery - local, regional and state/territory government (Steering committee for the evaluation of the second national mental health plan 2003). This research took South Australia (SA) and the Mental Health Reform period (2000-2005) as a case study. Mental health reform in SA had some difficulty reaching National Mental Health Strategy (NMHS) targets, including the 'service mix' goal, which was

To reduce the size or to close existing psychiatric hospitals and at the same time provide

sufficient alternative acute hospital, accommodation and community based services

(AHM 1992a, p. 9)

At the commencement of this research, inter-sectoral community based initiatives were limited as the state spent proportionally the least on community services and the most on stand alone public hospitals of any Australian state (CDHA 2002). Expenditure through mental health services on NGOs and community residential services was around one half and one twentieth of national averages respectively (CDHA 2002). The state's supported housing initiatives under the mental health reform implementation plan were initially deemed pilot demonstration projects only (DHS 2000). SA was also well below national averages for consumer and particularly carer participation mechanisms in mental health service delivery (CDHA 2002).

Ten years after the Burdekin Report, the Human Rights and Equal Opportunity Commission and Mental Health Council of Australia followed-up the Burdekin Inquiry (MHCA 2005). In the ensuing report the need for a range of 'community based care settings' (which included housing) and intergovernmental agreements between mental health services and housing was recognised (MHCA 2005). Around this time, parliamentary inquiries into supported accommodation and public housing had been completed in South Australia (Parliament of South Australia 2003; Parliament of South Australia Social Development Committee 2003). Along with the state's Homelessness plan (Social Inclusion Unit 2003), these inquiries variously recommended the development of a plan for supported accommodation, although this was slow to develop. In the final year of the mental health reform, following the State Housing Plan (DFC 2005), a state government unit was established to oversee 'high needs housing'.

Within the local policy context, crisis (rather than planned) responses to policy development and crisis events have been dominant. It may be an understatement to say that Dr Margaret Tobin's<sup>2</sup> murder (by a former colleague) in 2002 had a significant impact upon the local policy environment. Ten years prior, at the

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<sup>2</sup> Former Director of Mental Health Services during 2000-2003

commencement of the NMHS, a medical officer was murdered (by a patient) at the Hillcrest psychiatric institution in South Australia (State Coroner 1997). Between these two crisis events, the mental health sector underwent a series of ongoing reforms (including the closure of Hillcrest), and has been in reform since the introduction of the NMHS in 1992 (AHM 1992a). These reforms included the Mental Health Reform of 2000 which called for leadership and action (leading to the appointment of Dr Margaret Tobin) (Brennan 2000), upon which this study was based. Reform continued during and after the period of interest to this study, with the Generational Health Review of 2002 prioritising mental health (Generational Health Review 2002) and the state government Social Inclusion Unit overseeing a review of mental health which commenced in 2005 (Social Inclusion Board 2007). Both ongoing reform and crisis responses in mental health shape the context for this thesis.

#### **1.4 Structure of the thesis**

The thesis has ten chapters. Following this introduction, chapter two adopts a sociological level of analysis and introduces the critical theoretical perspective underlying this research. It introduces the concepts of governmentality, medical discourse and medicalisation critiques of mental illness (including community stigma). The second part of this chapter presents the new public health and social determinants approach used. It considers the implications for this research of prior research into community participation and intersectoral action. This chapter informs the reader about the particular concept of mental health and interventions adopted.

Chapter three employs a political level of analysis and explores theories of policy agenda setting and change. The distinction between policy development and accountability processes for policy is also discussed. In this chapter, the role of community participation and policy networks in policy making and accountability is explored. This chapter provides the basis for theory used to interpret the case study findings in this research.

Chapter four provides an account of the epistemological understanding, research approach and methods used within this thesis, and explains the researcher's connection to the researched. It outlines the study aims and research questions,

research design and methods, ethical considerations, and discusses the strengths and weaknesses of the study design and methods used.

Chapters five to eight are the results and discussion chapters. Chapter five presents the policy context of the South Australian case study. It is based upon a thematic analysis of relevant national and state policy and legislation pertaining to housing, mental health and disability. Chapter six considers the research participants' perceptions of housing problems for people with a psychiatric disability, the current policy context, and preferred housing models. The extent to which participants saw housing problems for people with psychiatric disability as important problems to be addressed was considered in this chapter. This was a precursor to the following two chapters which considered intersectoral collaboration and community participation within policy.

Chapter seven is written in response to the first two research questions on the intersectoral policy linkages between the health and housing sectors, and considers housing outcomes in relation to these linkages. It is based upon public servants, NGO and consumer and carer representatives' perspectives on intersectoral policy linkages.

Chapter eight primarily relates to the third research question on community participation in policy processes. It specifically considers the influence of NGOs and state-level consumer and carer groups on policy. In particular, groups' influence upon policy agenda setting and housing and related support initiatives is explored. Chapter nine is the conclusion chapter which draws together the research findings and interprets these in terms of policy theory, highlights the implications of this research and makes recommendations for policy change.

Throughout the thesis, the author date system of referencing and style recommended by the Commonwealth government of Australia's *Style manual for authors, editors and printers* is used (Commonwealth of Australia 2002).

## **1.5 Conclusion**

This chapter provided a background and introduction to the thesis. The rationale for the focus of this thesis was fourfold and located in 1) the policy context of the case

study and government feedback on policy initiatives, 2) academic research and evaluations on housing for people with a psychiatric disability 3) gaps in academic literature and public health research on intersectoral action and policy agenda setting, and 4) researcher background and experiential knowledge (see chapter 4). The chapter also heralded particular issues shrouding the local policy context, namely crises responses and slow development of housing and community based strategies. Subsequently, a critical perspective of society and policy agenda setting was employed within the case study.

### **1.5.1 A note on terminology: People with psychiatric disabilities**

There is no consensus on a preferred term for people with a mental illness (Mental Health Commission 2005) or mental health conditions. The World Health Organisation uses the broad category of 'mental health problems' which includes diagnosed 'mental and behavioural disorders' (WHO 2001). Australian policy documents distinguish between diagnosed 'mental disorders' and less serious but more common 'mental health problems' (CDHAC 2000).

People with a mental illness requiring accommodation support have been referred to in Australia as 'people with a serious mental illness' (Thomas & McCormack 1999). Mental illness is not a term often used in this study, in recognition that some people reject being defined in relation to illness (MHCA 2005). Mental illness is a term less often used within the disability sector, whilst the more common 'psychiatric disability' is now more often used within the mental health sector (Beresford et al. 2002).

Some academic research uses terminology focusing upon service provision rather than disability or 'illness condition'. 'Service users' or simply 'users' is a common term to describe people with psychiatric disabilities in the United Kingdom (Disability Education Association NSW/ACT Inc 2004). 'Consumer' is a commonly used term within Australia and reflected in Australian mental health policy. The 'consumer' category is often preferred by service users as it is used internationally in a political movement (Mental Health Commission 2005). However, in one Australian study, the term 'client' was preferred over 'consumer' (Lloyd et al. 2001), although

'client' may imply passivity in contrast to the word 'customer' (Muetzelfeldt 1999).

Within this study, the phrase 'people with psychiatric disabilities' is primarily used. However, having impairment or being a mental health service user should not be equated with having a disability (Fulcher 1989) and not all mental health service users will have ongoing disability requiring support. The term 'psychiatric disability' is used here for the following reasons:

- This term emphasises people rather than illness or disability first (Zola 1993), as is often advised (American Psychological Association 2006), and the term is considered part of non-discriminatory language (University of Sydney 2002-2007).
- Using the word 'psychiatric disability' corresponds with mental health organisations' move toward disability policy and politics (Beresford et al. 2002).
- 'Service users' is a term which appears to de-emphasise the rights and interests of people with psychiatric disabilities beyond health and community services, or capture people who are not recipients of services. The use of the term 'health consumer' or 'service user' may also de-emphasise the particular interests of people with psychiatric disabilities as a population group.
- The 'market discourse' of customer/client/consumer seems inappropriate to people with psychiatric disabilities who often either do not have consumer choices or have few alternatives available (Percy & Birrell 2004; Hazelton 2005). Additionally, the needs and wants of consumers are often being developed and sold to 'consumers' by professionals (Grace 1991).

Where people with a psychiatric disability or their carers are in representative roles, or when discussing health research, the term 'consumer or carer representative' has been used here, to reflect the current language used in health services and research.

## **2 The governance of mental illness and new public health interventions**

Power is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategical situation in a particular society.

(Foucault, n.d.)

Is NAMI [National Alliance for the Mentally Ill] a health care advocate as it would have the public believe? Having accepted \$11.72 million from eighteen drug firms between 1996 and mid-1999, it is no less an arm of the pharmaceutical industry than is psychiatry itself.

(Baughman 2006)

This chapter introduces the overarching critical social science perspective taken in this study, which has implications for the analytical stance on policy making adopted in the next chapter. The chapter is divided into four main sections. In the first section, critical theories are used to examine governance.<sup>3</sup> In particular, the impact of dominant and dispersed neo-liberal and medical discourse upon governmentality<sup>4</sup>, community participation and cross-sectoral interventions are discussed.. In the second part of this chapter, critiques of medicalisation are presented which demonstrate how social factors affect the classification of mental illness and stigmatisation processes. In the third section, alternatives to the dominant medical model of disability and health are explored. In particular, new public health perspectives are presented and research into community participation and intersectoral action strategies are critiqued. Finally, the last section outlines implications of the theoretical approach taken and previous studies upon this research.

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<sup>3</sup> Governance is used in this thesis to refer to the processes of managing and administering public policy and resources which go beyond traditional executive government.

<sup>4</sup> Governmentality is used in the Foucauldian sense: Foucault used the term ‘governmentality’ to describe both the ‘links between the levels of state and global politics, on the one hand, and the level of individuals and their conduct in every range of life, on the other’ (Danaher et al 2000, p. 82).

## **2.1 Government, state policy<sup>5</sup> and the potential for community empowerment**

The potential for societal change through state policy processes, and the role of culture and ideologies in contributing to existing conditions, was explored within this thesis. The extent to which the state is acting on behalf of oppressed people with psychiatric disabilities and their carers, or responding or contributing to discrimination and stigma, was one consideration. The state's potential role in emancipation is discussed below in light of a range of critical perspectives.

Historically, feminist and Marxist critical perspectives saw the state as a unitary force reflecting and reproducing existing class-based economic and patriarchal interests. Marxist-influenced critical theory represented by the Frankfurt school asserted the role of culture in reproducing power<sup>6</sup> arising from economic bases (Cheek et al. 1996). In a departure from Marxist economic determinism and the Frankfurt School's cultural determinism, Gramsci (1971) adopted a dialectical approach to culture and ideology (Gramsci 1971). For Gramsci, the autonomous economic sphere, state and civil society had variable influences upon each other (Bocock 1986). Gramsci shifted the focus of power struggles from the economic sphere to the political sphere where he believed that power [also] resides, and ideology itself was the primary context of class struggle (Waters 1994). Gramsci (1971) outlined a dominant 'hegemony' (or ideological/value system) which supported class based interests, powerful due to its potential to influence subordinate groups. Gramsci argued that the main battle in challenging hegemony lie in civil society, where groups had internalised the dominant value system and thereby agreed

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<sup>5</sup> In this thesis, the term 'state' is used in two ways: 1) in the political sense, to describe the 'nation-state' and affiliated government, and 2) in the context of Australia, which is made up of a federation of states; in this latter case, South Australia is sometimes referred to as 'the state'. In this section, the term is being used in the first meaning.

<sup>6</sup> Power can either be seen as concentrated and negative (in a Marxist sense) or more positive and facilitating individuals and groups to influence people and processes ('power-over' or 'power with' in Laverack's (2005) terminology). A Foucauldian concept of power is later discussed where power is seen as diffuse and enabling, and relating to regulation, including self-regulation.

to or sanctioned their own subordination (Fonte 2001).

A 'cultural hegemony' was also implied by early socialist feminist critiques of the state. Feminists saw state policy such as 'community care' as being based on capitalist and patriarchal cultural assumptions (Barrett 1980; Finch & Groves 1980; Wilson 1982; Finch & Groves 1983; Mowbray & Bryson 1984; Edwards 1988), and ideologies of the family and community (Wilson 1982; Dalley 1988; Dalley 1996). For example, Dalley (1996) argues that there is a 'familist ideology' behind community care impacting upon the provision of public resources. This term refers to the notion that there is an ideology of domestic relations inherent in state policy and adopted by families themselves

because of the hegemonic nature of familism, assorted categories of individuals subscribe to, or have internalized, the values of that ideology even though its dominance may, objectively, run counter to their interests.

(Dalley 1996, p. 27)

Familist ideology is based on the expectation that families comprise a male breadwinner and woman confined primarily to the private sphere, unless the woman is single, childless, supplementing a male wage, or unless the market calls for it (Dalley 1996). A somewhat contradictory notion of 'possessive individualism' accompanies familist ideology (Dalley 1996). This refers to the value of autonomy of individuals free from government dependence, but when accompanied by familist ideology assumes the preferred autonomy of the family unit (Dalley 1996).

Feminists predicted that the policy of community care would largely mean care by individual women in families, and conflicted with equal opportunity policy. The presence of 'familist ideology' in policy would not only downgrade the urgency of housing problems for people with psychiatric disabilities, but also promote the role of carers within policy. However, 'disabled feminists' pointed out that community care was intended to mean greater independence for people with disabilities (Begum, in Graham 1993; Morris 1993), in alignment with a rights discourse on disability (Fulcher 1989). Rather than being dominated by patriarchal cultural assumptions supporting capitalism, some feminists claimed that the state was an expression of various interests, with the greatest stake being the interpretation of people's needs (Fraser 1989). This point is taken up in the next chapter when considering 'problem

representation' (Bacchi 1999) within policy debates.

### **2.1.1 Dispersed power, discourse and governmentality**

The concept of hegemony was important to Foucault's (1980) alternative understanding of governance, which goes beyond government<sup>7</sup>. Marxist based approaches predominantly saw power as being concentrated across spheres of society (economic, state, civil society), and manifest through 'invisible' forces such as the hegemonic value system. For Foucault, power was manifest through language and discourses of the sciences rather than a centralized state (Danaher et al. 2000). Medicine and other specialist knowledge and their associated institutions were seen to transfer power from economic and political forces to the management of daily life (Foucault 1980). Foucault (1980) elucidated this transcendence of power by emphasising the way in which power is decentralized, diffuse and dispersed throughout local settings (Turner 1997), and the various points at which groups or individuals could resist power.

The historical relationship between the law and psychiatry as described by Foucault (1989) enabled the classification of psycho-medical problems on a continuum (McCallum 1997). Foucault (1980) argued that this knowledge basis was able to exert power at a local level, with the potential to make comment on the capacity or otherwise for individuals to be self-managing. Furthermore, Foucault established the knowledge/power nexus, whereby any increase in knowledge is perceived to lead to an extension of power and vice versa (Foucault 1980).

For Foucault, power is evidenced and manifest through discourse (Gilbert 2003). Discourse refers to 'historically specific systems of meaning which form the identities of subjects and objects' (Howarth, in Fischer 2003, p. 73). According to Foucault 'our subjectivity is situated within, and transformed by, discursive flows' (Danaher et. al 2000, p. 44). Discourse brings meaning to one's identity and the understanding of oneself (Howarth, in Fischer 2003, Foucault, in Lupton 1997). However, 'discourses [also] have uses rather than inherent meanings' (Bowles and

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<sup>7</sup> By government, I am referring to the executive level of government which is responsible for executing and monitoring the approved legislation and policies of the reigning political party.

Gintis, in Fischer 1989, p. 25) and inform social practices.

Liberalism is a central discourse described as a practice or 'way of doing things' by Foucault (1989b, in Dean 1999). Liberalism is associated with the exercise of power through new forms of governmentality (Dean 1999; Danaher et. al. 2000). Neo-liberalism<sup>8</sup> is associated with a drawing back of an interventionist state and the placement of former government services in the hands of private and non-government services (Dean 1999; Danaher et al 2000). These new forms of governmentality are made possible through various 'technologies' which encourage self-regulation (Dean 1999; Danaher et al. 2000). Dean (1999) identifies two key technologies of neo-liberalism

From the perspective of advanced liberal regimes of government, we witness the utilization of two distinct, yet intertwined technologies: *technologies of agency*, which seek to enhance and improve our capacities for participation, agreement and action; and *technologies of performance*<sup>9</sup>, in which these capacities are made calculable and comparable so that they might be optimized.

(Dean 1999, p. 173)

'*Technologies of agency*' include strategies such as contracting out for service provision, and also 'technologies of citizenship' which enhance the rights of user groups through representation, consultation and empowerment (Dean 1999).

'*Technologies of performance*' include techniques to monitor and evaluate the expertise of different professions in the welfare state (Dean 1999). These technologies can also be associated with particular 'mentalities of government' or 'forms of thought' influencing policy (Dean 1999). Examples of 'mentalities of government' include organizational and management theory influence upon government, which has affected public sector reform, policy and administrative structures (Ham 2004, Tiernan and Burke 2002).

Foucault's (1980) conceptualisations of power, discourse and governmentality are relevant to understanding policy processes and the way in which community groups

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<sup>8</sup> Neo-liberalism in this sense is associated with neo-conservative politics and should not be confused with social-liberalism or progressive politics.

<sup>9</sup> Author's italicese

may be subject to or play a role in perpetuating particular discourses. Examples of Foucauldian concepts informing research studies and their relevance to community participation and community care policies for people with disabilities are discussed further below.

### **2.1.2 Dispersed power and self-regulation**

In one study of community empowerment, a Foucauldian concept of 'dispersed' power was utilised, where individual (power within), community (power with) and institutional power (power over) categories were used (Labonte, in Williams and Labonte 2003). These forms of power overlapped and/or operated in different contexts (Williams and Labonte 2003). Participants within a local community action group gained power both as individuals and as part of the community group. Partnerships between the community group and organisations with greater institutional power (determined by skills and economic resources) were instrumental in the groups' advocacy efforts. The group successfully advocated for changes in housing for marginalized groups, or at least in bringing issues to the policy environment. However, the dissolution of the group and its key partnership with a religious organization was paradoxically associated with increases in individual group member's power and that of the group overall. This suggested issues with power sharing as the group emerged, where increases in personal power could lead to more disruptive social relationships and the community group expected greater equity and autonomy within partnerships. Additionally, institutional power and associated neo-liberalist discourse influencing debates on housing ultimately predominated at the policy level (Williams & Labonte 2003).

Another Foucauldian example of bio-politics or bio-power<sup>10</sup> can be found in one study of community care services in the UK (Gilbert 2003). Biopolitics is

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<sup>10</sup> 'technologies that were developed at the same time as, and out of, the human sciences, and which were used for analysis, controlling, regulating and detaining the human body and its behaviour' (Danaher et al, p. 64)

a very precise form of power, essentially moral in character, operating through social practices and social science

Gilbert (2003, p. 37)

Within Gilbert's (2003) study, the discourse of community care transformed the identity of people with intellectual disability from dependent individuals to 'self-managing' people with rights and obligations. Through the commissioning and tendering process for community care services, this discourse became hegemonic, including for organisations beyond commissioning agencies. Organisations and state services which did not accept the supported living model were alienated, and power was taken away from housing associations which did not support this model. For example, a provider of housing used his contract with housing associations as a tool to promote the supported living model, where individuals with learning disabilities had tenancy agreements. The provider intended to choose a new housing association (over another association who formerly held the contract) to lease his properties as the former association was reluctant to give individual tenancies to people with disabilities (Gilbert 2003). Holding an individual contract for housing did not necessarily equate with additional resources to maintain leases or support tenancies for people with disabilities

### **2.1.3 Neo-liberal discourse, carers and consumerist participation strategies**

Along with Foucault's reasoning on liberalism, Dean (1999) associates neo-liberalism with constructing a particular notion of individual freedom (in order to ultimately achieve government objectives). However, freedom is considered not in an emancipatory sense and aligned with social movements, but rather in terms of individual autonomy and personal responsibility (Dean 1999). The effect can be seen where people with disabilities and public housing tenants are identified as individual 'consumers' involved in the management of services (Gilbert 2003, Clapham in Jacobs et al 2004, Marston 2004). It can also be seen where informal 'carers' are expected to care for their members with disabilities. For example, Henderson's (2005) discourse analysis of mental health policy in Australia suggests that a moral imperative for families to care for their own members currently exists.

Being identified or identifying as an individual 'consumer' or 'carer' emphasizes

individuals' experiences rather than the interests and rights of people with disabilities (and their carers) as a group, heralding problems with community empowerment. A useful distinction has been made between 'consumerist' and 'democratic' philosophies behind user involvement in services (Beresford 2002). The consumerist approach is associated with 'efficiency, economy and effectiveness', and uses consultative strategies for participation (Beresford 2002). Agencies decide upon plans and determine the level of input into services, and external comment on these plans is obtained (Beresford 2002). The 'consumerist approach' is tied to individual input into services, rather than the wider interests of local communities (Taylor et al. 2006). Alternatively, in the democratic approach to participation, the aim is to empower citizens both personally and politically and enhance opportunities to make change (Beresford 2002). The democratic approach to participation is associated with disability movements which challenge social constructions of disability (Barnes & Mercer, in Beresford 2002), and can be linked to a 'rights' discourse on disability (Fulcher 1989, see next chapter).

One problem with the 'consumerist' approach to participation is the assumption of individual 'consumer choice'. Being labelled as a 'customer' or 'consumer' [or even carer] creates an expectation that people are rational decision makers with choices, well informed enough to contribute to policy, its implementation, and accountability (Clapham, in Jacobs et al. 2004). The notion of consumer choice is not necessarily commensurate with the life experiences of people with a psychiatric disability (Percy and Birrell 2004, Hazelton 2005), or their carers. It has been suggested that there are 'exit, voice or loyalty' options for service users, with the 'exit' tactic of consumers leaving services (and business rethinking their involvement in service provision) easier to achieve than service users' voices being registered (Hirschman, in Hill 2005). However, Hill (2005) notes that often there are really only 'entry' rather than 'exit' options for people who rely on public services. Where consumers do leave services, the only alternative option may be family care.

The notion of 'consumer choice' within a consumerist approach overlooks the way in which health service users are constructed as 'health consumers' in need and want of goods and services by health practitioners (Grace 1991). Health professionals and governments determine community needs (i.e. via needs assessments) and then

promote these back to the community in question (Grace 1991). According to Grace (1991), management discourse implies that community empowerment will be achieved via organising services to meet the needs of individuals. Conversely, Skelcher (1996) advocates for public servants to consult with 'consumers' to improve and provide appropriate and efficient public resources, whilst recognising public servants role in controlling and constraining these resources (Skelcher 1996).

Market ideology underlies but is masked by the management/'organisation of services' approach to community participation (Grace 1991). Promotion of the values and rules of the market is a central part of the cultural reform associated with neo-liberal practices, which lead to a reduced supply of public services (Dean 1999). Neo-liberalism is associated with the conception of the market as efficient and rights principles upheld in the law (Dean 1999). However, the 'organisation of services' approach to community participation actually takes away any potential political antagonism (Grace 1991) through the notion that services are meeting the needs of services users. It thus avoids the assertion of broadly defined rights

It is ironic that a discourse articulating a concern to promote health in the name of freedom and "wholeness" functions to alienate people from their capacity to engage in protest, and effectively operates to subject them further to the political and economic order.

(Grace 1991, p. 341)

Captured and absorbed by the relation of consumer and provider, the demands of the health movements become many additional needs that can be fulfilled by a proliferation of the market.

(Grace 1991, p. 334)

Being identified and labelled as a consumer or carer can not only reproduce existing conditions. Notions of consumer rights and control over services have even been used to enable government to take away services. For example, Gilroy (1998) argues that tenant participation strategies in the UK were part of broader neo-liberal strategies allowing government to exit from service provision. Such neo-liberal approaches to participation are not only linked to conservative political agendas. Beresford (2002) suggests that a 'consumerist approach' to participation began with a right wing political agenda, however continued along with social democratic 'third way' politics and managerialism.

#### **2.1.4 Medical discourse and governmentality**

Medical discourse is another form of bio-politics which promotes individuals' perceptions of and behaviour toward themselves. For example, Foucault (1989) describes how psychiatry was born, tracing the birth of the asylum and removal of prison shackles to a 'moral imprisonment' monitored by fear and one's conscience. This led to an objectifying of oneself for the other and so an 'authority of reason' (Foucault 1989) was born, enshrined in positivism. Monitoring not only occurred through the asylum keeper, but also through asylum residents who were required to be constantly watchful and in a state of self-surveillance and judgement (Foucault 1989). In this way the power of medical discourse not only transcended the asylum walls but also professionals.

Community participation processes have contested the potential for medical discourses to define identity. Barnes & Shardlow (1996) claim the importance of processes of personal identity to mental health user participation, including the development of 'active agents' and challenges to traits associated with mental illness, such as incapacity and incompetence (Barnes & Shardlow 1996). Barnes (1999) also noted a shared sense of identity as one motivation for collective action, along with the desire to influence health and community services. Barnes & Shardlow (1996) argue that structural issues have not been addressed through such participation groups because they have cultural/ideological motivations (in align with new social movements) rather than structural ones (Barnes & Shardlow 1996). However, cultural and ideological motivations are not necessarily incompatible with the desire to see structural change. In this study both the *desire* and potential for individuals and groups to resist power exercised through medical discourse and challenge structural conditions experienced by people with psychiatric disabilities were considered.

In Foucauldian style, Roach-Anleu (2002) has suggested the permeation and acceptance of medical discourse beyond an 'institutional basis', extending to the family and lobby groups. She cites the US based National Alliance for the Mentally Ill (NAMI) (cited in the introduction to this chapter) as a radically conservative body upholding the medical model. This organisation opposes patients' rights to refuse medication, advocates for carer involvement in the management of people with

psychiatric disabilities (Roach-Anleu 2002), and receives considerable funding support from pharmaceutical companies (Baughman 2006). Conversely, carers have been traditionally excluded from treatment environments which may be explained by the Hippocratic Oath and updated Declaration of Geneva principles of commitment to patient confidentiality. Lobbying efforts for better partnerships to reduce family carers' burden of care through engagement in 'care planning', are faced with confidentiality principles, supported by current privacy law at a national level. The case study used in this thesis provided the opportunity to examine these complex issues.

## **2.2 Medicalisation critiques and community empowerment**

Foucauldian perspectives should be distinguished from 'medicalisation critiques' as they have different implications for emancipation (Lupton 1997). Within Marxist based 'medicalisation critiques', which highlight the process of medicalisation of social problems, relatively powerless patients are considered to be subjugated and dictated to by a class based profession, with scope for empowerment (Lupton 1997). The concept of emancipation has been seen as more problematic from a Foucauldian perspective where medical discourse is a 'belief system' which works through relations and also shapes patients' own understanding and experience of their bodies (Lupton 1997). Lupton (1997) argues that from a Foucauldian standpoint, patient autonomy and agency is difficult to achieve, as patients are seen to be colluding with medical discourse and practices for various (not only negative) reasons. Whilst this study sees the potential for individuals and groups to critique their social reality and become empowered through consumer participation processes, medicalisation and stigmatisation processes were perceived to be especially powerful due to their influence upon identity and social processes.

'Medicalisation critiques' include medical sociologists (Friedson 1970; Zola 1972), sociologists of deviance (Roach-Anleu 2002) and the anti-psychiatry movement (Laing 1969; Szasz 1974). The anti-psychiatry movement led by Psychiatrists (Szasz 1974, Laing 1969) has long raised questions on the degree to which mental health

problems are; 'problems of daily living', problems of brain malfunction, moral problems as interpreted by a class-based profession, the result of stigmatization processes, or problems which were created by a growing profession. Labelling theory (Scheff 1974) is closely associated with and was a contemporary of the anti-psychiatry movement. Together these approaches are briefly revisited here as classifications of mental illness and related stigma continue to have a powerful impact upon individuals and shape the policy environment.

According to Szasz (1974) the psychiatry profession is both in pursuit of 'scientific truth' and of itself. Szasz (1974) emphasized the moral and political nature of classifications of mental illness, including the re-classification of problems such as 'social maladjustment' as illnesses over time. He saw this was in the interest of the psychiatry profession. Illnesses were diagnosed through 'scientism' where a 'strong and healthy body' and mind is the current virtue (Szasz 1974, p. 195). Psychiatry was understood as a modern replacement for witchcraft in interpreting problems in human and social relationships. Szasz (1974) perceived that urban poverty gave rise to 'social therapists' [Szasz term] such as Marx, who challenged the individualism inherent in capitalism. This individualism was believed to be upheld by the upper classes, especially the medical profession and psychiatry. As an example of the individualism inherent in psychiatry, Szasz (1974) argued that, in contrast to other physical diseases, psychotherapy relies on the belief that individuals bring mental illnesses upon themselves, unconsciously, and that such illnesses have some value or meaning to the individual concerned.

'Anti-psychiatrist' Laing (1969) found a lack of clearly defined symptoms of schizophrenia troublesome, and suggested the reaction of the Psychiatrist and family contributes to symptoms of the disease. Laing proposed that the role of mental patients was defined by stigmatisation, claiming his own reactions to patients meant they in turn responded differently to him and failed to demonstrate the same symptoms revealed to others (Friedenberg 1973). Goffman (1963) similarly points out the role of mental health hospitals in 'teaching' people how to behave in accord with expectations about behaviours of the mentally ill (Goffman 1963). The role of labelling/stigma and institutional environments in mental illness was demonstrated through Rosenhan's (1972) famous experiments where study participants without

mental illness were sometimes considered mad, whilst people with illness were sometimes thought to be 'pseudo-patients' (Rosenhan 1972). The social process of labelling and stigma has enabled an understanding of why mental problems may be social (affecting different people with similar low status) rather than psychological (Friedenberg 1973).

### **2.2.1 The impact of stigma on participation processes and community care/housing**

The implications of stigma (Goffman 1963) and labelling (Scheff 1974) processes can be found in Barnes's (1999) study of local governance participation processes. This initially found that people with disabilities were not thought to be capable of participating in policy processes, suggesting the role of stigma in affecting perceptions about the capacity of individuals. Similarly, according to Percy and Birrell (2004), the 'clinical gaze' could lead to situations where

users of mental health services who have been given a psychiatric diagnosis may be constructed as lacking insight and competence on the basis of their condition itself...Put simply, there is a danger that a service user's expressed dissatisfaction with service provision may be interpreted as a symptom of their psychiatric condition, and dismissed out of hand.

(Percy & Birrell 2004, p. 4)

Community attitudes may also be a significant barrier to people with disabilities entering community participation groups or processes in the first place, as people with disabilities often fear rejection from the wider community (Social Exclusion Unit, in Morris 2005). However, in Barnes's (1999) study, when community participants were involved and organised and demonstrated the relevance of their issues, they were accused of being unrepresentative activists (Barnes 1999).

Commenting upon this study, George (2003) states that the findings demonstrate

one way for authorities to retain power is by legitimizing people as beneficiaries and consumers only if they are passive, dependent, and isolated individuals, rather than as citizens and active participants in their own health care

(George 2003, p. 4)

This suggests professionals' (not only medical professionals) interests in maintaining the dependence of community participants. The process of stigma creation, reactions

to stigma in the form of shame (one's re-evaluation of 'normal'), fear of or waiting for a reaction, self-consciousness and insecurity (Goffman 1963) may be intrinsic to the process of developing or classifying not only mental illness but also to preferred interventions. Stigma is perpetuated by Psychiatrists through attitudes, diagnostic labels, and the prescription of treatments leading to side effects marking a person experiencing mental illness (Sartorius 2002). In the follow-up to the 'Burdekin Report', the Australian community prioritised the need for programmes to promote change in the attitudes of health professionals toward mental illness (MHCA 2005). In one Australian study, health professionals rated the potential long-term outcomes for people with mental disorders (e.g. likelihood of violence/drug abuse) more negatively and the potential discrimination faced by people with mental disorders higher than the general public (Jorm et al. 1999). Health professionals' greater contact with people with severe mental disorders may be one reason why they may have overly negative attitudes, however expectations for negative outcomes may also impact upon prognosis (Jorm et al. 1999).

Professional attitudes can also impact upon family members of people with psychiatric disabilities. The stigma which may transfer to families of people with mental illness has been referred to as 'courtesy stigma' (Goffman 1963). In 1948, Fromm-Reichman first introduced the theory that mother's behaviour was a causal factor in schizophrenia, coining the term 'schizophrenogenic mother' (Fromm-Reichman 1948; Cheek 1964). There has been some questioning and disproof of 'schizophrenogenic mothers' and the notion that families cause schizophrenia (Parker 1982; Ferreter & Huband 2003). However, carers of people with a psychiatric disability (both historically and currently) report health professionals' negative attitudes toward them (Highet et al. 2004). The potential for stigma to impact upon both people with disabilities and the voice of families within participation processes was one consideration in this study. These observations on stigma also suggest the importance of emancipation strategies which challenge medical discourse and medical dominance.

The experience of stigma is widespread and has been associated with discrimination in housing, education and employment (Hocking 2003), and self-esteem, relationships and job opportunities (Lai et al. 2000). People with a psychiatric

disability and their carers may experience a 'double stigma' based upon not only their health condition but also other factors such as their residence in social housing (Lipsky 1980, Halper, in Evans et al 2003, Palmer 2004). Fonte (2001) has suggested that the state may be an important player in tackling community stigma, however, Lipsky (1980) observes that simply interacting with 'street level bureaucrats' can be stigmatising.

Conversely, one recent research study showed that the general public had a higher level of acceptance of the mental disorder schizophrenia than was anticipated, except in situations of close personal contact (e.g. in the workplace), and where fears of the dangerousness of people with schizophrenia prevailed (Thompson et al. 2002). Despite or because of community fears about their dangerousness, people with a serious mental illness actually experience extremely high rates of lifetime sexual and physical victimisation (Mc Farlane et al. 2007).

These perspectives from the literature have implications for perceptions about community living programmes. Programmes may be generally supported to protect people with disabilities; however local residents may be concerned about living in close proximity to this group due to fears about their dangerousness, in turn leading to political barriers to the establishment of such programmes. Additionally, health professionals' attitudes about the capacities of their clients (and interests in maintaining passive and dependent clients) could potentially impact upon their commitment to community housing proposals and initiatives.

Goffman (1963) purports that people attributing labels are often responding to stereotypes rather than real people, and justify their treatment of others in terms of perceptions about deservingness. The issue of 'deservingness' could be particularly important in public debates affecting the policy environment, which the general community can help to shape through avenues such as the media. It has been argued by Borsay (in Fulcher 1989) that some disability groups are seen as more deserving of public resources than others, leading to a 'hierarchy of disability'. This suggests that stigma could operate where low-status groups are competing for public resources as

It is easy to build resentment aimed at a person or group, especially among those who feel poorly treated themselves, and, importantly, among their highly empathic advocates.

(Thompson 2006, p.4)

### **2.3 Alternatives to medical discourses on health: social determinants approaches**

Challenges to the dominant medical model of health and disability can also be found in new public health approaches to health (Baum 2002, Keleher and Murphy 2005). A 'determinants' approach is central to this approach, which leads to a focus upon health promotion and prevention strategies targeting 'upstream' factors contributing to health (largely from outside of the health sector), rather than 'downstream' curative techniques (McKinlay 1974). Social determinants of health targeted for prevention include; the social gradient of health, stress, early life experiences, social exclusion, work and unemployment experiences, social support, addiction, food and transport (Wilkinson & Marmot 1998). Whilst this approach challenges traditional medical discourses on health and disability, in pointing to the social factors influencing health they are highly compatible with the approach to mental illness of anti-psychiatrists (Laing 1969, Szasz 1974).

The new public health also takes an ecological approach to health and illness, which entails the consideration of biological, psychological, social, economic, cultural and political factors simultaneously, and the interrelationship between such factors (Lawrence 2004). An ecological perspective of health has been described as

the outcome of complex interrelationships and interdependencies between human beings, the determinants of health, and the broader environment in which they exist.

(Keleher & Murphy 2005, p.320).

An ecological perspective of mental health thus entails consideration of the interaction between social determinants and bio-psycho-social causes.

From a 'mental health promotion' perspective, the 'absolute classification system' of mental illness (described by Foucault 1989) is replaced by a continuum (Seedhouse 2002). Within this continuum, it is possible to be mentally healthy or perform well in

the social world if a person has a physiologically abnormal brain (and is defined as mentally ill), just as an inability to cope (be mentally unhealthy) is possible in a person not categorized as being mentally ill (i.e. with no abnormal brain) (Seedhouse 2002). Where one stands on such a 'mental health' continuum may rely upon enabling factors such as the social determinants of health, in particular social inclusion. The trajectory of mental illness can also be associated with determinants such as social support and social exclusion, mediated by labelling and stigmatisation processes. People may generally be exposed to 'dynamics of inclusion and exclusion' in social groups, affecting mental state (Lemert, in Turner 1987).

### **2.3.1 Community participation as a key strategy of the new public health approach**

A new public health approach advocates political strategies to change the social conditions of disability and social determinants of health (Baum 2002). A central tenet for new public health is the 1986 Ottawa Charter for Health Promotion, which includes strategies such as community participation, intersectoral action and the development of healthy public policy (WHO 1986). The need to address obstacles to the development of healthy public policy in non-health sectors is a key part of this charter (WHO 1986). Subsequently, the new public health acknowledges the important contribution of political science to public health (Baum 2002), and theories of policy making are dealt with in the next chapter.

The new public health is considered to be in alignment with the democratic principles of new social movements, and has also been described as a social movement itself (Petersen & Lupton 1996). Its strategy of community participation aligns with the broad-based involvement and approach of new social movements. However, there have been many critiques of the capacity for empowerment through community participation (Dixon 1989; Grace 1991; Petersen & Lupton 1996; White 2000). The following section considers such critiques together with research on the potential for (and specific barriers to) community empowerment which has influenced this thesis. Following this, literature on intersectoral action is discussed before considering the connections between intersectoral action and community participation research.

### **2.3.2 Value placed upon community participation in policy and planning**

In public health and urban planning literature and research, community participation is often represented as a highly desirable process which occurs on a 'continuum' (Arnstein 1969, Pretty in Jones 2003, Laverack 2005). For example, Arnstein (1969) developed a 'ladder of participation', with its first two rungs considered 'non-participation' ('manipulation' and 'therapy'). These stages entail rubberstamping and the education and cure of participants. At the next stage, 'tokenism', 'informing, consultation and placation' occurs. 'Placation' is where community representatives appear on agencies or public boards but are unaccountable to a constituency or easily outvoted by the majority elite (and where participants may be assisted, leading to 'genuine placation'). At the higher rungs of the ladder of participation are 'partnership' (where the community is able to bargain with power-holders), 'delegated power' (where communities control programmes or plans) and 'citizen control' (where communities themselves govern programmes or institutions). In another similar continuum model, at the highest level of participation, 'self-mobilisation', people endeavour to change systems separately to those systems and control the use of resources (Pretty, in Jones 2003).

Conversely, Bishop and Davis (2002) argue that decisions about public participation in policy should be removed from 'values-based' continuum models of participation, and be determined by policy problems, resources and 'political judgements' (by bureaucrats) about the topic's importance (Bishop & Davis 2002). This perspective is in contrast to approaches which see a key role for health practitioners in developing community participation in policy and advocacy. For example, within each of Laverack's (1999, in Laverack 2005) empowerment domains, a range of roles for practitioners are identified which aim to strengthen the empowerment process (for example, bringing community groups together or assisting them to identify their priorities). Conversely, Carlisle (2000) provides a conceptual framework where professionals are either ('ideally') co-workers assisting to empower community groups, or those with expert status helping to protect and prevent individual's poor health. In her 'community activism' domain, the role of practitioners is to assist in developing political advocacy and coalition building skills (Carlisle 2000). This is the domain of most interest to this study as the focus is on community empowerment

through community influence upon policy outcomes.

### **2.3.3 Participation, professionals, elitism and 'knowledge elites'**

Professionals' role within community participation has been critiqued within a number of research and theoretical studies. Community participation in a development environment has identified the paternalistic role played by 'elites' who dominate participation processes (Botes & van Rensburg 2000). Somerville (1998) argues that to prevent elitism and encourage broader participation within tenancy participation, [expert] education and training is required for community groups (Somerville 1998). Charles and DeMaio (1993) also see a need to educate lay people in 'expert knowledge' to provide them with information to enable them a higher degree of participation (Charles & DeMaio 1993). Like Bishop and Davis (2002), they suggest it is for health professionals to decide the 'appropriate level of lay participation' prior to encouraging this (Charles & DeMaio 1993, p. 896). They also suggest that community participation mechanisms may serve to consolidate professional power rather than empower people as citizens (Charles & DeMaio 1993).

Similarly, Petersen & Lupton (1996) point to the dilemma arising where training of lay people by experts can reinforce existing power relationships. They argue that in the new public health, scientific based knowledge shapes problems and solutions and 'professional expertise remains privileged over lay expertise' (Petersen & Lupton 1996, p. 8). As in academic research, health professionals often require that community participants increase their knowledge and rationality through health professionals' expertise (Petersen & Lupton 1996). However, there are few suggestions that experts should be trained in lay knowledge and rationality (Petersen & Lupton 1996). A 'hegemony of participation' is implied, where individuals (whose 'consumer' status is constructed) participate in health services provided, or communities are 'developed', by a dominant group (Petersen & Lupton 1996). More empowering participation may be evidenced by participants being regarded as 'legitimate knowers' rather than endless voluntary resources (Nelson & Wright 1995) or people requiring expert training.

Bell (1973) has coined the term 'knowledge elites' to describe controllers of the key resources of knowledge and information in our post-industrial society (Bell 1973).

Storr (2002) argues that in an information society, power is closely related to access to, and control over, sources of information rather than the means of production. New social movement theory perceives struggles over information (its ownership, control and distribution) and struggles through the means of information (i.e. information technology) as core activities of social movement groups (Storr 2002). Because mental illness is associated with a lack of social and educational resources (in both a 'causal' and 'drift' affect) (WHO 2001), struggles over information and educational resources are likely to be pronounced in the mental health policy context.

### **2.3.4 Community participation and empowerment in the mental health context**

One prominent criticism of community participation in a mental health context is that 'participation' often becomes an end in itself, rather than a means to achieve improved social-structural conditions (Barnes & Bowl 2001). Following Arnstein's (1969) critique of 'therapy' as a form of participation, Barnes & Bowl (2001) warn that empowerment activity could be co-opted as a tool of therapeutic intervention of professionals, rather than a means to developing material and social change. Perceiving empowerment as an end-goal is seen an obstacle to material and social change (Barnes & Bowl 2001).

In one Australian study of consumer participation in mental health services, the effectiveness of 'consumer' participation was viewed in terms of health and treatment outcomes, rather than the 'empowerment' of service users (Tobin et al. 2002). In Tobin's (et al 2002) study, the role of professional culture in acting as a barrier to participation was noted, and researchers concluded that clinicians must be engaged if participation is to be 'effective'. 'Consumer' participation in treatment and recovery, and involvement in service development activities and projects, was extremely limited (Tobin et al 2002). There was virtually no 'consumer' led participation strategies identified, and the majority of 'consumers' were not familiar with the concept of participation in services (Tobin et al. 2002). A high decline in participation activities was attributed by researchers to people not wanting to be identified as 'mental health consumers' (Tobin et al. 2002).

An unwillingness to be fixed to the identity of 'mental health consumer' can be understood in terms of labelling theory (Scheff 1974), and stigmatisations processes

(previously discussed). However, in relation to WHO Healthy Cities projects, low levels of community input have been attributed to professional dominance and poor access to formal decision-making processes (see Petersen & Lupton 1996), factors which appeared pertinent to Tobin's (2002 et al) study.

Percy & Birrell (2004) argue that empowerment is a main but unclear or undefined goal of mental health services in the UK, but may be costly and counterproductive for service users. They argue that processes aimed at empowerment must be driven by service users themselves (Percy & Birrell 2004). However, a distinction can be made between 'participation' (where participation is as an end) and 'empowerment' (where participation is a means) (Somerville 1998, Laverack 2005). Empowerment has been defined as a process which leads to an increase in control over life choices leading to greater freedom (Somerville 1998), or as

the notion of people having power to take action to control and enhance their own lives, and the processes of enabling them to do so.

(Grace 1991, p. 330)

Access to decision making which determines resources has been seen as important to an empowering form of participation (Oakley 1991; Carlisle 2000; Laverack 2005). One example of action in Carlisle's (2000) 'community activism' domain is citizen juries, where communities have been involved in establishing health priorities and advising on resource allocation (Mooney & Blackwell 2004).

### **2.3.5 Problems with modes and processes for participation**

Professionals often expect discipline to conform to hierarchical models of administration when it comes to community participation processes, with consequences for the scope of political action

There is little recognition of how these hierarchical and idealized models of 'participation' constrain thinking about other possible forms of political intervention, or of how expert discourses themselves define and delimit the sphere of 'participation' and the subjects who are the 'participants'.

(Petersen & Lupton 1996, p. 157)

Gilroy (1998) similarly suggests that hierarchical decision-making processes of urban regeneration projects promote quick decisions and outputs and require cultural

change in decision making in order to be more inclusive, which is difficult to achieve. Jones (2003) also refers to a 'politics of inclusion' where community participants are drawn into governance arrangements and coerced into agreements.

Another problem for community participation as a vehicle for 'empowerment' is that processes may limit access to decision-making activity amongst a wide range of community representatives. As participation is determined along the same class, age, race and gender categories (i.e. similar people are consistently involved), it has been declared a 'minority activity' (Jones 2003). Representatives may be selected by professionals without constituencies or not act on behalf of (or without support of) community members they purport to represent (tokenism as described by Arnstein 1969)

Participatory methods are not automatically inclusive. They actively construct boundaries around communities or user groups by legitimizing some voice and not others

(George, 2003, p. 10)

Consumer representatives can be encouraged to look beyond the role perspective of individual 'health service user' and take upon a public policy perspective, being more mindful of the public good (Charles and DeMaio 1993). However, participation being a source of obtaining power/status [for both professionals and consumer representatives] suggests personal interests confounding the problem of representation (Jones 2003) and empowerment. This is likely to be reinforced where individual members are selected by government or prominent members of the community and are unaccountable to a constituency.

### **2.3.6 Co-option by political parties or within neo-liberal strategies**

Transfer of the management of social housing to tenants has been seen as a means to tenant empowerment (Somerville 1998), and corresponds with 'citizen control' forms of participation (Arnstein 1969). However, Somerville (19998) points out that housing bodies with so-called 'conservative' tenancy participation processes may be more empowering - if they provide good housing and support - than those with more participatory approaches. In this definition, empowerment is not equated with 'citizen control' but rather access to resources. Somerville (1998) makes an

important point within a neo-liberal policy context where tenant management strategies have been associated with a decline in public resources for housing (Gilroy 1998).

In another study, Towers (1995) demonstrates the way in which social democratic 'third way' strategies and politics, which advocate for greater community involvement in political processes (Giddens 1998), were utilised by political parties across the political spectrum. Liberal-conservative politicians in the UK used strategies of community politics to successfully gain power in local government in Liverpool, using this power to abandon large public housing projects in favour of housing co-operatives. This power was eventually to be regained by a Marxist based party who were *less* supportive of community politics and sought to replace the housing co-operatives with council housing. Eventually this was to be disbanded by a liberal-conservative national government who saw local governments as being too powerful and financially inefficient. This would ultimately have a negative impact upon community architecture initiatives and local communities when competitive tendering was introduced (Towers 1995). These examples serve as a caution against equating participation in public services or government with empowerment, and the co-option of participation strategies across the political spectrum.

### **2.3.7 Role of NGOs in participation, advocacy and reform**

Aspirations toward 'citizen control' of planning and services may need particular support from professionals or NGOs, leading to tensions between experts and non-experts, and tensions amongst experts. Due to the nature of psychiatric illness and its links with socioeconomic status (WHO 2001), people with a psychiatric disability may also be excluded from participation by their own health concerns, skills and experiences. Key barriers for participation for people with disabilities include poverty and the costs of mobility, disincentives to participation in welfare systems, a lack of support for participation and attitudes towards people with disabilities (Morris 2005). Similarly, Lister (1997) suggests that women in caring roles do not have the resources necessary for citizenship, such as time for education and training (Lister 1997). Given such contexts, the right of people not to be involved must be understood (George 2003).

Advocates may be necessary to assist people to advocate during episodic periods of

illness, to challenge professionals less supportive of community participation, or to assist with the development of resources necessary for participation. Acting 'on behalf of' has been referred to as 'citizen advocacy', a form of advocacy which is judged as paternalistic and less empowering than 'self-advocacy' (Fazil et al. 2004). Citizen advocacy is said to highlight the 'incapacity' of people with disabilities (Fazil et al. 2004).

Nevertheless, participation within a policy environment should be deemed more of a community group or organisational activity rather than an individual 'self-advocacy' activity. Lavallo et al (2005) suggests that a focus on citizen participation as an individual activity in policy making is misplaced because it is in fact 'civil society organisations' (CSOs) playing a representative role who are the main players in participatory institutions (Lavallo et al. 2005). In Lavelle's (2005) case study of development activity in Brazil, CSOs were diverse and had different capacities for participation and different connections with their constituents. Civil society organisations which had strong connections to political actors were more likely to participate in a political realm.

In Australia, NGOs role in advocacy at a national level has been somewhat compromised by government in the early 2000s (Maddison et al 2004). NGOs often acting on behalf of groups or as intermediaries between community and government, have had their representativeness and credibility questioned, and feared the implications of advocacy activity (such as a withdrawal of their charitable status) (Maddison et al. 2004). But NGOs' fear of having their funding reduced provides an example of the state's indirect power over the exercise of citizenship rights for people with psychiatric disabilities and their carers. Such a culture may result in NGOs engaging in 'risk management' by adopting conservative advocacy strategies for the livelihood of organisations. As new forms of governmentality (Dean 1999) have led to NGOs playing a greater role within service provision, this may lead to tensions between their advocacy and service delivery roles, particularly in an environment where NGO advocacy is challenged by government.

Curbing NGOs activity may be detrimental to health minister's success in advocating for mental health within their ministry. Funk et al (2005) claims governments have an important role to play when it comes to advocating for mental health within their

own governments. The development of an advocacy movement supported by government is essential to support and progress mental health sector reform. Funk's (et al 2005) suggestions for governments include resourcing and supporting the formation of alliances, particularly to address stigma (Funk et al. 2005). The importance of advocacy coalitions to policy change has also been recognised within intersectoral action research (O'Neill et al. 1997), discussed further below.

### **2.3.8 Intersectoral collaboration for healthy public policy**

This research also takes a 'sectoral' focus, which has a specific meaning within a health policy context. A sector can be defined as having the following characteristics:

Institutionalised patterns of knowledge and expertise; well-defined 'professional / administrative/political territory'; continuity in planning, accountability, and action strategies; formalized hierarchies, and established resource allocations for specific functions and work.

(Degeling, in WHO 1997, p. 4)

a cluster or complex of organisations connected to each other by resource dependencies and distinguished from other clusters or complexes by breaks in the structure of resource dependencies

(Benson, in Hill 2005, p. 231)

Further, intersectoral action is also a main focus, which goes well beyond collaboration efforts for 'health service integration', or the 'horizontal' or 'vertical' integration of health services (Stoelwinder 1999). Intersectoral action has been defined as

the joining of forces, knowledge and means to understand and solve complex issues whose solutions lie outside the capacity and responsibility of a single sector. Intersectoral action can be used to promote and achieve shared goals in a number of areas, for example policy, research, planning, practice and funding. It may be implemented through a myriad of activities including advocacy, legislation, community projects, policy and programme action. It may take different forms such as cooperative initiatives, alliances, coalitions or partnerships.

(Health Canada 2002 viewed 21 August 2002, <http://www.hc-sc.gc.ca>)

a recognised relationship between part or parts of the health sector and part or parts of another sector, that has been formed to take action on an issue or achieve health outcomes...in a way that is more effective, efficient, or sustainable than could be achieved by the health sector working alone.

(National Center for Health Promotion, in Bettcher 1997)

Prior research into intersectoral action in public health has focused on the processes and structures useful for intersectoral action or the barriers to collaboration, both at an individual worker role and organisational level. At an individual level, values, attitudes, personal skills and the knowledge of individuals are important for successful collaboration (Walker 2000). Walker (2000) refers to 'collaboration tacticians' that ride the boundaries of agencies and facilitate collaboration, whilst de Leeuw (1999) identifies 'social entrepreneurs' effecting policy change in Healthy Cities.

According to Walker (2000), collaboration occurs on a continuum, starting with referral networks, through to relational contracting, joint planning, joint service provision, and ultimately collaborative (interorganisational) alliances. Such interorganisational linkages comprise both individual mediators and 'mediating structures' i.e. an interagency coordination committee with a stable structure and rules for operation (Walker 1992). Cross organisational processes are also essential for collaboration and require special skills such as negotiation, strategic planning, trust building and interpersonal skills (Walker 2000; Walker 2002). Negotiation is a process that has been described as 'the real work of a collaboration' (Walker 2000, p. 16) and negotiation skills are key to policy entrepreneurship (Kingdon 2003) and associated with women in leadership positions (Stanford et al. 1995).

Research on WHO Healthy Cities initiatives and other inter-sectoral collaboration has highlighted the importance of the process of people working together rather than simply the existence of structures in joint planning (Gray 1989; Costongs & Springett 1997). Processes for collaboration include developing a shared definition of the problem, joint ownership of decisions and collective responsibility for managing problems (Gray 1989). The exchange of beliefs and values occurring during intersectoral policy formation is an important part of processes bringing about genuine change (Costongs & Springett 1997).

Key problems for intersectoral collaboration include co-option by government, competition for resources and leadership, and turfism by professionals (Stern 1990). Baum (1992) has highlighted the way in which governments fund collaborative projects on a departmental basis as one obstacle to a collaborative approach (Baum 1992). The stability of an organisation and its staff (especially those individuals with the necessary skills for collaboration) is central to the maintenance of interagency agreements (Richardson et al. 1989). The turnover of top-level management can mean that coordination is difficult to achieve regardless of the type of interagency agreement employed (Richardson et al 1989). Such turnover could in turn effect trust which is also an important factor in collaboration (Walker 2000), particularly in institutional contexts (Sako 1992; Crane & Warnes 2000; van Eyk & Baum 2002). Inter-professional distrust and a reluctance to share information are main obstacles to interagency activity (Glastonbury, in Crane & Warnes 2000).

Ring (1997, in Walker 2000) describes two forms of trust that are relevant to inter-organisational relationships - 'fragile trust', which is trust in the predictability of the outcomes of interactions (trust that people or organisations will deliver) and 'resilient trust', or trust in the essential goodwill of others. Fragile trust is considered to be the foundation for developing relationships whilst resilient trust is more durable, however both help to explain successful long-term relationships (Ring 1997, in Walker 2000). External factors may impact upon trust even where people are recognised to be acting in good faith and resilient trust has been established. For example, competition for resources may impact upon trust (Walker 2002), both within and across sectors and between organisations and community groups. Walker (2000) suggests that a contractual environment has created competition in the provision of resources leading to ambiguous outcomes including the slow development of trust.

Van Eyk & Baum (2002) suggest that the development of partnerships based on trust, the negotiation of power differences and professional territories, and management of mistrust and interagency tensions are essential for achieving improved collaboration across the tertiary and primary health care sector. They suggest that well-defined professional territories also occur within and not only across sectors, further complicating the development of inter-sectoral work (van Eyk

& Baum 2002). Conversely, Tesoriero (2002) claims that trust is not essential for effective health promotion partnerships, and that trust is defined through cultural values. He also critiques idealistic perspectives on health promotion partnerships that aim for or assume consensus, arguing that consensus is not necessary for health promotion partnerships, and for the need to respect and utilise different agendas and interests aligned with various 'problem representations' (Tesoriero 2002). In their study of Healthy Cities' projects in Quebec, O'Neill (et. al. 1997) noted that inter-group conflict and divergent perspectives could be stimulated by a lack of adversaries. This was minimised by a search for consensus and the use of non-authoritarian mechanisms to resolve conflict (O'Neill et al. 1997). Conversely, insecurity brought on by economic and political environment can serve to facilitate political coalitions in the health and human services sector (Boissevain, in Weisner 1983). Weisner (1983) studied two new coalitions which had formed during the Reagan administration in the US. One of these emerged in order to advocate for legislation that would ensure community participation and decision-making in US federal block grants. The second coalition was a lobbying and information sharing group which directly arose from concerns that the US Reagan administration would dramatically cut funding to social programmes (Weisner 1983). These coalitions were comprised of allies within the context of the political environment (Weisner 1983).

Much of the intersectoral public health research is proscriptive or identifies barriers to intersectoral collaboration, and policy theory is not often explored in analysis. As discussed in chapter 1, de Leeuw (2005) calls upon public policy research to engage more with political action and theory (de Leeuw 2005). Those studies which have considered political theory and the public policy gains of intersectoral collaboration have similarly highlighted the failures of Healthy Cities projects. For example, O'Neill (et al. 1997) used coalition theory to understand the failures in Healthy Cities projects and the selfish interests of individuals and actors within coalitions (i.e. measuring transaction costs of involvement). O'Neill (et al 1997) further suggest that public health research needs to go beyond 'ideological' perspectives on intersectoral action and recognise that cross sectoral work is largely unsuccessful. Similarly, Goumans and Springett (1997) studied ten Healthy Cities projects and recognised that despite their 'healthy public policy' aim, the initiatives have remained projects

and not led to substantive policy change (Goumans & Springett 1997). They claimed that despite such failure, projects provided a vehicle through which people from a range of organisations met. This enabled the development of a common language and drew attention to health, not simply health care. One identified problem for projects was that they were too dependent upon individuals.

In contrast to these perspectives, de Leeuw (1999) suggests that Healthy Cities have led to policy change, promoting the role played by individuals within this process. de Leeuw (1999) used Kingdon's (1995, 2003) agenda setting theory (see chapter 3) to claim that social entrepreneurs were clearly visible across the ten WHO Healthy Cities projects researched. These leaders worked across 'problems, politics and politics' to facilitate policy change (Kingdon 1995, 2003), and were most successful where 'entrepreneurship' had been 'institutionalised' (de Leeuw 1999).

Institutionalising social entrepreneurship was particularly important due to the 'personal interests' incentive of social entrepreneurs, who moved on to better paid positions (de Leeuw 1999). de Leeuw (1999) considers an important part of this 'institutionalisation' process to be 'strategic organisational development'. Similarly, Goumans and Springett (1997) conclude that organisational and community development could create awareness about the role of public policy in health promotion.

### **2.3.9 Intersectoral collaboration and community participation**

Another theme which emerges from Healthy Cities research is the extent to which policy development can either be a top-down or bottom up process, involving either rational decision-making or incremental changes (Delaney 1994; Costongs & Springett 1997). Delaney (1994) claims that although largely ideal and ineffective, rational decision-making approaches with clear control and administrative structures are commonly used within intersectoral projects. Delaney (1994) proposes a 'middle ground' network model of policy change which recognises the resource interdependency of organisations in policy networks, and the local bargaining and power relationships which emerge.

There have been many problems identified for community participation within intersectoral collaboration research. Popay and Williams (1998) argue that public participation is in fact the most difficult aspect of partnerships due to power

differentials between professionals and service users, and between organisations and community groups (Popay & Williams 1998). Stern (1990) suggests that community groups can be cynical towards cross sectoral alliances where there are few resources enabling their engagement and where professionals may misuse community development agendas. Network models of policy development which can inform community participation in policy are discussed further in the following chapter.

## **2.4 Conclusions and implications for this research**

This chapter firstly considered conceptions of the role of the state in terms of societal change, before outlining the way in which people may be managed and self-manage beyond government policy processes. The potential for powerful discourses to influence the experience of people with psychiatric disabilities and carer groups was explored (including community care and medical discourses). Stigma and labelling processes which particularly impact upon people with mental illness were considered in relation to the mental health and housing policy environment. The chapter then explored a challenge to a ‘medical discourse’ on health, the social determinants approach, which recognises the contribution of factors outside of the health sector to one’s health. This alternative conception of health is associated with a ‘new public health’ approach, and strategies for intervention including the development of healthy public policy, intersectoral collaboration and empowering forms of community participation. This research not only aims to explore the impact of community participation groups upon the development of ‘healthy public’ policy (in particular intersectoral approaches to housing). It also examines the effect of medical discourses and stigma and labelling processes upon ‘community participation’ groups themselves and the mental health policy context more generally. The implications upon this study of the literature and research outlined in this chapter are further explored below.

### **2.4.1 The capacity for empowerment through community participation**

The concern here is the extent to which housing and support resources are available to people with psychiatric disabilities. The extent to which individuals and families

are expected to be 'self-managing' without support, or monitored within 'community living' is a focus. The permeation of discourses on 'community care' in policy environments and what this means for individuals and families in terms of self-regulation was one focus for the study. Of especial interest is how the various discourses of community care, community and 'consumer' participation and citizenship interact with a medical and rights discourses on disability (Fulcher 1989) and the 'clinical gaze' (Foucault 1975) of the medical profession.

The existence of modes of governmentality involving a range of parties (Dean 1999) highlights the need to look beyond the state when considering opportunities and barriers to societal change. This research should not only consider NGO and consumer groups, organisations and networks within policy processes, but also the effect of hegemonic discourses on policy debates and participation mechanisms. NGO and consumer groups contributing to policy could themselves be subject to 'consumerist' rather than 'democratic' principles for participation (Beresford et al. 2002). Groups may also engage with medical model explanations of mental health and illness (Roach-Anleu 2002), or reject identities based upon these discourses (Barnes & Shardlow 1996). Through the case study challenges to 'consumerist' and 'medical' discourses, and stigmatization processes, were explored by examining participation and advocacy processes.

#### **2.4.2 Empowerment as access to resources determining health**

The literature makes it very clear that practices of community participation should not be directly associated with empowerment. Neo-liberalism, the basis of new forms of governmentality (Dean 1999), reinforces self-responsibility and service users' involvement in governance at the same time as public services are withdrawn. Within this context, community participation needs to be evaluated in terms of the degree of empowerment, defined as access to resources (including for carers) rather than 'citizen control' (Arnstein 1969). A key focus of this study is the evaluation of the outcomes of participation and policy processes, or participation as a 'means', rather than an 'end' (Barnes & Bowl 2001).

### **2.4.3 Tension between citizen control and the need for professional support in participation processes**

This review suggested that citizen control (and redistribution of power) may be particularly difficult to achieve for people with disabilities and their carers, particularly within cross-sectoral policy environments. Firstly, these groups may need support for advocacy or participation within policy, particularly during times of illness. Support may also be required in order to develop resources for citizenship such as education (Lister 1997), and to prevent elitism within participation (Somerville 1998). Secondly, citizen control may be difficult in a cross sectoral environment where a range of public services are being managed (Hill 2005), and power differentials are enhanced (Popay and Williams 1999). Professional advocates supporting community participation may be particularly important within cross sectoral contexts due to the range of organisations and interests involved.

However, intersectoral action research has also highlighted tension between the need for professionals and individual social entrepreneurs in policy change, and the problems arising from too much focus on individual experts (de Leeuw 1999, Goumans and Springett 1997). The power differentials between professionals and mental health services users (and families) may also be reinforced where groups are led by 'knowledge elites'. These differentials are likely to be already strong due to the inverse relationship between mental illness and social-economic resources (WHO 2001).

### **2.4.4 Intersectoral collaboration and community participation discourses across sectors**

Common understanding, a common language and united vision have all been considered important and desirable factors within intersectoral collaboration (Gray 1989), although consensus is not necessarily essential for health promotion partnerships (Tesoriero 2002). Across sectors, there are likely to be different attitudes towards, discourses on and interests in intersectoral collaboration and community involvement (and health and disability) within policy processes. The cross sectoral environment explored within this research is likely to further illuminate the various discourses on participation, health and disability tied to interests within and across policy sectors, and their impact upon policy processes.

#### **2.4.5 Intersectoral collaboration, new forms of governmentality and trust**

This research is concerned with development of cross sectoral connections in organisational contexts, where a number of barriers to collaboration have been identified. Power and trust are likely to be two important factors in ‘new forms of governmentality’ (Dean 1999) and organisational contexts. Trust between professionals has been deemed important for collaboration both within and across sectors, although practices such as contractualism and competitive tendering have impacted upon trust (Walker 2000). Trust may also be affected where NGOs are playing both a service provider and advocacy role and where service-provider/service user power differentials are reinforced.

Institutionalising intersectoral action, developing coalitions and organizational and community development were some key recommendations for intersectoral policy change (O'Neill 1997, Goumans and Springett 1997, de Leeuw 1999). The development of networks for policy change and trust between organisations, professionals and service users is further explored in the research and focus groups of this case study. The next chapter considers a range of theories on policy development and change to illuminate policy processes.

### **3 The Policy Making Process**

What the political perspectives seeks above all is an understanding of ideology, to reach a point where ideology is denaturalized and defused through analysis – so that we may exchange a puzzled, depressed response to it for a clear-eyed, genealogical grasp of its sources and effects.

(De Botton 2005, p. 222)

Policy theory is important for understanding the achievement of empowering forms of participation, where communities have influence over policy processes and resources, and important for understanding barriers and enablers to intersectoral policy. In alignment with the critical perspectives of health and society discussed in the previous chapter, this chapter argues that policy making is best considered to be an irrational, haphazard and political process within which there are unequal participants. In particular, this chapter follows Lewis (2005) and Sabatier and Jenkins-Smith (1999) in emphasising the important role played by networks and coalitions in policy environments. Following on from the previous chapter's discussion on the role of medical and consumerist discourse, the chapter explores the connection between policy networks, ideas and power (Lewis 2005). The role of 'problem representation' in policy debates (Bacchi 1999) is also explored. The implications of these perspectives for the research questions are then considered.

#### **3.1 Traditional approaches to state policy making and critiques**

##### **3.1.1 The traditional 'policy stages' or 'cycles' approach**

Policy can either be seen as a statement of intent or public announcements of government, decision making to fund programmes, or the affirmation of rights within institutions (Bessant et al. 2006). 'Ideally' policy consists of public statements of government linked to resource allocation for implementation. Traditional approaches to policy making sees the process as the rational pursuit of goals by a 'single entity' government (Colebatch 2002). In alignment with this, Bridgman and Davis (2004) see government as being comprised of political, policy and administrative facets which are coordinated to ensure shared goals.

Traditional approaches to policy are variously described as the 'policy stages', 'policy cycle', or 'stages heuristic' and see policy being developed incrementally through a series of consecutive stages organised by government (Bridgeman & Davis 2004). These stages include agenda setting, policy formulation and legitimation, implementation and evaluation (Bridgeman & Davis 2004). Hill (2005) suggests that most policy analysis is largely 'proscriptive' rather than 'descriptive' and this fits with the traditional policy cycle approach. Claims to the stages approach should be modest as interruptions may affect the neat policy 'stages', and the impact of values upon policy is largely overlooked in this approach (Bridgeman & Davis 2004). Sabatier (1999) also criticises this 'traditional approach' for focusing upon a single policy process rather than the more usual multiple, interactive cycles, and the essential connections of the supposedly 'distinct' policy stages (Sabatier 1999).

Traditional approaches view policy goals initially being formulated through the will of the public via representative democracy, rather than a political process where dominant and subordinate groups vie for influence (Hill 2005)

The theory of representative democracy sees expressions of the popular will as an 'input' into the political system leading through various processing stages to a policy outcome as an 'output'.

(Hill 2005, p. 19).

However, within 'stages' approaches to policy making, community groups have a role in a 'consultation' stage, dependant upon public servants' skills and decisions to go beyond their key organising and decision-making role. For example, Skelcher (1996) focuses on problems that arise where consulting and involving people in discussions about public service provision are new roles for public servants, for which they may be ill-equipped (Skelcher 1996).

### **3.1.2 The 'garbage can' or 'multiple streams' approach to policy development**

One reaction to the policy stages approach is Kingdon's (2003) 'multiple streams' or 'garbage can' approach. Kingdon argues that public policy is best explained as the result of the ways in which 'problems, policies and politics'<sup>11</sup> do and don't come

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<sup>11</sup> The difference between policy and politics is discussed below in relation to Kingdon's (2003) three

together. He suggests that sometimes policy change is the result of the direct political acknowledgement of the importance of a problem. At other times it is the result of communities of interest adhering to policy solutions, without much attention to the nature of the problems to which they are a response. Policy change is the result of the different ways in which the disparate streams of problems, policies and politics interact, an interaction which is mediated by 'policy entrepreneurs' (Kingdon 2003).

In Kingdon's 'problem stream', the interpretation of indicators or evidence in defining problems is highlighted. He distinguishes between conditions, evidence and indicators, feedback and problems. Problems are first identified through monitoring government indicators (e.g. complaints or monitoring processes), expenditures and the impact of expenditures, and government reports or academic research. Budgetary considerations, especially budgetary constraints, can explain the placement or withdrawal of items from political agendas

Programmes, agencies, and professional careers wax and wane according to their budget share. A budget pinch very directly affects both bureaucrats and legislators since the programmes in which they have a personal career stake are affected. Budgetary considerations sometimes force items higher on the governmental agenda, acting as a promoter. At other times, budgets act as constraints, holding some items low on (or even off) the agenda because the item would cost more than decision makers are willing to contemplate.

Kingdon (2003, p. 105)

However, indicators must be powerful, must be pushed and have an agreed interpretation to become 'problems' (which I refer to subsequently as 'policy problems'). 'Policy problems' need to be promoted, either through crises (or other 'focusing event'), pressure group activity or the personal experiences of policy makers. Values, comparisons and the way in which problems are categorized play an important role in the political stake of problem definition. Not all indicators and feedback will be interpreted as 'policy problems', and for such interpretation to occur people must both see a problem and want to act on it (Kingdon 2003).

Kingdon's 'policy stream' contains the policy communities which form around a

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'problem, policy and politics' streams.

'policy problem', including experts both inside and outside of government. These include public servants, researchers/academics and interest group policy analysts, as well as group's ideas and specific proposals. The existence of organised interests pursuing policy goals helps to explain why Kingdon's 'policy stream' may be separate from the 'problem stream'. Kingdon argues that policy communities are more or less fragmented, and the more fragmented the community, the more disparate and unstable are policy agendas. Close knit policy communities occur within the health sector in Kingdon's US example. A close knit policy community

generates common outlooks, orientations, and ways of thinking. These common features, a result of the relatively tight integration of the community, in turn strengthen that integration. As people have a common language, they can better communicate with one another.

(Kingdon 2003, p. 121)

In Kingdon's view, a policy proposal linked to a perceived 'policy problem' enhances chances for its success. Ideas play an important role in policy with policy entrepreneurs preparing people across streams through the diffusion of ideas, going beyond political advocacy within their own coalitions. However, ideas must be both technically feasible and accord with values if they are to survive. In particular, ideas floating around in the policy community must accord with the values of policy specialists

Proposals that survive in the policy community are compatible with the values of the specialists. Obviously, all specialists do not have the same values, and in the instances of disagreement among the specialists, conflicts spill over into the larger political arena. But in some respects, the bulk of the specialists do eventually see the world in similar ways, and approve or disapprove of similar approaches to problems.

(Kingdon 2003, p. 134-35)

This notion that policy solutions need to be socially or politically acceptable, rather than simply justified by technocratic information and rationality, fits in with a social constructionist approach to policy (Fischer 2003) (discussed below). It also corresponds with Lewis' suggestion that health policy networks are resistant to any solutions which proffer alternatives to a bio-medical perspective of health and challenge medical dominance (Lewis 2005) (see below).

Finally, Kingdon's 'political stream' encompasses community mood, political

campaigning, elections and changes of government and the influence of political party ideology. Success in policy agenda setting is partly a result of the degree of consensus amongst interest groups, and the negotiations undertaken in the policy development process. Success is also dependent upon public interest in issues and 'events' within the 'political stream', such as a change in government.

From Kingdon's perspective, 'matching streams' for policy agenda setting occurs through 'policy entrepreneurs' seizing 'windows of opportunity' by presenting their long-awaited specific policy proposals. Policy entrepreneurs either come from the largely hidden actors presenting policy alternatives (academics, career bureaucrats, policy consultants for interests groups), or public figures (politicians, journalists) who contribute to the broad policy agenda. Policy entrepreneurs are willing to invest their resources to advocate for policy solutions for a range of reasons (e.g. personal interest in the topic, desire to be close to the political environment). Policy entrepreneurs seize 'political windows of opportunity' brought about by changes in government, changes in key personnel or the agendas of key personnel. Alternatively, entrepreneurs can seize 'problem windows of opportunity', opened when governments become aware of an urgent problem and desire to act. They can also play a role in pushing things higher up agendas through the way in which they present problems (Kingdon 2003).

Kingdon also argues that 'policy spillovers' create windows of opportunity for other 'similar subjects'. A policy spillover occurs when policy activity in one area influences another area. For example, deinstitutionalisation within the health sector was one potential opportunity for a 'policy spillover' within the housing and disability sectors, as people with psychiatric disabilities would no longer be housed within institutions.

Tiernan and Burke (2002) used Kingdon's model to examine Australian housing policy and claim that the Australian housing policy context is even more unstable than the US policy context described by Kingdon. They partly attribute this to administrative and political changes stymieing the development of particular beliefs and understanding amongst policy participants (in the 'policy' network). The institutional context and associated beliefs and understandings were considered important to policy development. The close relationship between politicians and

bureaucrats explained the gap between the range of possible policy responses to the problem of low income people requiring housing assistance, and the actual solution of 'rental assistance' that was adopted. Policy responses outlined in housing reviews (e.g. management reforms) were considered largely irrelevant to the problems upon which they were based (e.g. lack of supply side housing). 'Market-liberal' 'economic-rationalist' discourse was aligned to 'safety net' housing, more commercial modes of operation and new management practices in the public sector from the 1990s, rather than 'supply side' reform (Tiernan & Burke 2002).

Given the suggested importance of the institutional context and the close relationship between politicians and bureaucrats in Australian housing policy (Tiernan and Burke 2002), the institutional theory of policy making is explored below.

### **3.1.3 Institutional theory, political discourse, and policy implementation**

Institutional theory considers the 'venues' for influencing policy (such as the legislature, bureaucracy) as political actors in their own right (March and Olsen, in Hill 2005) and key barriers to potential policy change (Skocpol, in Hill 2005)

Institutional theory is clearly relevant for the exploration of the barriers to change that are erected when efforts are made to get separate organisations to work together in new ways. If traditional bureaucratic organisations have well-established, complex institutional arrangements that include standard operating procedures, organisational cultures and value systems, then there will be resistance to ways of working with others that threaten these.

(Hill 2005, p. 232)

Institutional theory may be particularly relevant for understanding barriers to intersectoral collaboration and the implementation of programmes across government departments.

Whilst institutional theory sees institutions as key political actors, implementation theory explains how policy development and implementation are separate stages involving different policy actors or interest groups (Rein 1983). For Rein, policy implementation is the most significant 'stage' for determining democratic processes in policy making. He refers to a 'politics of implementation' to describe how policies may be altered once they are administered, and how policy implementation is an

extension of the political process. Rein argued that government agencies create constituencies and generate their own agendas for reform through implementation. New policies are raised through the executive of government through politicians' attempts to manage the resource problems of government (Rein 1983).

Lipsky (1980) similarly points out a discrepancy between policy development and implementation stages by suggesting that 'street level bureaucrats' may alter stated broad policy objectives through service delivery processes. Street-level bureaucrats may seek greater autonomy by making discretionary decisions and ignoring central agency policy (Lipsky 1980). Lipsky (1980, p. 60) claims that 'clients seek services and benefits; street-level bureaucrats seek control over the process of providing them'. Delaney (1994) suggests that the personal values and working constraints of street level bureaucrats and their influence upon intersectoral collaboration should be considered in addition to goals and structures. The influence of 'street level bureaucrats' highlights the importance of user involvement in policy implementation (Lipsky 1980, Delaney 1994).

Implementation theories have been linked to the traditional 'stages' models of policy discussed earlier, and have been criticised for lacking explanatory power (Sabatier 1999). However, the general notion that policy agendas arise through implementation stages (Rein), or are altered through implementation stages (Lipsky) is complimentary to and helps explain Kingdon's argument that there may be 'policies' in search of 'problems'. Both implementation and institutional theories imply a close connection between Kingdon's separate 'policy' and 'politics stream', or the connection between politicians/political party ideology and policy makers in an institutional setting.

Modern institutional theory helps to describe the way in which policy actors all operate within the confines of political discourses linked to institutional practices. According to Hall

politicians, officials, the spokesmen for social interests, and policy experts all operate within the terms of political discourse that are current in the nation at a given time, and the terms of political discourse generally have a specific configuration that lends representative legitimacy to some social interests more than others, delineates the accepted boundaries of state action, associates contemporary political developments with particular interpretations of national history and

defines the context in which many issues will be understood.

(Hall, in Hill 2005, p. 84)

Thus political discourses give rise to the political voices and agendas of policy actors (or an 'enunciative position', a term explored later in this chapter).

Support for modern institutional theory is found in claims of the influence of neo-liberalist political discourses, connected to government institutions, upon housing policy (Tiernan and Burke 2002; Williams and Labonte 2003). However, traditional institutional theory has less explanatory power given new forms of governmentality (Dean 1999). Lewis (2005) claims that health governance is characterised by more complex governance arrangements, where health organisations are increasingly involved in shaping policy and delivering services. The move toward more complex governance provides the rationale for researchers to consider actors beyond the 'core executive' of the state when analysing the policy making process (Richard and Smith, in Hill 2005).

### **3.2 Policy networks beyond the state**

One basis for Sabatier's (1999) criticism of the 'stages' models of policy is that the framework fails to pinpoint 'causal drivers' in policy. In response to this limitation, the advocacy coalition framework (ACF) offers an explanation for co-ordinated political alliances across professions and institutions (e.g. media, academia, government) actively engaging in policy processes (Sabatier & Jenkins-Smith 1999). It considers such alliances, referred to as 'advocacy coalitions', and competing networks forming in reaction to such alliances (Colebatch 2002).

Advocacy coalitions are said to be motivated by their various levels of beliefs. At the first level are 'deep core beliefs' resistant to change, in alignment with broad left/right political parameters. At the next level, there are more flexible 'policy core beliefs' which hold coalitions together; these are 'a coalition's basic normative commitments and causal perceptions across an entire policy domain or subsystem' (Sabatier and Jenkins-Smith 1999, p. 121). 'Secondary aspects' of beliefs include those beliefs particular to an advocacy coalition, including perceptions about the importance of

problems and policy preferences. According to Sabatier and Jenkins-Smith (1999), coalitions seek to manipulate government and other agencies and individuals in order to realize their own 'belief system' through policy. Whilst advocacy coalition's belief systems, rather than institutional affiliations, are the focus of analysis, public policies are also considered to be 'belief systems' which incorporate perceptions about the causes and magnitude of a policy problem, and the way in which a problem may be resolved (Sabatier and Jenkins-Smith 1999).

The ACF was partly developed as a response to the notion that there are open policy processes in representative democracy. The ACF acknowledges that there are a range of participants within policy development (or a horizontal approach to policy making; Colebatch 2002). However, it also claims powerful alliances between members of government, policy makers and professionals which may exclude some members of the community. In this way it synthesises its 'desire to synthesize the best features of the top-down and bottom-up approaches to policy implementation' (Sabatier and Jenkins Smith 1999, p. 119). Due to the role which it sees government playing within coalitions, the ACF has the capacity to explain how the political process of policy making can extend into implementation stages (Rein 1983).

Advocacy coalitions exist within a 'policy subsystem' which contains many actors with different values, interests and perceptions across professional domains, and disputes involve deeply held interests, values, money and authoritative coercion. The extent to which policy areas should be considered a policy subsystem depends on the level of legal autonomy and integration. Within each policy subsystem there are a number of advocacy coalitions, each of which shares beliefs and resources and some level of coordination activity. Advocacy coalitions competing within policy subsystems selectively present or misrepresent evidence, making policy processes sometimes resemble political debates (Sabatier and Jenkins-Smith 1999). Advocacy coalitions are more stable within longstanding policy subsystems (Kingdon 2003).

The ACF assumes that coordination activity will occur as those sharing beliefs would want to pool resources, a sufficient reason to overcome the 'transaction costs' of interaction (Sabatier and Jenkins-Smith 1999). Organizational interests may however prevent coordination activity, especially where organisations are competing for funds. Competition for government resources also potentially explains government

policy actors being cautious about engaging in coalitions with external policy actors.

Policy core beliefs may change with new information or experiences, or perceptions about the impact of government programmes. This is referred to as 'policy oriented' learning. Additionally, 'policy brokers' may mediate between advocacy coalitions and engage in policy learning even where this may be difficult across coalitions. 'Policy oriented learning' also occurs across policy subsystems through 'prestigious' forums dominated by professional norms, in which professionals from different advocacy coalitions are forced to participate. Policy core beliefs should be avoided in such learning forums, as they can lead to defensiveness amongst participants (Sabatier and Jenkins-Smith 1999).

The ACF approach additionally acknowledges the role of political parties and events in major policy change, such as changes in government and administration. Policy change in the ACF approach is primarily a consequence of external events and competition with the policy subsystem. External pre-requisites to policy change include socio-economic changes, changes in government and policy decision-making from other sub-systems. Other influences include a country's political system, the degree of consensus required to affect change, the influence of hierarchical government upon change, public opinion, or the replacement of coalitions. Major policy changes are infrequent and not all external change leads to major policy change (Sabatier and Jenkins-Smith 1999).

### **3.2.1 Structural interests, networks and ideas in health policy analysis**

A number of political science perspectives of health policy have identified dominant structural interests either resisting or advocating for policy change (Alford, in Palmer and Short 2000, Ham 2004, Lewis 2005). These approaches take what Lewis (2005, p. 173) refers to as a 'macro level of analysis'. For example, Alford (in Palmer and Short 2000) claims that there are three key interest groups influencing the health policy environment. These include professional monopolists (medical practitioners and pharmaceutical manufacturers attempting to maintain the status-quo and resist policy change), corporate rationalisers (planners, administrators and consultants motivated by efficiency, effectiveness and equity) and community structural interests (organisations and agencies often representing particular client groups, motivated to

improve health care particularly for specific client groups). Alford considers the 'professional monopolists' to be the dominant groups in health policy processes, but challenged by corporate rationalisers. Similarly, Ham (2004, p. 141) argues that 'corporatism may be a more accurate description than pluralism of a policy-making system in which producer groups are dominant'.

Palmer and Short (2000) point to problems in Alford's approach which, unlike the ACF approach, ignores the role of political parties and the impact of government upon health policy. The role of trade unions in health policy and the heterogeneity of the medical profession (where some groups are seeking to change the status quo) are also overlooked in this approach (Palmer and Short 2000). Additionally, 'structural interests' approaches can overlook the way in which ideas and discourses are used by different groups within policy processes, or the way in which political discourses may give rise to 'structural interests'.

Conversely, Lewis (2005) builds upon the network approach of Sabatier and Jenkins-Smith, making the connections between health policy networks, ideas and power. From Lewis' (2005) perspective, the health sector is held together by intrinsic beliefs about health and the medical profession. Lewis (2005) suggests, based on her research in Melbourne, that networks of influence in health governance are associated with a 'deep structure ideation'

A deep structure ideation is used to convey a sense of the foundational and slow-change realm of ideas. It consists of the intellectual and normative framework that underpins any particular sector and grants power and legitimacy to those associated with it. Here, ideas are broad and enduring and so embedded that they can seem beyond change.

(Lewis 2005, p. 96)

[Deep structure ideation is defined as] a fundamental set of ideas, associated beliefs, values, and perspectives that determine problem recognition and definition, shape the policy discourse and constrain possible policy proposals and strategies. But deep structure ideation is not an anchorless set of ideas: actors use ideas for their own purposes, drawing on them to give meaning and normative direction to their thinking and action, and structures shape the environment within which policy making happens.

Lewis (2005, p. 98)

Lewis (2005, p. 96) refers to Kingdon's policy ideas in the policy stream as 'surface

level ideation' as they are proposals based upon ideas which may readily change. Conversely, a 'deep structure ideation' acts as a barrier to possibilities for policy changes as the policy framework is constrained by the dominant biomedical model in health (Lewis 2005). This 'deep structure ideation' is also different to the 'deep core' beliefs of advocacy coalitions which exist along broad political parameters (e.g. left/right wing) (Sabatier and Jenkins-Smith's 1999).

Lewis (2005) also advocates consideration of the various professions within health policy analysis and their relationship to the state. According to Lewis (2005, p. 176), medicine has a 'cultural authority' tied to a bio-medical paradigm of health and illness. Changes to conceptions of health and illness are considered necessary to health policy change, but 'social determinants' approaches are also deemed controversial as 'alternative views of health that focus on social determinants are troublesome because they challenge the underlying bias of the health sector and the foundations of politics and policy, including the portfolio structures of government and the short-term focus of politics' (Lewis 2005, p. 176). Thus Lewis (2005) highlights the power structure associated with a medical discourse of health and disability, and its congruence with broadly defined political interests.

### **3.3 The role of discourses in policy development: social and critical constructionism**

#### **3.3.1 The social and political acceptability of evidence for policy**

Whilst Sabatier and Jenkins-Smith (1999) and Lewis (2005) connect ideas to advocacy coalitions, networks and power, social constructionists such as Hajer (in Fischer 2003) argues that 'discourse coalitions' should be the main focus of policy analysis. Fischer (2003, p. 102) explains discourse coalitions as being 'policy coalitions ... held together by narrative storylines that *interpret* events and courses of action in concrete social contexts.' Unlike advocacy coalitions, discourse coalitions are not necessarily active or involved in coordination activity within policy environments (Fischer 2003).

This discourse coalition approach is part of the social constructionist perspective on

policy making, based upon Foucauldian concepts of power discussed in chapter 2, and currently popular in Australian housing policy debates (Kemeny 2004). Within social constructionist approaches to policy, the social-political context of the policy environment is emphasised, and values, beliefs and associated discourses and ideologies are seen as central to the definition of policy problems and their solutions (Fischer 2003). Following Foucault, social constructionism considers 'non-political' realms such as science as influential to policy and governance, *in addition to* political institutions and players (Fischer 2003). Policy making from the social constructionist perspective is conceptualized as

situated at the intersection between forces and institutions deemed 'political' and those apparatuses that shape and manage individual conduct in relation to norms and objectives but are deemed 'non-political' such as science or education

(Gottweis, in Fischer 2003, p. 81)

From a social constructionist approach, politically undesirable evidence will not necessarily lead to policy change, as factors considered 'social problems' integrate both normative factors and empirical evidence (Fischer 2003). Policy decisions incorporate social and political realities and assumptions, not just technical information (Fischer 2003). Policy solutions must be socially and politically acceptable, rather than simply justified by a technocratic information and rationality. Social trust is important to developing the acceptability of policy proposals (Fischer, in Fischer 2003). The social constructionist perspective is helpful to understanding why proposals supported by evidence on housing shortages/problems for people with psychiatric disability may be unsuccessful and the way in which evidence could be interpreted differently across policy sectors. This recognition of the importance of social/political factors in policy processes also corresponds with Kingdon's (2003) concept that policy proposals must match up with 'community mood'.

The social constructionist approach draws upon 'discourse theories, the sociology of social problems, symbolic interactionism, and the sociology of power' (Jacobs et al. 2004, p. 1). Following Foucault, Fischer argues (2003) that discourses and processes outside of the political environment shape values that are important in the development of policies. Fischer argues that discourses determine the 'facts' and chosen solutions for policy, and are instrumental in bargaining over policy problems

and solutions:

For postempiricist policy analysts, the social construction of 'facts' and their subjective interpretations are the stuff of policy politics. Towards this end, they emphasize the role of subjective presuppositions and assumptions that direct our perceptual processes in pre-shaping what are otherwise generally taken to be strictly empirical factors.

...[Postempiricist] analysts start with the recognition that different discourses, definitions and questions lead to different policy prescriptions

(Fischer 2003, p. 14)

Using a social constructionist perspective leads to an exploration of how social meanings embedded in discourses are being claimed and reproduced and relate to institutional practices, rather than the proscriptive policy analysis of traditional policy approaches (Jacobs 2004). Discourse is developed through social interactions, and therefore is in a process of constant negotiation through social practices, and political and social struggles. Gramsci, according to Fischer (2003 p. 78) saw that 'hegemonic politics emphasizes the constant struggle around the points of greatest instability between classes or groups, in an effort to build, sustain, or block alliances'. This implies a context of unequal power relations to such bargaining, although social constructionists de-emphasise the link between power and political actors.

From a social constructionist perspective, policy change entails engaging with and changing discourses in policy environments. Hajer and Wagenaar (in Fischer 2003) argue that the goal of the post-empiricist policy analyst is to encourage interactions between bureaucratic decision makers, policy analysts and the broader community in order to illuminate various policy debates, and support alternative choices based upon the interests of citizens. For Fischer (2003, p. 15) post empiricist policy analysis 'aims to facilitate informed political choice'.

### **3.3.2 Contextual constructionism, problem representation and voices and silences in policy debates**

The social constructionist perspective has been criticised for being unconnected to social conditions, policy actors and institutions

Although it is clear that much of social "reality" is "socially constructed", these frameworks

generally a) leave ideas unconnected to socioeconomic conditions or institutions and b) conceive of ideas as free-floating, that is, unconnected to specific individuals and thus largely non falsifiable.

(Sabatier 1999, p. 11)

Similarly, Bacchi (1999) suggests that a strict social constructionist perspective to social problems is problematic because of the way in which it fails to adopt a political agenda, which ultimately results in supporting the status quo

The view that all we have in the world of public policy are competing framings of problems is, I would argue, a species of pluralism which supports the status quo.

(Bacchi 1999 p. 57)

As an alternative, Bacchi adopts a 'contextual constructionist' position, which makes a distinction between the evidence for social problems (based on some objective conditions), and the way in which claims about social problems are made. Similar to Kingdon's distinction between 'conditions' and 'problems', Bacchi distinguishes problems from their 'representation'. This distinction between conditions and problems is distinct from a traditional social constructionist perspective where 'claims making constitutes social problems' (Ibarra and Kitsuse, in Kemeny 2004). More recent social constructionist approaches have also found problematic the suggestion that social problems exist only so long as they are articulated by pressure groups (Gordon, in Kemeny 2004).

Bacchi (1999) also highlights the connection between 'problem representation' at every level of policy processes, and policy solutions being offered. However, governments and policy makers are not seen to be merely responding to 'competing interests' or definitions of problems, but are central to the way in which problems are represented in policy. In fact, 'we are all implicated in the structuring discourses of our era and our cultures' (Bacchi 1999, p. 49). Bacchi (1999) critiques policy perspectives based on the notion that governments respond to competing interests

I see the limitations of their analysis encapsulated in their use of the language of 'problem definition'. This language encourages a continuation of the view that indeed this is a separate part of the policy process, despite the occasional nod to the inextricable links between problem definitions and solutions. The continuing separation in their model is highlighted by the discussion of availability, acceptability and affordability of particular problem 'solutions'. By

contrast, a What's the Problem? Approach would draw attention to the contending representations at work at every level of discussion – about acceptability, affordability and availability. For these reasons, I distinguish my approach as concerned with 'problem representation'

(Bacchi 1999, p. 37)

In the contextual constructionist approach, *policy* is discourse with inherent problem representations and interventions. Utilising Bacchi's approach, Henderson (2005, p. 253) argues that 'policy frames social problems in such a manner as to make the recommended interventions seem self-evident'.

One example of Bacchi's (1999) different 'problem representations' can be found in the academic research discussed above. For example, Tiernan and Burke (2002) argue that the departmental link made between housing assistance and other human services was part of strategies for the 'rationalisation' of housing, which did not address problems such as housing shortages. Alternatively, housing and linked support (across service delivery-policy) is crucial for the housing stability of people with a psychiatric disability (O'Brien et al. 2002), and the administrative separation of health and housing policy concerns has been problematic for successful deinstitutionalisation strategies (Bostock & Gleeson 2004). These different 'problem representations' within the academic literature appear to contain inherent solutions regarding the structure of government departments.

One of Bacchi's (1999) central criticisms is the way in which policy approaches commonly focus upon actual policy actors, debates and agendas rather than items which are excluded from policy debates, or the impact of silences within policy debates. According to Bacchi, current policy approaches often consider actual policy or what does not get implemented, overlooking what does *not* get analysed or what is deemed non-political. She advocates taking an 'enunciative position' (Maroney, in Bacchi 1999)<sup>12</sup> in policy analysis, which considers 'who gets to make claims and who gets their claims heard' (Bacchi 1999, p. 57). She aims to 'draw attention to the silence in existing political agendas, not simply to items which fail to get onto agendas' (Bacchi 1999, p. 60). Examples of such 'silences' in policy discourses

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<sup>12</sup> This term refers to the position of being able and permitted to articulate interests and concerns.

include power and gender relations (Bacchi 1999), i.e. gender relations and women's socio-economic position influencing who takes on carer roles.

Another aspect of contextual constructionism is analysis of the effect of the construction of problems upon subjects (Bacchi 1999). For example, Bacchi (1999) refers to the way in which social conditions are individualised to construct 'troubled individuals', leading to a situation where conditions fail to reach 'social problem' status. One illustration of this is found in Fulcher's (1989) analysis of disability policy, which is highly pertinent to the policy realm in this research. Using a social theory of disability to understand disability in education policy, Fulcher considers disability to be 'primarily a political construct rather than a medical phenomenon' (Fulcher 1989, p.25-26). She suggests that there are in fact five discourses on disability linked to various institutional bases and practices, including the medical, rights, charity, lay and corporate discourses (Table 1 below).

The *medical discourse* on disability, which highlights individuals' incapacity and links impairment with disability, is considered to be dominant and influential upon the lay and charity discourses of disability prevalent in the community. The medical discourse can be linked to the dominant bio-medical view of health or medical model (Baum 2002; Lewis 2005) previously discussed. This discourse is associated with the professional regulation of people considered disabled; however disability is seen as a personal responsibility rather than social condition (Fulcher 1989). The medical discourse is also therefore complementary with neo-liberal values which encourage individualism, a sense of personal responsibility and self-regulation (Dean 1999).

**Table 1: Discourses on Disability (Fulcher 1989)**

Discourse on disability	Description
Medical	<p>'Links impairment and disability. It draws on a natural science discourse and thus on a correspondence theory of meaning....Through the notion that impairment means loss...and the assumption that impairment or loss underlies disability, medical model discourse has deficit individualistic connotations. Further, through its presumed scientific status and neutrality, it depoliticizes disability; disability is seen as a technical issue, thus beyond the exercise of power. Medical discourse individualises disability, in the sense that it suggests individuals have diseases or problems or incapacities as attributes, Finally, it professionalizes disability: the notion of medical expertise allows the claim that this (technical) and personal trouble is a matter for professional judgement.'</p> <p style="text-align: right;">Fulcher (1989, p. 27)</p>
Charity	<p>'is part of the discourse deployed in corporations which have organized services outside the limited provision the welfare state makes. The charity ethic defines people called disabled as in need of help (Llewellyn 1873), as an object of pity (Borsay 1986), as personally tragic (Oliver 1996), as dependent and eternal children...</p> <p>This discourse has an institutional base in an extensive corporate sector, which has a range of residential, or 'total' institutions in Goffman's sense (1969) and non-residential institutions; its institutions include sheltered workshops and overall it provides extensive employment for a range of professionals and other employees'</p> <p style="text-align: right;">Fulcher (1989, p. 28)</p>
Rights	<p>'Self reliance, independence, consumer wants (rather than needs); its concepts are discrimination, exclusion and (in America and Britain) oppression. It is overtly political in contrast to the submerged politics of a professional discourse on disability...</p> <p>In Australia, Llewellyn suggest the conditions for the emergence of a rights discourse came from the 'contradictions and inequalities of rehabilitation...[which]...helped to delineate the independent living movement towards self-care, maintenance, integration, and normalization (1983: 27)'</p> <p style="text-align: right;">Fulcher (1989, p. 30)</p>
Lay	<p>'Lay perceptions of disability are informed by medical discourse, a charity ethic and fear, prejudice, pity, ignorance, misplaced patronage and even resentment (Marles, 1986: A2). It is these themes which inform social practices which are blatantly discriminatory'</p> <p style="text-align: right;">Fulcher (1989, p. 29)</p>
Corporate	<p>'managing disability' is one of its themes and its institutional base is emerging among professionals in government welfare agencies and, increasingly, in the private sector in rehabilitation companies.'</p> <p style="text-align: right;">Fulcher (1989, p. 26)</p>

The *lay discourse* of disability is characterised by fear and prejudice towards people with disability, and is pertinent to labelling and stigma discussed in the previous chapter. In a *charity discourse* of disability, linked to total institutions of care, people with disabilities are seen as the objects of pity in need of help by those more able. Fulcher (1989) considers the charity discourse to be well entrenched within Australia, through private organisations which provide sheltered workshops. The *corporate discourse* is intent on managing disability through professional services such as rehabilitation (Fulcher 1989). Finally, the *rights discourse* on disability distinguishes physical impairment from disability, pointing to social factors which lead to disabling environments. Fulcher argues that this discourse has a 'tenuous' institutional base within equal opportunity organisations in some states in Australia. However, a rights discourse has not successfully challenged 'the hegemony of a professionalised discourse on disability' (Fulcher 1989, p. 31). Evidence for these various discourses on disability within policy networks and policy processes will be explored through this study.

### **3.4 Policy development, accountability and cross sector policy**

Policy agenda setting and development should be distinguished from accountability for policy outcomes, but engagement in accountability processes is important to consider as it may also lead to attempts to control policy (Hill 2005). In addition to political accountability (tied to traditional approaches to policy making), accountability mechanisms for policy include hierarchical, direct democratic, legal, professional and bureaucratic accountability (Hill 2005). Top down forms of political accountability are most common, but more direct consumer control of policy processes will help to realise 'representative democracy' (Hill 2005).

Hill (2005) argues that government control over policy implementation (or political accountability) is increasingly difficult due to new forms of governmentality involving a range of service providers (and theoretically, service users). Conversely, new forms of governmentality rely upon 'technologies' which may enable greater control of organisations. For example, Muetzelfelt (1999) argues that contracting ('a

technology of agency' according to Dean 1999) is one strategy which governments use to control policy decisions and subject *both* government and its contractors to greater accountability (Muetzelfeldt 1999). Professional standards and norms in new governance arrangements may provide a challenge to political accountability (Hill 2005). However, 'clinical governance' (a method of professional accountability) has been seen as part of the UK National Health Service's long history of 'top down' forms of change and attempts to direct and make accountable the professions (Hill 2005).

Challenges to political accountability have been made through attempts at greater democratic accountability, or accountability to the public (Hill 2005). The promotion of consumer choice and involvement within 'bottom-up' accountability processes has been supported by new public management theory (Hill 2005). However, it has been claimed that it is difficult to incorporate consumer control mechanisms of accountability in 'joined up' government programmes (Hill 2005) (although there may be many common clients of public services). The case study considers the role of different accountability mechanisms across sectors and participation processes upon policy processes.

### **3.5 Conclusions and Implications for this research**

This chapter explored a range of perspectives on policy development and change. 'Stages' approaches to policy development, tied to 'top down' representative government and political accountability, were critiqued. 'Stages' approaches were considered less relevant to current complex governance arrangements (Dean 1999, Lewis 2005). This research adopts radical critiques of power and policy making, as described by Colebatch (2002), to which Kingdon is ascribed. Policy making is not viewed as a rational and incremental process of representative government as described by traditional approaches. Rather, policy making is seen as a chaotic and political process involving policy players both inside and outside of government (Kingdon 2003, Sabatier and Jenkins-Smith 1999). This study's recognition of a range of discourses on disability (Fulcher 1989) and the role of values/stigma to definitions of mental health (Goffman 1963; Laing 1969) also make 'stages

approaches' less pertinent as they say little about the role of ideology upon policy and the contextual nature of policy. Further implications of this chapter upon this research are outlined below.

### **3.5.1 Policy development theory and the role of discourse**

The notion that policy solutions may be pursued by coalitions of interest (Sabatier and Jenkins-Smith), but unconnected to 'problems' (Kingdon) was presented in this chapter, along with the notion that policy debates (and policies) contain an inherent view of problems (Bacchi). This research adheres to the latter position. It considers the way in which problems, policy debates and policy actors' identities can be interpreted through various discourses. As in Fulcher's (1989) and Lewis' (2005) studies, the link between discourses, institutional bases and practices, and policy networks was examined. More broadly, the link between political discourse and institutions (Hall, in Hill 2005) was considered through public servants' perspectives of policy, and the effect of political discourse on the voices favoured within policy processes.

### **3.5.2 The role of community groups within policy, and the attitudes of professionals towards participation at a policy level**

The role of non-professionals and service users in policy agenda setting is not explicit in multiple streams or ACF models, although 'interest groups' are tied to Kingdon's (2003) 'politics stream'. For Alford (in Palmer and Short 2000), community groups are a relatively powerless feature of health policy processes. Conversely, Lewis (2005) suggests that influential health governance networks, which now have an important role in shaping policy, exclude 'equity advocates and consumers'. Maintaining an 'enunciative position' (Maroney, in Bacchi 1999) was important in this study where there may be dominant policy networks or experts dictating terms of participation (Petersen & Lupton 1996) in governance arrangements. The existence of a 'hierarchy of disability', where some groups are seen as more deserving than others (Borsay, in Fulcher 1989) also highlights the importance of considering the 'enunciative position' (or who is permitted to have their claims heard).

Additionally, the *impact* of 'voices and silences' within policy debates (Bacchi 1999) was considered across policy sectors, in particular the voices and silences of people with psychiatric disabilities and carers within housing policy debates and networks. Both community groups' connection to policy networks and institutions - and the effect of their involvement or absence - across the consultation-implementation-accountability spectrum was explored. The problems conceived or 'represented' (Bacchi 1999) by participants were compared with the problems pursued by interest groups and policy discourses. A comparison between user group and carer priorities, NGO advocacy interests, and public debates across sectors also illuminated silences within policy debates.

Three articles discussed in background chapters advocated for health professionals or bureaucrats to consult with or decide the level of public participation within policy (Charles and DeMaio 1993, Skelcher 1996, Bishop and Davis 2002). This suggests assumptions about professional's power to decide the appropriateness and capacities of services users involved in policy (not just people with disabilities, where professionals' attitudes toward their *capacity* to input into policy have been negative; Barnes 1999). The implications for professionals' attitudes towards community participation at a policy level, and the effect of attitudes upon the participation of groups within policy, was also considered within this study.

### **3.5.3 Policy making and social constructionism**

In alignment with Bacchi and Fulcher, this case study research rejects a strictly social constructionist approach to policy due to the critical social science perspective undertaken which recognises powerful coalitions in policy processes. However, the concept that changing discourses is important to policy change (Fischer 2003) is considered important, particularly given the previous chapter's discussion on the emergence of neo-liberal values tied to new forms of governmentality (Dean 1999) and the link between ideas and policy networks (Sabatier and Jenkins Smith 1999; Lewis 2005). Factors such as 'social trust' and the social/political acceptability of proposals may also be particularly pertinent to the mental health policy environment because of the associated stigmatisation. This study will consider the role and negotiation of discourses on participation processes and concepts of health and disability, the accessibility of user groups to policy debates, and the impact of

community values on policy debates.

As in Bacchi's approach, 'social problems' are distinguished from the representation of problems, and 'problem representation' is considered across all levels of policy. However, this research did not question, as Bacchi (1999, p. 31) does, 'the adequacy of defining problems in terms of the possibility of intervention'. This research is based on an assumption about the close connection between problems and the possibility of taking action in response to them, on the basis of clear policy principles and ideas. It is concerned with the achievement of universal human rights (shelter and health) and sees housing as part of an adequate standard of living for health (UN 1966; UN 1994), in alignment with a rights discourse on disability (Fulcher 1989). The research is based on the premise that people with psychiatric disability have a right to live and be cared for in the community without discrimination (UN 1991). Solving social problems arising from a lack of adequate housing (housing instability or a burden of care for women in families) were linked to intersectoral action and healthy public policy. This is a 'social determinants' approach which Lewis (2005) suggests challenges the underlying bio-medical framework of health policy, portfolio government structures and short-term solutions to policy.

#### **3.5.4 Policy networks, ideas and views of policy change**

Different perspectives on power were presented in the last two chapters, with different policy change solutions. An agency view of policy change was emphasised by reference to the impact of individual policy entrepreneurs (Kingdon), networks and policy brokers (Sabatier and Jenkins-Smith, Lewis), experts in policy forums (Fischer) or changes in government and bureaucracy (Kingdon, Sabatier and Jenkins-Smith). Major change has been linked to changes in government and bureaucracy (Kingdon and Sabatier and Jenkins-Smith).

According to Kingdon (2003), fragmented policy networks have less chances of success for agenda setting. In this study the cross-sectoral policy environment is likely to involve a range of policy networks within different 'policy subsystems' [Sabatier and Jenkins-Smith's term]. 'Policy subsystems' are likely to contain very different understanding of policy problems, with a range of 'publics' and experts and discourses operating within different social and political contexts. Changes in government may impact similarly upon 'policy subsystems', whilst changes in

bureaucracy may differentially impact upon 'policy subsystems' (depending upon the structure of departments). The extent to which the mental health and housing sectors can be considered different policy subsystems containing different policy networks, and the impact of changes of government across sectors, was explored here.

Fischer (2003) advocates for challenging dominant discourses through policy processes which aim for the 'democratisation of discourse' [Fischer's term]. Through these processes, experts can empower people to express their concerns in everyday language and criticise their social reality so that interests emerging within policy processes can be countered. Strategies for policy change which address and enable the critique of ideas, or the ways in which resistance to change is played out within and across policy sectors, was also explored.

## 4 Research Approach and Methods

the intellectual's error consists in believing that one can know without understanding and even more without feeling and being impassioned (not only for knowledge in itself but also for the object): in other words that the intellectual can be an intellectual (and not a pure pedant) if distinct and separate from the people-nation

(Gramsci, 1971, p. 418)

Scientific habits of mind are compatible with passionate advocacy, strong faith, intuitive conjecture, and imaginative speculation...The cold and aloof scientist is, then, a myth.

(Scheffler 1967, p. 4)

This chapter describes and justifies the epistemological paradigm, research approach, research methodology, research design, data collection techniques and ethics of this study. It also discusses the limitations of the approach undertaken. The epistemological paradigm used was 'reflexive-dialectical' (Kemmins & McTaggart 2000) and understood the interrelationship between subjectivity and objectivity. This was applied research rather than basic research described as 'knowledge for the sake of knowledge' (Patton 2002, p. 215). It was applied research as it was based on an understanding and questioning of problems experienced by people with a psychiatric disability (Patton 2002). However, it necessarily adopts the 'basic research' aim of contributing to theory development (Patton 2002), using a cross sectoral case study environment.

### 4.1 Research Approach: View of Knowledge and Practice held

This study broadly used a 'critical social science' framework, incorporating a range of critical theories which are

concerned in particular with issues of power and justice and the ways that the economy, matters of race, class, and gender, ideologies, discourses, education, religion and other social institutions and cultural dynamics to interact to construct a social system

(Kincheloe & McLaren 2000, p. 281)

Understanding the role of human agents in constructing, reproducing or changing

society, in interaction with pre-existing conditions, has also been referred to as a 'critical realist' approach (Pilgrim 1999). A critical social science approach is based upon critiques of positivism and aims at emancipation through individuals and groups critiquing commonly held views of social reality (Cheek et al. 1996)

Another key feature of critical social science is that it enables a process of enlightenment from which it is possible for individuals to recognize the way that the social conditions constitute their particular social reality.

(Cheek et al. 1996, p. 163)

According to Sarantakos (1998), exposing and removing false beliefs about the nature of social reality and empowering people to change is a key purpose of research using a critical perspective. From this perspective, even a neutral stance or ignoring moral questions is thought to be political (Neuman 2003). The researcher is critical of dominant cultural ideologies (in this case dominant medical model of health and ideologies of community care) perpetuating existing social conditions and aims to illuminate them. An emancipatory view of knowledge was thus taken. This is consistent with the 'critical-emancipatory-knowledge-constitutive interest', where individuals are largely autonomous and able to critique their understandings of social reality (Habermas 1972).

This study takes an epistemological understanding whereby subjectivity and objectivity are considered to be interrelated. All researchers approach the subject or object of research with particular biases, and subjectivity and objectivity are both interrelated and associated with a particular social-historical context. This approach has been referred to as the 'reflexive-dialectical view of subjective-objective relations and connections' (Kemmins & McTaggart 2000, p. 276). A unitary version of the nature of 'truth' (e.g. either subjective or objective) is rejected in favour of a 'reflexive-dialectical' understanding of social practice and knowledge (Kemmins & McTaggart 2000). A dynamic and mutual relationship between 'objective' events, actions and subjective meaning was considered. Individual and group/social behaviour was seen to both shape and be shaped by agency, social processes and structures, discourses and historical conditions. If we apply critical theory to this view of knowledge, facts are not considered to be value-neutral but rather require interpretation to provide a true picture of unequal and inequitable social conditions

(Neuman 2003).

Critical ethnography or the 'critical-emancipatory' paradigm (de Laine 1997) was particularly drawn upon within this study, in order to examine the culture of community participation and my own role in the research. What anthropologists refer to as an 'etic' approach was used - or an 'observer-oriented' perspective (de Laine 1997) - whilst acknowledging the effect of the researcher upon the researched and vice versa. In recognition of a reflexive-dialectical perspective (Kemmins & McTaggart 2000), the historical and social context of both author and subject was also openly considered through a critical self-awareness, or 'a critical-interactive self-other conversation' (Tedlock 2000, p. 465). There was a need to be an open and honest contributor to this research through the use of an ethnographic critical diary (Field Diary). This was important for reflexivity and due to the researcher's personal connection to the researched (as discussed below).

Being open about one's interest allows researchers to be conscious and sceptical in interpreting situations and alternative explanations (Wadsworth 1998). Feminists encourage such an open identification with research participants - it has been described as a 'conscious partiality', or awareness of one's connection to the researched through 'partial identification' (Fonow & Cook 1991). Wadsworth (1998), whilst claiming that researchers can never be truly objective, suggests that researchers often refrain from contributing their opinions or values in the interests of being 'objective' or 'value-free', but that this can ultimately lead to bias or distortion because subjective positions are hidden. Similarly, Lather (in Rice & Ezzy 1999) states that research that is not reflexive and purporting not to be political is not rigorous.

Reflexivity is also important for this study given the perspective that all research accounts are essentially social constructions. Some feminists claim that all social research is essentially biased by the perspective and interpretations of the researcher, 'masculinist assumptions', and the socio-historical context (Atkinson & Hammerley 1994). Others emphasise the importance of the professional-scientific environment (Albury 1983) or socio-political context (Fischer 2003) within which research is produced. Albury (1983) argues that political power within the scientific community determines the judgements of that community. The acceptability of technical advice

produced by this community is based not upon its validity or researcher competence, but its ability to uphold and support existing positions (Nelkin, in Albury 1983). Researcher bias is particularly problematic within the current environment where research is commonly funded by organisations interested in particular problems (Albury 1983), e.g. drug companies sponsoring mental health research may not support research into social factors relieving mental health problems due to their own commercial interest.

To summarise, the research adopted the following key principles;

- Reflexive-dialectical

Congruent with qualitative research, meanings/symbols were considered to be reflective of the social context in which they are developed (Sarantakos 1998), and change according to context.

It was understood that dynamic interrelationships occur between traditional dichotomies such as 'objective/subjective' (i.e. feminist notions that 'reason' is not separate to but can be informed by emotion and vice versa, or Foucauldian understandings that knowledge can be being influenced by social factors such as power).

- Context and time bound

The humanistic and interpretive approach of ethnography has been contrasted with a scientific and positivist approach, and criticised for its contextual nature (Atkinson & Hammerley 1994). Within this research, the context and time bound nature of all research was acknowledged, due to the dynamic relationships between agency and structure, researcher and researched, action and subjective meaning (Kemmins & McTaggart 2000).

Contextual studies allow for the practicalities of a particular situation to be used as a guide for methods employed. For example, research on the experience of consumer representatives may have to take into account the previous experience of user groups within services and with professionals. It may also necessitate the researcher's own identification with the researched (which occurred here due to the researcher's previous interactions with user and carer groups).

- Use multiple methods

A critical-reflexive approach recognises the need for multiple methods due to dialectical relationships, usage of multiple paradigms, and an understanding that social practice is multi-faceted (Kemmins & McTaggart 2000). Multiple methods allow for method triangulation and greater rigour, and were applied here (e.g. document analysis of policy combined with interviews and/or focus groups with consumer and carer representatives and professionals, and participant observation).

- Naturalistic

Naturalistic studies are 'true to the phenomena, (people's beliefs, concerns and aspirations)' (de Laine 1997, p. 21) of those being researched. Observations and the semi-structured interviews and focus groups mostly occurred in real-world settings (i.e. at NGOs).

- Open and exploratory

Sarantakos (1998) describes field research as either being exploratory, descriptive or hypothesis-testing. An exploratory approach was undertaken here, particularly as the particular policy context being studied is little researched. An exploratory approach allows for an accurate picture to facilitate the development of theory.

The real world setting and acknowledged effect of the researcher upon the researched (and vice versa) was also relevant to an exploratory approach.

- Critical perspective and critical ethnography

Whilst being primarily exploratory rather than 'hypothesis-testing', due to the critical social science perspective adopted, the theoretical or ideological perspective of the researcher also determined the focus of inquiry (Patton 2002). Patton has coined the term 'orientational qualitative inquiry' to describe qualitative research that uses this critical approach (Patton 2002). The objective in orientational studies is not simply to describe and understand, but to 'critique ... society' (Patton 2002, p. 131). This is akin to 'critical ethnography' or the 'critical-emancipatory paradigm' (de Laine 1997) and an observer-oriented perspective (de Laine 1997).

- Identification with the researched

Using a feminist approach and critical ethnographic narrative, a conscious awareness of the connection between the researcher and researched was developed. This was done via the Field Diary which recorded perceptions of the researcher throughout the research. The connection of the researcher to the researched prior to undertaking the research is explained below (4.2).

## **4.2 Researcher background and connection to the researched**

The topic of this thesis evolved from a combination of cumulative professional and personal experiences in the health and housing sectors, a review of previous academic research and personal knowledge of the state policy context. These factors all led to my concern with the gaps in public mental health services, cross sectoral partnerships between the mental health and housing sectors, and partnerships between community and government. A particular interest of mine was the role of communities in policy development and public services' accountability towards the community, and the consequences of a lack of housing and community services following deinstitutionalisation. Prior learning and experiences also informed the critical theoretical approach taken within this thesis and is outlined in more detail below.

### **4.2.1 Educational background**

My educational background included a Bachelor of Arts (Social Sciences) with majors in Psychology and Sociology. Just prior to commencing Honours I worked with people with intellectual disabilities in Tasmania, through which I met a number of family carers. My Honours thesis used literature on the sociology of the family and explored the experience of carers under Australian Home and Community Care policy (Battams 1994). Through this, I was aware that since the Human Rights and Equal Opportunity Commission's 'Burdekin Report' (HREOC 1993), access to housing had been raised as a significant issue for people with a psychiatric disability. From this research I also learnt first hand from carers of people with disabilities in

Tasmania, who expressed a need for differentiated public support services, and the competition which existed for such services, particularly accommodation.

I later undertook a qualification in Health Service Management through which I learnt about the challenges of health service accountability, and issues surrounding current accountability mechanisms. This course also led to an appreciation of the different discourses across public health and health service management when it comes to participation. I utilised some health service management frameworks and evidence on leadership and management and organisational structure to interpret the findings within this thesis (chapter 7).

#### **4.2.2 Work experience**

From working in the health sector in health service administration (General Practice organisations), I was cognisant of the lip service that could be paid to community participation and the cultural and organizational resistance to service users' participation within publicly funded services. I was also aware of mental health consumer and carer representatives' struggle to develop policy and processes for participation in state policy and services in South Australia. Long-term efforts to develop a state policy on participation in mental health services appeared to be abandoned after the murder (by a former colleague) of Dr Margaret Tobin in 2002, the state's former chief Psychiatrist and Director of Mental Health Services. I was aware of the frustration with community participation efforts felt by some consumer and carer representatives whom I had worked with through General Practice organisations, in the developmental stages of the state Health Consumers Alliance and as a consultant/adviser to the Carers Association of South Australia. I was also conscious of the problems with consumer/carer participation within services. Through involvement with non-government organisations (NGOs) I also appreciated the frustration expressed with NGO partnerships in policy and service planning.

Professionally and personally, I have come into contact with a large number of people with mental illness and a range of (dis)abilities, and their carers. I have experience in community development whilst with the Carers Association of Tasmania and was also a member of the Carers Association of South Australia's Policy Subcommittee and Mental Health Carers Taskforce. Through these connections I contributed to a number of submissions to government and wrote a

discussion paper on a South Australian (SA) whole of government carers' policy which had input from carers.

I come across a range of people with mental illness from across SA through my role as panel assessor with the District Court of South Australia (hearing appeals to decisions made under the Mental Health and Guardianship Acts). I have understood how the interpretation of mental health legislation could lead to families concerns that people are becoming extremely ill before being treated and supported. I am also aware that 'treatment' could equate with medication and visits by or to health professionals overseen by Psychiatrists with frequent turnover in the public system.

Both work and personal experiences along with background consultation for the thesis focused my attention upon the broader issue of housing and intersectoral partnerships within policy. Deinstitutionalisation and the housing and support needs of people with psychiatric disability were significantly overlooked in the first discussion paper for the development of the state government's housing plan (Housing Management Council 2002) which I had responded to whilst in a work role. The lack of connection between housing, homelessness and mental health policy processes and confidentiality and privacy practices across government agencies were other issues that arose.

Various experiences made me aware of the considerable focus upon the clinical needs of people with mental illness/psychiatric disability and the connection between clinical services, rather than social determinants such as housing, or disability support services. During my time with GP organisations, a heavy focus in mental health services was on the 'vertical integration' within the health sector (i.e. between Psychiatrists and GPs). Problems such as dwindling public and private housing supply and linked support appeared unaddressed except through small projects. I also became aware of the high priority and need attributed to 'mental health' services by GPs, particularly rural GPs. A significant Australian government funding contribution had been made for case conferencing and care planning during my time with Australian Divisions of General Practice. However, NGO/public services and GPs often complained that there were few services to refer to, or services were receiving GP referrals without being able to fulfil these demands. This led to additional federal expenditure on allied services for general practice which were

largely targeted to mental health services. Whilst these were positive initiatives, focus was maintained upon clinical and health professional services rather than social determinants of health such as housing, employment and social support.

This latter expenditure occurred around the time private Supported Residential Facilities (SRFs) in South Australia were either complaining about and advocating for a lack of publicly funded support or withdrawing from the sector. Through my time in social planning, I was conscious of the ‘monitoring’ role of local government when it came to private SRFs, and their conflict of interest in this role (due to finances councils receive from home and business owners and the proximity of councils to local politics). I also became aware of disparities in the attitudes of staff toward people with psychiatric disabilities accessing or wishing to access Home and Community Care (HACC) services across service regions, and the absence of mental health representatives on one regional HACC network (potentially creating equity issues). When attempting to work on a social housing project I also became acutely aware of general community stigma towards public housing tenants.

#### **4.2.3 Personal experiences**

My experience includes having family members with a chronic mental illness, the impact of which has been profound. Thus I have had interaction with the formal mental health service system across the past ten years as a result of the personal experiences of a family member. From this I perceived poor ‘horizontal’ links between police, housing, homelessness and health service agencies and families. I understood how confidentiality practices may be used as an excuse for not conveying information that would potentially act in the interests of a homeless person with psychiatric disability. From my perspective, the lack of connection between public services and the confidentiality and privacy practices across government agencies were libertarian practices which prolonged the experience of homelessness. Mental health services were exclusively focused on clinical care over ongoing support, i.e. for employment or support linked to housing.

Although I do not identify as a ‘carer’, these experiences have enabled me to see how truly fractured services are, the absence of a support ‘system’ as such, the role of families, and the stigma associated with mental disorders, despite the goodwill of individual practitioners or advocates working in this area. A strong motivation for

undertaking this research was to gain a better understanding of the situation for people with psychiatric disabilities and carers, as compared with stated broad policy objectives and activities, and to explore the barriers to improving housing provision and support for people with psychiatric disabilities. Whilst my interest may have come partly from professional and personal experiences, in a dialectical fashion my theoretically based sociology and health services management training has also informed and been a part of this experience.

### **4.3 Research Methodology**

Qualitative methods were primarily used for this study because of their applicability to studying real-life situations, behaviours and meaning behind actions (Sarantakos 1998). Critical ethnography (de Laine 1997) was used because of its assumptions of hegemonic practices and the construction and perpetuation of ideologies. Critical ethnography attempts to portray the culture or lived experience of people in asymmetrical power relations (Quantz, in de Laine 1997). The main purpose of this methodology is not to represent and reify such relations ('giving an outsider an insiders' view') but to subject the insiders' view to critical analysis to understand the nature of disempowerment as the researcher sees it (de Laine 1997). Critical ethnographic techniques have been chosen in order to explore and understand the culture and nature of community participation and advocacy in a medical-bureaucratic context. At the same time, a critical self awareness was maintained through an ethnographic critical diary, or Field Diary (Jan 2003-April 2007).

Triangulation of method occurred, as this creates a more comprehensive study (de Laine 1997) and also develops validity (Rice & Ezzy 1999). Also, different methods were used because as previously stated, evidence can be viewed in various ways simultaneously within a reflexive-dialectical view of practice (Kemmins & McTaggart 2000). The research included an initial stage of policy document analysis to provide the policy context, which is not traditionally considered to be a qualitative method. In addition to triangulation of method, triangulation of data sources occurred at all stages of research. Whilst this study supports the view that all research is essentially biased (Wadsworth 1998), by stating my position as researcher (in the

researcher background section above) and using multiple data sources, methods and triangulation techniques I aim to counteract any 'unseen' bias or bias that may emerge from using singular perspectives and methods.

#### **4.3.1 Embedded Case Study**

The primary method was an embedded case study of South Australian organizational units in government and advocacy and community groups in the mental health and housing sectors. This case study was 'embedded' (Yin 1994) in the sense that it will consider a range of groups across different levels and perspectives such as policy makers, programme managers, service delivery professionals, consumer and carer representatives and NGO professionals. The case study has been chosen because it enables whole units to be explored in their totality, rather than particular aspects of units (Yin 1994). The case study has been chosen for its capacity to provide both in-depth information (de Laine 1997) and a collection of various sources of evidence using various methods to prevent errors (Yin 1994).

A 'structure focused' rather than individually focused case study was undertaken. The unit of analysis was organisations and groups involved in South Australian policy and practice on housing and services for people with psychiatric disabilities, and consumer and carer representative involvement in policy and programmes. Choosing the region of South Australia could be seen to be critical case sampling, where a case is chosen either because it is *unlikely* to demonstrate a theory (Rice & Ezzy 1999), or can demonstrate a point dramatically (Patton 2002). de Laine (1997) also describes three types of case studies; the intrinsic case study (chosen for its intrinsic interest), the instrumental case study (chosen for its relationship to an issue or potential to refine a theory, the case itself is of secondary interest), and the collective case study (a collection of case studies is chosen to lead to a better understanding). This study is deemed an 'intrinsic interest' ; South Australia provides intrinsic interest because of the state's poor record on developing community based residential facilities following deinstitutionalisation and community participation strategies (CDHA 2002). The case study is therefore likely to highlight barriers to intersectoral collaboration and community participation at a policy level.

## **4.4 Research Design**

### **4.4.1 Study Aims and Research Questions**

Aim 1: To determine the extent of inter-sectoral activity between the housing and mental health sectors in developing housing provision for people with a psychiatric disability in South Australia (over the Mental Health Reform period 2000-2005).

Related research questions:

- To what extent have inter-sectoral links between mental health services and the housing sector been developed through the implementation plan of the South Australian Mental Health Reform 2000-2005?
- To what extent have these links been effective in improving housing options for people with a psychiatric disability?

Sub question related to these research questions:

- Is there evidence of the issue of providing adequate housing for people with a psychiatric disability making it to the policy agenda in the mental health sector?

Aim 2: To assess the effectiveness of community participation mechanisms in encouraging advocacy for housing provision for people with a psychiatric disability and their carers in South Australia (over the Mental Health Reform period 2000-2005).

Related research question:

- To what extent have community participation mechanisms<sup>13</sup> contributed to the development of policy or programmes on housing provision for people with a psychiatric disability?

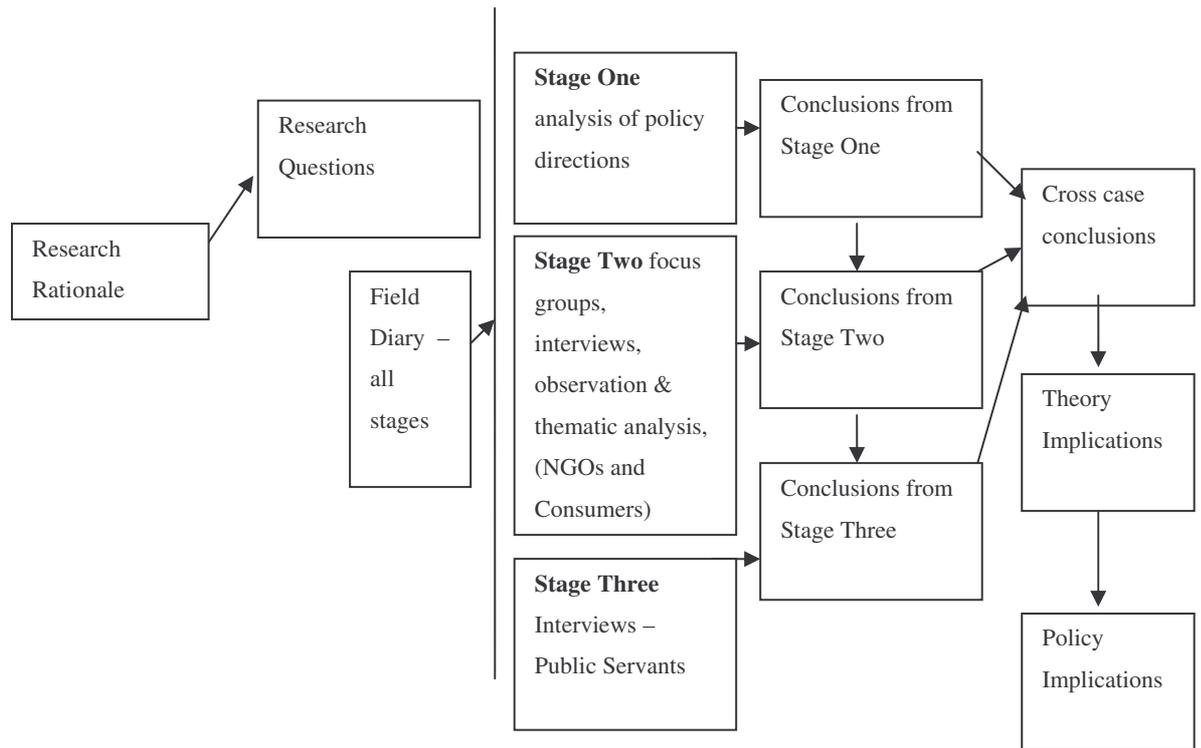
Sub-questions related to this question:

- How have community participation mechanisms been able to influence the mental health reform process and the development of housing initiatives for people with a psychiatric disability?
- What evidence is there for various discourses operating and being negotiated in community participation mechanisms?
- Is there evidence of professionals controlling the agenda of community participation mechanisms and bureaucratic processes for participation making genuine participation difficult?
- To what extent are carers' views incorporated in community participation and advocacy efforts for housing provision for people with a psychiatric disability?

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<sup>13</sup> Community participation mechanisms' refers to both organisational forms and processes for community input into policy and programmes. Organisational forms include peak Non-Government Organisations (NGO) or member based groups, or state-level consumer/carer representative groups or forums and processes operating during the Mental Health Reform period. The term 'peak NGO' refers to an umbrella advocacy agency, with membership including a range of NGOs or consumer groups. Peak agencies often act as a link between government and NGOs within a particular sector or those with a particular representative role (e.g. consumer representation).

**Diagram 1: Overall Research Design**



## 4.5 Methods of Data Collection

As identified in Diagram 1 above, there were three key stages to the research. Stage one primarily involved a document analysis of the policy context pertaining to health, housing and disability. Stage two focused on research question three and involved focus groups, participant observation and interviews with non-government organisations and individual consumer and carer representatives. Stage three focused on research questions one and two and comprised interviews with public servants primarily from the health, housing and disability sectors. These stages are elaborated upon below.

### 4.5.1 Stage One Review of Policy Context, Sampling and Administrative Procedures

Stage one involved a comprehensive review of major mental health, disability and housing policies, plans and programmes in South Australia and Australia (see Table

2). Criterion for document inclusion included the currency and relevance of policy, legislation, bi-lateral agreements or reports and evaluations on key programmes or projects related to housing and mental health (e.g. related to NMHS or housing or disability services), or consultations or drafts pertaining to key policy and programmes in this area.

The main focus was the mental health reform period 2000-2005, however key national mental health policy documents from before this period were also included as the National Mental Health Strategy initiated in 1992 (and its associated plans) was still current. Additionally, policy trends in relation to housing were considered by examining the bi-lateral commonwealth-state housing agreements and commentaries on housing policy trends. Some documents produced in 2006 (where reviews were undertaken during 2000-2005) were also included.

The policy review followed the steps outlined below.

- 1) The intersectoral and community participation components of major national policies and bi-lateral agreements and programme initiatives and state level policy and programmes were firstly considered. Specific reports on intersectoral linkages across the mental health and housing sectors in South Australia (e.g. Rymill 1992) and housing for people with a psychiatric disability (e.g. Health Outcomes International 2002) were also included. A narrative report was written based upon this initial review.
- 2) Using feedback from the National Mental Health Reports, a short report was written on South Australia's progress on the 'service mix' goal of the National Mental Health Strategy since the introduction of the strategy (see Appendix 16).
- 3) Information on the development of policy and plans in relation to community participation in mental health policy and services was supplemented by information retrieved from the state department of health (Field Diary, Minutes from community groups). A separate record on the history of community involvement in the mental health sector across the mental reform period in South Australia was developed, based upon this information (see Table 7, Appendix 8). Information on the history of community participation

in housing was requested from and specially prepared by the state department of housing (Ottaway 2003) and taken into account when comparing community participation across sectors.

- 4) More broadly, major themes within policy consultations, parliamentary reviews and government policy responses and evaluations of policy were also considered (e.g. the neo-liberal trend towards privatisation in mental health, see Appendix 17). This stage had a greater focus on the housing sector and commentary on national policy trends in this sector (e.g. Parliamentary of Australia Parliamentary Library documents such as Monroe 1997).
- 5) Finally, themes across policy sectors were considered along with key policy trends across time. Themes were analysed in relation to the theory outlined in chapters 2 and 3 and discussed in the following chapter.

For stage one, documents were obtained via the internet and through direct contact with government departments and NGO services.

**Table 2: Stage one analysis of policy documents: Documents included in the thematic analysis of policy**

	National	State	Community Participation
<b>Mental Health Sector</b>	<p>National Mental Health Strategy documents pertaining to this period e.g. the National Mental Health Policy (AHM 1992a) and Mental Health Statement of Rights and Responsibilities (AHM 1991), the three National Mental Health Plans (AHM 1992b; AHM 1998; AHM 2003) and evaluations (National Mental Health Strategy Evaluation Steering Committee 1997; Thornicroft &amp; Betts 2001; Steering committee for the evaluation of the second national mental health plan 2003).</p> <p>The national mental health promotion strategy ensuing from the Second National Mental Health Plan: National action plan for promotion, prevention and early intervention for mental health (CDHAC 2000).</p> <p>The National Mental Health Reports of government (Commonwealth of Australia 1993; CDHA 2002; CDHA 2003; CDHA 2005) and recent AIHW report (AIHW 2005d).</p> <p>The follow-up to the Burdekin Inquiry on Human Rights and Mental Illness (MHCA 2005).</p> <p>Parliamentary inquiries and responses related to mental health at a national and state level (Commonwealth of Australia 2005; Parliament of South Australia 2006; Senate Select Committee on Mental Health 2006).</p>	<p>Three key mental health reform documents: South Australian Mental Health Services Review 2000 (Brennan 2000) and related government plans: A New Millennium-A New Beginning Implementation Plan 2000-2005 (DHS 2000) and 'A New Millennium - a New Beginning Action plan for Reform of Mental Health Services 2001' (DHS 2001).</p> <p>South Australian report on mental health services just prior to the National Mental Health Strategy e.g. SA Mental Health Information 1989-1992 (Elzinga et al. 1994)</p>	<p>State Mental Health Reform documents: A Framework for Developing Partnership Between Consumers and Carers and the Mental Health Sector (drafts) (Department of Human Services 2001 and Tobin version 5).</p> <p>Information on state policy developments in relation to community participation was also gathered from the minutes of state-level community groups (Stage 2) and the Field Diary.</p>
<b>General</b>	There was no current National Health Strategy. Mental	The South Australian Generational Health Review	National Health Strategy (1993)

<b>Health Sector</b>	health policy was still current and trends across time were considered.	Consultation Summary (Generational Health Review 2002), and Better Choices, Better Health (Generational Health Review 2003) and responses to this by the South Australian government - First Steps Forward South Australian Mental Health Reform (Government of South Australia 2003). The Review of Mental Health Legislation Issues Paper (Department of Health 2004) which resulted from the GHR.	Healthy Participation: Achieving greater public participation and accountability in the Australian Health Carer System (to consider policy trends across time).  State level Department of Health Consumer and Community Participation Principles and Framework for Action (n.d.),
<b>Housing Sector</b>	<p>There was no current National Housing Strategy. A relevant background paper was included: Sach and Associates (1991) The housing needs of people with disabilities, discussion paper prepared for the National Housing Strategy.</p> <p>The current Commonwealth State-Housing Agreement 2003-2008 (Commonwealth of Australia 2003) and background consultation paper (Government of South Australia 2003) and related reports (AIHW 2005a) were considered.</p> <p>Available documents and commentary on the National Housing Strategy and subsequent commonwealth state housing agreements were included to consider housing policy trends (Monro 1997; McIntosh 2000; AHM 2001; McIntosh &amp; Phillips 2001; DHS 2003; FACS 2006).</p> <p>The National Strategic Framework for Community Housing (National Community Housing Forum 2004).</p>	<p>The South Australian State Housing Plan Discussion Paper (Housing Management Council 2002), South Australian State Housing Plan Issues and Options Paper (Housing Management Council 2003), and the final Housing Plan for South Australia (DFC 2005).</p> <p>State level framework for the Department of Families and Communities which oversees housing (Minister for Families and Communities 2005). Recent state level reports on public housing including the South Australian Housing Trust's Trust in Focus (SAHT 2004) and the Triennial Review of the South Australian Housing Trust (Stamfords Advisers/Consultants 2005).</p> <p>The Parliamentary Inquiry into the South Australian Housing Trust (Parliament of South Australia 2003) and the Inquiry into the Operations of the South Australian Community Housing Authority (Parliament of South Australia Legislative Council 2000).</p>	'History of Tenant Participation in the South Australian Housing Trust' (Ottaway 2003) prepared for the researcher.

	Current legislation related to homelessness, the Supported Accommodation Assistance Programme Act (AGD 1994), national documents on homelessness (FACS 2000; McIntosh & Phillips 2000), and government reports and commentary on homelessness services (AIHW 1999; Chamberlain 1999; FACS 1999; AIHW 2003; Chamberlain & MacKenzie 2003; FACS 2003; Erebus Consulting Partners 2004; Erebus Consulting Partners 2004; Psychogios 2004; AIHW 2005b; AIHW 2005c). State level discussion papers and plans on homelessness (DHS 2001; DPC 2002; Social Inclusion Unit 2003; Social Inclusion Unit 2003; Social Inclusion Unit 2004; Haggerty 2005).		
<b>Disability Sector</b>	Current legislation related to disability including the federal Disability Discrimination Act (AGD 1992), the Commonwealth State Territory Disability Agreement (FACSIA 2002) and related disability policy and reports (AIHW 2002; FACS 2004; AIHW 2005e; AIHW 2006; CDFCSIA 2006; FACS 2006) and information on the Home and Community Care programme (DHAC 2006).	Current State level framework on disability services; Connecting to the Future (Minister for Families and Communities 2005).	
<b>Intersectoral</b>	Mental health, housing and homelessness discussion paper arising from the National Mental Health Strategy Working Group (Magor-Blatch 2003).  National discussion paper on mental health and homelessness arising from the National Homelessness Strategy (St Vincents MHS & Craze Lateral Solutions 2005).	The Parliamentary Inquiry into Supported Accommodation (Parliament of South Australia Social Development Committee 2003).  Evaluation of the Supported Housing in the North demonstration project (Health Outcomes International 2002).  State level government reports on boarding houses and Supported Residential Facilities (Anderson et al. 2003; Doyle et al. 2003).	State-level documentation on carers, including the SA Carer Recognition Act (2005) and related SA Carers Policy (DFC 2006) (whole of government policy).

		<p>Information on the development of the Southern Mental Health and Housing Alliance (2000).</p> <p>Draft Protocols between SA Mental Health Service and the SA Housing Trust (1994).</p> <p>State level report: Making the Links, a report on the management of behaviours associated with psychiatric disability in the Supported Accommodation Assistance programme (Rymill 1992).</p>	
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### 4.5.2 Stage Two Community Participation Mechanisms

Stage two *primarily* related to research question three and sought to determine what state level advocacy/member based groups are advocating for or what policy processes community groups are participating within or commenting upon. It also explored progress and challenges in these endeavours. This stage also informed an understanding of the development and outcome of inter-sectoral linkages, as perceived by members of NGOs and state level consumer/carer groups (questions one and two).

Data collection was triangulated through the various components of the stage two research. Stage two was divided into two further stages; 2A. Data collection from Non Government Organisation advocacy/member groups and 2B. Data collection from state-level Consumer/Carer groups. Methods for Stage 2A included observation and participant observation at the community participation and advocacy mechanisms, a thematic analysis of documents such as minutes and submissions to parliamentary inquiries and reviews from these groups, and one focus group. Stage 2B involved a focus group and interviews with consumer and carer representatives from a former state level participation mechanism, and a thematic analysis of the notes from minutes of state level consumer and carer participation groups. Details of these stages are discussed further below.

**Table 3: Summary of Stage 2A with NGOs**

Stage 2A NGO advocacy groups	Sampling	Administrative Procedures
Observation and participant observation	52 NGO professionals involved in regular meetings: 12 people at Shelter SA board meetings 16 people at the Community Housing Council Disability Focus Group, 24 people at the Mental Health Coalition general meeting.	Direct contact with the CEO or Director of the Board  The participant observation sheet of key themes to be explored was used (Appendix 2) for this and the document stage below. Meetings attended:  Three board meetings of Shelter SA. <i>(In addition, two public forums convened by the organisation and the Annual General Meeting were attended).</i>  Three meetings of the Community Housing Council of South Australia's Disability Focus Group <i>(a fourth meeting attended was cancelled).</i>  Four meetings of the Mental Health Coalition of South Australia, including two board meetings and two general meetings which

		comprised a larger group of NGO members of the organisation and observers. ( <i>In addition, the Annual General Meeting was attended</i> ).
A thematic analysis of documents of advocacy groups	Notes from Minutes of meetings of NGO groups involved in participant observation attended May-November 2005. Strategic or business plans and annual reports of these three organisations. Key submissions and documents from the groups involved in participant observation, including; <ul style="list-style-type: none"> <li>• Generational Health Review (GHR) submissions</li> <li>• Mental Health Legislation Review submissions</li> <li>• State Housing Plan submissions, and</li> <li>• Submissions made to the Parliamentary Inquiries into Supported Accommodation and Parliamentary Inquiry into the South Australian Housing Trust</li> </ul> Key platforms and submissions of the state-level lobby group, the South Australian Council of Social Service Mental Health Lobby Group, which preceded recognition of the Mental Health Coalition of South Australia as a peak body.	Obtained from NGOs and the internet.
Focus groups with NGOs	One focus group with 4 staff from advocacy NGOs in mental health and housing (see questions for NGOs/advocacy focus group in Appendix 3).	Letters to professionals
Interviews with NGOs	Interviews were undertaken with an additional 6 people who were unable to attend the focus group, including: <p>2 NGO community housing staff (one current, one former) one of which was a member of Homelessness SA (who was unable to attend the advocacy focus group) and both of which had attended the Southern Mental Health and Housing Alliance</p> <p>2 people from an NGO providing services to prisoners and offenders</p> <p>1 person who had been involved in disability advocacy, including upon housing advocacy issues</p> <p>1 person who had been involved in a state level health consumer NGO</p>	

In Stage 2A, observation of three community participation groups within their natural setting enabled an analysis of what groups were participating in, commenting upon or advocating about. This was compared with their stated objectives (as outlined in their policy documents). The discourses and interactions amongst the

group were also observed. The participant observation technique provided different 'case study' material than that reported on in interviews, focus groups or the policy context (see chapter 8). Participant observation was used in the groups rather than other observational techniques (observer, observing participant, participant), as I was an observer but drawn into activities of the group due to previous contact with members.

Notes from participant observation were recorded during and directly after meetings attended by the researcher. A participant observation sheet with broad themes was then used to organise the notes from the participant observation (see Appendix 2). These themes were derived from the critical theoretical context and evidence on the barriers to participation described in chapter 2. For example, 1) the extent to which medical discourses were being adopted by groups, 2) the extent to which housing was considered an issue by consumer participation mechanisms, and 3) extent to which NGOs and consumers were participating on cross sectoral issues or engaging in intersectoral advocacy on mental health and housing was observed. This participant observation method also contributed to an understanding of the role of professional advocates in supporting empowering forms of participation, and the extent to which they enabled service users to speak for themselves.

Stage 2A facilitated consideration of the extent to which professionals and community groups were involved in policy networks. Following on from chapters 2 and 3, this stage also contributed to an understanding on the extent to which participation was a 'means' or 'end' in itself, or the extent to which service users held an 'enunciative position' (themes discussed in chapters 2 and 3).

Triangulation from participant observation occurred via reflections upon a thematic analysis of notes from minutes of past meetings (across six months), strategic plans, and advocacy documents such as submissions to the State Housing Plan and South Australian parliamentary inquiries into Supported Housing (Parliament of South Australia Social Development Committee 2003) and the South Australian Housing Trust (Parliament of South Australia 2003). Information from these documents was also organised according to theme using the participation observation sheet (Appendix 2).

A third triangulation method was a focus group and interviews with NGO representatives from both sectors. The focus group method is an appropriate tool to use with participants from across sectors, as it enables access to information through group interaction (Rice & Ezzy 1999).

An additional triangulation method regarding community input into policy was the inclusion of the perspectives of consumer and carer representatives who had worked at a state level (via a focus group and interviews). The two focus groups (one with an NGO, one with consumer and carer representatives) provided a reflection upon opportunities for, and experiences of, progressing agendas via advocacy from outside the bureaucracy (in the case of the NGO/advocacy group) versus progressing issues from inside (in the case of the state-wide consumer/carer structure in mental health, see below). Where participants could not attend a focus group, interviews were conducted.

As there was no current state-level mental health consumer/carer group advising the Mental Health Unit when the research was being undertaken, participant observation with such groups was not possible. Instead, information was sought from the government regarding the minutes of previous state-level mental health groups, and supported by focus groups and interviews with consumer and carer representatives who had been involved in previous state-level groups. Triangulation occurred via interviews with professionals who had been involved in community participation groups and processes across sectors.

**Table 4: Summary of Stage 2B with state level consumer carer groups**

Stage 2B Consumer Groups	Sampling	Administrative procedures
A thematic analysis of the notes from minutes of the consumer/carer groups that existed over the period of the mental health reform 2000-2005 at a state level (minutes from 2001-2004).	South Australian Consumer Advisory Group (SACAG)  Mental Health Consumer Carer Steering Group  'Interim Committee', comprising members of both of the above following the death of Dr Margaret Tobin <sup>14</sup>	Permission sought from then Director of Mental Health Services to access minutes.
Focus Group with consumer and carer representatives	One focus group with 4 former members of the consumer/carer groups that existed over the period of the mental health reform. See questions for focus group and interviews with consumer and carer representatives (Appendix 5).	Initial contact with the Director of Mental Health, then contact with the former chair of SACAG who initially sought interest. Emails and letters, with follow-up phone calls with consumers and carers.
Interviews with consumer representatives and professionals who worked with state level groups	Interviews with 3 consumer representatives who were unable to attend the focus group.  Interviews with 2 professionals who had worked on community participation within bureaucracy (three interviews, one person withdrew).	Professionals directly contacted, who had worked with the Mental Health Consumer Carer Steering Committee and SAHT Operational Policy Advisory Committee.

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<sup>14</sup> former Director of Mental Health Services and Programmes in South Australia, who had instigated the Mental Health Consumer Carer Steering Group.

### **4.5.3 Stage Three Interviews with Public Servants**

Stage three relates to research question one and two and incorporated interviews with twenty one key housing, disability and mental health sector professionals employed as public servants. It included interviews with eight professionals in housing roles and nine people in health roles (one person withdrew), one person in disability and three public guardians<sup>15</sup>. They involved both people in regional management/service delivery roles as well as state level policy/programme roles. Some interviewees had either crossed roles (from regional management/service delivery to state policy/programme management) or sectors (between health, disability and housing).

Semi-structured in-depth face-to-face interviews were undertaken in order to gauge experiences of collaboration in policy development and programme management, perspectives of the importance of and barriers to inter-sectoral relationships between the mental health, disability and housing sectors, discourses on mental health, disability and housing, and examples of successful collaboration efforts in the form of housing options for mental health consumers (see Appendix 6). In-depth face-to-face interviews were chosen in preference to a focus group. The apparent sensitive and political nature of mental health and housing issues within the departments (and the period of restructuring change that was taking place) made interviewing a more appropriate method for Stage 3. Please refer to Appendix 1 for brief descriptions of Interviewer IDs used from chapters 6-8.

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<sup>15</sup> Public guardians were from the Office of the Public Advocate (OPA) who make decisions or administer affairs on behalf of some of the most vulnerable members with a mental illness (who may not have informal carers). The OPA submission to the Australian Senate Select Committee on Mental Health was also considered in the document review (Office of the Public Advocate South Australia 2005, *Australian Senate Select Committee on Mental Health, Submission by the Public Advocate*: 30.)

**Table 5 Summary of Participants in Interviews and Focus Groups  
by Sector and Agency**

	<b>Health Sector</b>	<b>Housing Sector</b>	<b>Other sector<sup>16</sup> interviewees</b>	<b>Total number of Participants</b>
<b>STAGE 2</b>				
<b>Non-Government Organisations</b>	One Interview and Two people from Advocacy Focus Group	Two Interviews and Two people from Advocacy Focus Group	Three Interviewees in two Interviews	10 Participants
<b>Professionals working with state level consumers and carers or tenants, not in NGOs</b>	One Interview <sup>17</sup>	One Interview		2 Participants
<b>Consumer and Carer Representatives</b>	Three Interviews, and one Focus Group (4 people).	[NB <i>Not able to access tenant groups</i> ]		7 Participants
<b>STAGE 3</b>				
<b>State policy/programme/agency professionals</b>	Six Interviews <sup>18</sup>	Seven Interviews	Four Interviewees in two Interviews	17 Participants
<b>Regional programme/service delivery professionals</b>	Two Interviews	One Interview		3 Participants
<b>Totals</b>	<b>19 Health Sector Participants</b>	<b>13 Housing Sector Participants</b>	<b>7 'Other sector' Participants</b>	<b>39 Participants in interviewees and focus groups</b>

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<sup>16</sup> Includes interviewees from the disability/corrections/justice sectors.

<sup>17</sup> Would have been an additional person however one public servant (mental health sector) withdrew. Additionally, one person from Stage 3 who worked on general health reform could also comment on community participation in the health sector.

<sup>18</sup> An additional public servant (mental health sector) withdrew.

#### **4.5.3.1 Sampling and Administrative Procedures for Stages Two and Three**

##### Stage 2

There were a total of 91 participants within the case study, 52 people involved in participant observation and 39 in interviews and focus groups. There were 71 participants in Stage 2, and 20 ‘final’ participants in Stage 3. Sampling processes for Stages 2 and 3 are described below.

There were four main groups of participants across research stage two. These were primarily part of what Wadsworth (1998) calls the critical reference group, or the ‘researched for’ such as those who are to be informed or influenced by findings, or, at a more fundamental level, those who have a problem on which the research is to cast light’ (Wadsworth 1998). These groups included:

1. Consumer and carer representatives directly connected to Mental Health Services and engaged in state level consumer and/or carer groups during the Mental Health Reform period;
2. Professionals involved in advocacy and/or peak Non-Government Organisations in mental health, disability and housing sectors (i.e. representative groups) with a primary advocacy role;
3. Non-government organization staff in management or service delivery roles who were working with people with a psychiatric disability and whom were connected to peak NGO advocacy groups;
4. Professionals, either public servants or consultants who had worked with state level participation structures.

##### Stage 2A Advocacy NGOs

The advocacy groups were selected because they are the key state-based mechanisms in the mental health and housing sectors. For a description of aims and mission statements of these groups, see Appendix 7. Groups observed included;

- Health Sector

The Mental Health Coalition of South Australia (MHCSA). This is the peak advocacy group for NGOs in South Australia, established in December 2002, with funds from the then Department of Human Services (now Department of Health). It primarily consists of representatives from eighteen NGOs, and represents NGOs rather than individual carers and consumers. The MHCSA is primarily a group of professionals, however members of this group largely come from agencies which are often representative of consumers and carers rather than in an exclusively direct service provider relationship to them (i.e. eleven of the eighteen agencies). Individuals who have direct experiences of mental health services may be members of the group by virtue of the fact that personal and professional interests and experiences are often interrelated; and this is particularly evident in the mental health sector in South Australia. A key goal of the MHCSA is 'Advocacy and representation of consumers and carers at local, state and federal levels'.

- Housing Sector

Shelter SA has existed as a peak housing group advocating on housing matters including 'improved housing outcomes for everyone' since 1977. Membership is mainly comprised of non-government housing or housing support providers. Operating since 1997, the Community Housing Council of South Australia (CHCSA) is the peak group representing Housing Association and Housing Co-operatives, and contributes to policy development and advice on housing issues at a state-wide level. The CHCSA's Disability Focus Group is the disability specific interest group for Housing Associations and Housing Co-operatives supporting people with a range of disabilities, including mental disorder, and it was this group whose meetings were attended for this research. However, the submissions of the CHCSA were included in the thematic analysis.

## Stage 2B Consumer Participation Mechanisms

- Health Sector

The Health Consumers Alliance of South Australia has a contract with the

Department of Health's Mental Health Unit to represent consumer and carer views (end 2004). By June 2005, this group did not feel well established enough to participate in this study, a situation exacerbated by staff turnover, and did not believe the housing focus of this study relevant to their organisation. By mid February 2006, this group was in the process of developing a Mental Health Consumers Taskforce. However, one former and two current people closely associated with this organization were involved in this study (by interview and/or focus group). One was contacted based upon their prior involvement in state-wide consumer/carer participation. Subsequently, individuals from former state-level consumer/carer groups were contacted for this study (see below).

The South Australian Consumer Advisory Group had a (subsequently disputed by government) advisory role to the Minister of Health and was administered by the Mental Health Unit of the Department of Human Services. This group comprised individuals directly connected to Mental Health Services and carers, but has been abolished since 2002. The group co-existed with the Mental Health Consumer Carer Steering Committee established following the Mental Health Review to develop a new structure for input into mental health policy and programmes. An 'independent consumer consultant' facilitated some meetings of the group. This group and the focus group which immediately preceded it had a fluent Terms of Reference (see Appendix 8). These two state-level groups joined to form an 'Interim Committee' following the death of the then Director of Mental Health in 2002. Former members of these groups were accessed for this study, as were minutes of these groups. See Appendix 8 for a description of the Terms of Reference of these three groups and Chapter 5 for a full description of these various groups.

- Housing Sector

The researcher approached the former South Australian Housing Trust's Customer Involvement Unit (SAHT) in order to access two state-level housing tenant groups which they administered. These groups were the Public Housing Customer Forum and the SAHT's Operational Policy Advisory Committee

(OPAC). The Public Housing Customer Forum enables tenant representation and participation on housing matters at a state level<sup>19</sup>. The OPAC group was established in 1997 and comprises; customer representatives from seven Regional Advisory Boards to the SAHT, customer representatives from 'special customer focus groups' (e.g. mental health, disability, CALD and outer southern metropolitan), NGO's such as Shelter SA, Housing Assistance and Advice Service SA (HAASA) (a service for housing trust customers), Homelessness SA ('advocating for the rights of people who are homeless' and 'striving to address the conditions that create homelessness and inequality'), and the Agency for Non Government Organisations SA - Disability Sector (ANGOSA), and four housing trust staff.

The Operational Policy Advisory Committee has a stated role in providing advice to the SAHT and is akin to the (now defunct) SACAG's role in relation to the provision of advice to the Mental Health Unit. The SAHT declined access to participant observation and minutes of both of these groups, one of the reasons cited being a lack of involvement from the mental health disability field. However, a staff member connected to customer involvement in the SAHT was interviewed for this research. Additionally, one mental health consumer representative was interviewed who was also a member of a Regional Advisory Board of the South Australian Housing Trust (approached to participate due to their prior involvement in health consumer activities).

The community participation mechanisms selected for stage two were also chosen to ensure maximum variation sampling (Rice & Ezzy 1999), as they are positioned differently in relation to the state. They also comprise a mix of people including professionals advocating on behalf of consumers as well as consumers representatives. The groups involved also appear to have different functions in terms of participation; 'advocacy' and 'advice'.

The views of carer and consumer representatives who had belonged to state-level participation structures connected to the mental health bureaucracy were obtained

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<sup>19</sup> Information on these two groups was obtained from a document specifically developed for the researcher by Helen Ottaway, Project Officer, SAHT Customer Involvement Unit

through a focus group and face-to-face interviews with those unable to attend the focus group. The choice to incorporate the views of carers and consumers connected to Mental Health Services aims to avoid 'elite bias', a term coined for research where only the views and opinions of high status respondents are captured (Hubermann 1994).

In regards to administrative procedures, following an initial telephone call or face-to-face meeting, letters were sent or emailed to leaders of NGO advocacy groups explaining the purpose of the study and requesting permission to attend the group as an observer (see Appendix 9, 13). Focus groups and interviews were similarly arranged (see Appendix 10), and were taped and transcribed, with the permission of participants. Along with the letter of request, information on the study was provided (see Appendix 11) as well as consent forms to participate (see Appendices 12, 13, 14).

The state level consumer groups within the mental health bureaucracy had disbanded and there was little consumer participation activity in mental health when the research was undertaken. The former head of SACAG was approached, through the Director of Mental Health. This person then contacted consumers and carers directly regarding this study, asking if they agreed to have their details passed on. Where agreement was obtained, the researcher contacted these people directly by telephone, followed up with letters (see Appendix 9, 10).

### Stage 3 Interviews with Public Servants

For Stage 3, key informants from the state mental health, disability and housing bureaucracy were selected for interview (in policy and operational roles), based upon their seniority and their role in relation to mental health, housing and disability issues. Staff members from regional agencies of state government were also interviewed. The choice of participants was driven by the study's particular interest in inter-sectoral linkages between the mental health, disability and housing sectors at the state level, and recommendations from senior policy/programme staff on the most appropriate interviewees given the research topic.

Participants included; the Director of the Department of Health's Mental Health Unit, regional level staff, generic health policy and programme staff, public servants who

had formerly worked on mental health programmes at a state level, the Deputy Director of the Department for Families and Communities and other housing policy/programme staff, managers within key state housing agencies and staff from the DFC High Needs Housing Unit, and staff from Client (now Disability) Services, the Office of the Public Advocate and the Office of Health Reform.

Public servants from the mental health, disability and housing sectors were contacted directly, initially via an email or phone-call, followed up by a letter and/or phone call. Toward the end of the data collection phase, the Department of Families and Communities (DFC) requested that approval to interview staff of the department be sought. This approval was obtained via the newly developed DFC Social Inclusion Unit's Research Development Committee.

#### **4.5.4 All Stages Field Diary**

The Field Diary was kept at all stages (and commenced from when the thesis proposal was initially developed), recording and noting ideas, important information and phone calls, which included personal observations and reactions to ensure that a critical self-awareness was maintained. This was also used as a tool for triangulation of method for the three key research stages. As part of the Field Diary, newspaper articles on mental health were collated in order to keep in touch with local, state and national public debates on mental health and housing. The Field Diary covered the period January 2003-April 2007.

## **4.6 Methods of Data Analysis**

### **4.6.1 Stage One Data Analysis**

Stage one was a comprehensive review of state and national policy, review and consultation documents, with common themes derived from these. A thematic analysis was used for this stage, where

themes of important messages inherent in the material are looked for. These messages emerge from the perspective of the material under examination. The emerging themes are then the categories of the analysis.

(Rice and Ezzy 1999, p. 106)

In this stage, themes were not indexed and reorganised using a qualitative data package, but rather the history and narrative of the broad policy context was considered. This stage was undertaken prior to stages 2 and 3, in order to understand the context within which research participants operated.

#### **4.6.2 Stages Two and Three Data Analysis**

Firstly, familiarisation with the data was undertaken, which involved reading participant observation notes and reorganising them according to the themes in the participant observation sheets (Appendix 2). The organisational plans, minutes from meetings and submissions to government were also themed under the broad headings of the participant observation sheets. A report was written on each of the three organisations observed for Stage 2A (with participant observation and other documents themed under broad headings identified), prior to the conduct of focus groups and interviews.

This study used the process for analysing qualitative data in focus groups and interviews and participant observation recommended by Ritchie and Spencer (1994). It consists of five key stages: 1) familiarisation of data, 2) identifying a thematic framework, 3) indexing (applying the framework to data), 4) charting (reorganisation of data according to the appropriate thematic reference) and 5) mapping and interpretation. Data were firstly analysed according to stage of research, and prior to the next stage of research being undertaken.

Ritchie and Spencer's (1994) process was used for the analysis of focus groups and interviews, with a common index used, and subcategories for sectors. Indexing occurred, or coding by reference to the thematic framework. Similarly, charting (rearranging the data by theme) occurred according to thematic reference - and by sector (mental health or housing) where necessary. Finally, mapping and interpretation occurred through the pattern matching of themes to data, reviewing themes and comparing themes across sectors. Themes were compared across groups using an analytic framework approach where the focus was upon the discourses and issues evident across sectors. A brief report was written for the sub-phase of Stage 2A, before final reports were written for this stage of the research.

For Stage 2B, Ritchie and Spencer's (1994) framework for data analysis was also

applied, with a common thematic framework and sub-categories according to sector. As there was overlap between stages 2 and 3 (for example, public servants commenting on consumer participation and consumer and carers commenting on housing matters), a common index and thematic framework was used for both stages. The qualitative software package NVIVO was used to organise the data according to themes.

A report was written for each stage of the research, prior to the next stage of research, with cross-case conclusions developed from these reports. 'Analytic induction' and 'analytic generalisation' was used to link the themes to the original questions in order to make inferences for theory development. Policy implications were derived from themes on the nature of inter-sectoral linkages across the housing sector and community participation.

#### **4.7 Generalisability and Validity**

Validity and rigour were achieved via triangulation of methods and data sources. In Stage two, construct validity was developed through the use of triangulation of both methods and data sources. Participant observation was combined with a thematic analysis of documents, a focus group and interviews. Data source triangulation occurred via inclusion of community participation mechanisms across sectors, as well as from various sources such as professionals, consumers and advocacy groups.

In Stage three, construct validity was established via the triangulation of data sources; again, bureaucrats from across sectors were subjects for in-depth interviews, across policy and operational roles. Internal validity was developed through cross-analysis of data from interviews in Stage three, i.e. the actual inter-sectoral linkages that are occurring as perceived by professionals across sectors and working at different levels of policy or service provision. A chain of evidence was established through cross-case conclusions from stages two and three. Construct validity was also developed via the review of transcripts by interview participants.

To increase the rigor of the study, researcher reflexivity was developed by using the critical ethnographic Field Diary throughout the research process, which was used in

a triangulation process across the three research stages.

## **4.8 Ethics**

Ethics approval was obtained from the Flinders Social and Behavioural Ethics committee in June 2005. Ethics were also considered in the approved application for the NHMRC Public Health Scholarship application (Jan 2005). In September 2005, upon request by government, approval was also sought and obtained from the Department for Families and Communities Social Inclusion Unit's Research Development committee (see Appendix 15).

Access to the NGOs was first sought through the Executive Officer or equivalent, who then sought approval from the board or chair of the organisation. Access to consumer groups was sought through the Director of Mental Health and subsequently the former chair of one consumer/carer group. Access to tenant groups was sought through the SAHT Customer Involvement Unit. Informed consent was obtained for all interviews and focus groups as well as the participant observation stage prior to meetings. Study participants were provided the opportunity to withdraw from the study at any time and two public servants from the mental health sector withdrew after interviews were conducted. These interviews were not used in this study and all paper and electronic versions were deleted and not stored.

Feedback on study findings was provided through invitations to attend the progress reports of the PhD candidate. Individual interviews and focus groups and their participants remained completely confidential, unless legal issues arose in the disclosure of information. Feedback on interview and focus group transcripts was obtained prior to analysis. The researcher indicated to participants that the research would not necessarily lead to changes of policy and practice, in order not to raise expectations amongst participants.

Another risk identified was that of revealing the identity of interview and focus group participants when using quotes within the study. Interviewee IDs have been used when reporting quotes from interviews, with only brief descriptions of interviewees by sector (Appendix 1). The names of interviewees were not kept with

the transcripts during the course of the study.

#### **4.9 Scope & Limitations**

This study adopted a critical social science approach and held an emancipatory view of knowledge, which is consistent with participatory action research (PAR).

However, PAR was not employed. Precisely because of the critical perspective (with its notion of false consciousness) an 'etic approach' or observer-oriented (de Laine 1997) perspective was adopted. Participatory research also often involves 'user group' participation in the development of research questions, and it was also impossible to use this 'bottom-up' PAR approach as the research questions were developed separately to research participants prior to the commencement of the study. It was also difficult to be 'bottom up' research where the views of policy makers were included and important to questions on intersectoral collaboration. However, the study did draw upon previous consultations with consumers and carers through other sources (MHCA 2003). The researcher is also part of what Wadsworth (1998) calls the 'researched for' –or critical reference group - in both the sense of having been a professional in the health and housing sectors and having personal knowledge of the issues studied.

Additionally, whilst this research considered different discourses as part of its critical approach, a strict 'discourse analysis' was not undertaken. A thematic analysis of interviews and focus groups was instead used to reflect upon discourses on disability (Fulcher 1989) and neo-liberalism.

The research aimed to be comprehensive through its inclusion of key informants across professional and user groups across sectors. It was difficult to access some NGOs or participation groups for the following reasons; newness of one NGO and perceptions about their relevance to the topic of housing, workload and the 'representativeness' of tenant participation groups. Some key groups either declined to be involved in participant observation stages or could not be accessed through public services (e.g. Homelessness SA, Health Consumers Alliance, Public Housing Customer Forum), although individuals from these organisations were involved in the study. This research could have been enhanced by the participation of housing

tenant groups located in the bureaucracy, and in particular, more people with a psychiatric disability who were members of such groups (although they did not exist at the time of the study). Additionally, the inclusion of politicians' views of intersectoral collaboration and policy processes would have been beneficial to this analysis.

The observation stage of this research was conducted over a relatively short period of time (around 6 months), although was intended to provide insight upon the 'reform period' of interest to this study. To counteract some bias emerging from a focus upon a short period, the Field Diary was maintained over the entire period of research. Additionally, interviewees and focus group participants were asked to comment upon the reform period as a whole, and minutes, documents and submissions were considered across the entire Mental Health Reform period (2000-2005). Minutes and correspondence from the various consumer and carer groups in mental health were accessed; however these were sometimes incomplete and only covered approximately a three year period (May 2001-July 2004). This was related to the dissolution of the groups in question. Also as a result of the dissolution of these groups (and related factors), consumer and carer representatives who were part of state-level participation groups were difficult to access.

#### **4.10 Conclusion**

This chapter discussed the critical social science perspective taken in relation to the research approach, and discussed the associated research design, multiple methods, data analysis techniques, ethics, scope and limitations. Whilst a 'reflexive-dialectical' approach to knowledge was taken, and the researcher connection to the research acknowledged, these factors were not seen as incompatible with using multiple methods for triangulation and greater comprehensiveness within the study. The multiple method, embedded case study approach was considered appropriate for the complex cross sectoral policy environment being studied. In the following chapter, the stage one policy context of this research is explored.

## **5 Mental Health and Housing Policy Context**

Any general statement is like a cheque drawn on a bank. Its value depends on what is there to meet it.

(Pound, in Ratcliffe 2003, p. 242)

This is the first results and discussion chapter and is relevant to all of the key research questions. It involved a review and thematic analysis of national and state mental health and housing policies over the recent Mental Health Reform (2000-2005) in South Australia (key policy and legislation considered is outlined in Table 6 below). Supporting information on the policy context from the Field Diary and academic studies of the policy context was also considered. Key reviews (and responses) of state government policy and legislation and parliamentary inquiries covering the health and housing sectors were also considered. When undertaking a thematic analysis, the focus was also on aspects of these documents pertaining to housing and disability support for people with a psychiatric disability, and the inter-sectoral and community participation components of policies.

**Table 6: Key policies, legislation and reviews affecting Housing and Mental Health Sectors since the National Health & Mental Health Strategies and National Housing Strategy 1990-2005**

National and State Housing (& Disability) Policies	National and State Mental Health Policies
<b>2005</b>	
<ul style="list-style-type: none"> <li>▪ Housing Plan for South Australia</li> </ul>	<ul style="list-style-type: none"> <li>▪ SA Carer Recognition Bill 2005</li> <li>▪ SA Mental Health Legislation Review</li> <li>▪ National Senate Select Committee on Mental Health</li> <li>▪ MHCA/HREOC 'Not for Service' Report</li> <li>▪ SA Inquiry into Mental Health and Corrections commenced</li> <li>▪ SA Premier announces intention for Social Inclusion Board to consider mental health as a priority</li> <li>▪ National Mental Health Report (2005) Released</li> <li>▪ Palmer Inquiry into the wrongful detention of Cornelia Rau</li> </ul>
<b>2003</b>	
<ul style="list-style-type: none"> <li>▪ SA Inquiry into Supported Accommodation</li> <li>▪ SA Inquiry into the South Australian Housing Trust</li> <li>▪ SA State Housing Plan consultations commenced</li> <li>▪ Commonwealth State Housing Agreement (CSHA) 2003-2008</li> </ul>	<ul style="list-style-type: none"> <li>▪ SA Generational Health Review launched</li> <li>▪ 3<sup>rd</sup> National Mental Health Plan 2003-2008</li> </ul>
<b>2001</b>	
	<ul style="list-style-type: none"> <li>▪ A new millennium, a new Beginning State Mental Health Reform Action Plan</li> <li>▪ WHO Mental Health Report</li> </ul>
<b>2000</b>	
<ul style="list-style-type: none"> <li>▪ SA Parliamentary Inquiry into the Operations of the South Australian Community Housing Authority</li> <li>▪ National Homelessness Strategy</li> </ul>	<ul style="list-style-type: none"> <li>▪ SA Mental Health Reform Brennan report</li> <li>▪ SA Mental Health Reform Implementation Plan</li> <li>▪ National Action Plan for Promotion, Prevention and Early Intervention for Mental Health</li> </ul>
<b>1999</b>	
<ul style="list-style-type: none"> <li>▪ CSHA 1999-2003 first focus on 'high needs'</li> </ul>	
<b>1998</b>	
	<ul style="list-style-type: none"> <li>▪ Second National Mental Health Plan 1998-2003</li> </ul>
<b>1996</b>	
<ul style="list-style-type: none"> <li>▪ CSHA 1996-1999 focus on individual housing outcomes</li> </ul>	<ul style="list-style-type: none"> <li>▪ Realignment of Mental Health Services in South Australia</li> </ul>
<b>1994</b>	
<ul style="list-style-type: none"> <li>▪ Supported Accommodation Assistance Programme Act</li> </ul>	
<b>1993</b>	
	<ul style="list-style-type: none"> <li>▪ HREOC National Inquiry into the Human Rights of People with a Mental Illness 'Burdekin Report'</li> <li>▪ First National Mental Health Plan 1993-1998</li> <li>▪ 1993 SA Mental Health Plan</li> </ul>
<b>1992</b>	
<ul style="list-style-type: none"> <li>▪ National Housing Strategy</li> <li>▪ Federal Disability Discrimination Act</li> </ul>	<ul style="list-style-type: none"> <li>▪ National Mental Health Policy</li> </ul>
<b>1991</b>	
<ul style="list-style-type: none"> <li>▪ Commonwealth State Territory Disability Agreement (CSTDA)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Mental Health Consumer and Carer Statement of Rights and Responsibilities</li> <li>▪ Australia signatory to the UN Resolution on the <i>Principles for the protection of persons with mental illness and the improvement of mental health care</i></li> </ul>
<b>1990</b>	
	<ul style="list-style-type: none"> <li>▪ National Health Strategy</li> </ul>

## **5.1 Common themes across national policy**

### **5.1.1 Increased privatization across sectors consistent with neo-liberalism**

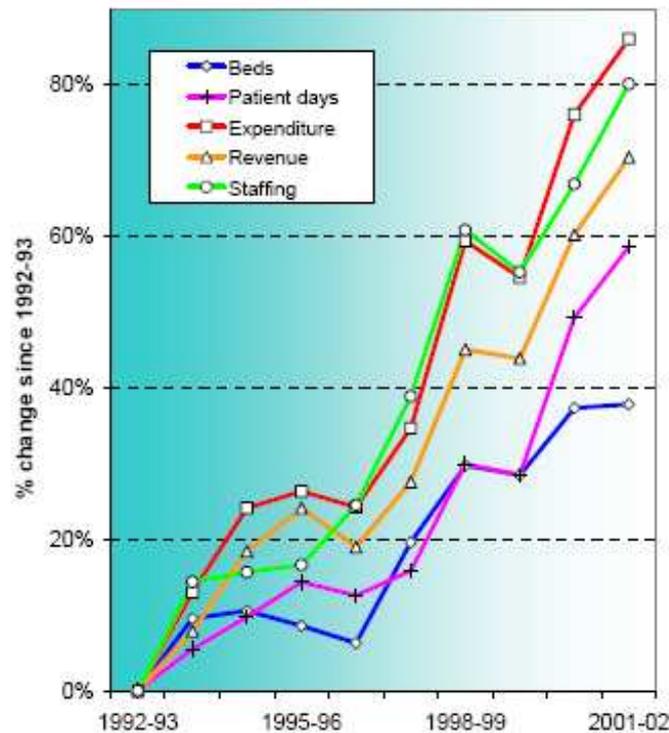
Social housing (which incorporates both public and community housing) has become increasingly residual in Australia (McIntosh 2000, p. 37; McIntosh & Phillips 2001). Following the 1997 and 1998 national Housing Minister's conference, the Commonwealth State Housing Agreement (CSHA) - the main vehicle laying down terms for the provision of funds from the commonwealth government to states and territories for social housing - was targeted toward those most in need (McIntosh & Phillips 2001). Additionally, funding for the CSHA has declined and reduced in real terms by 31% from 1991/1992 to 2001/2002 (DFC 2005).

Common to both the health and housing sectors, there has been a considerable expansion of private services and public support for private and non-government (NGO) solutions. The decline in public housing stock has been paralleled by private strategies to address problems such as housing affordability. The funding focus on the Commonwealth Rent Assistance scheme has led to a situation where this scheme is now the main source of housing assistance in Australia (McIntosh & Phillips 2001). Australian government assistance for home purchase and private rent is up 33%, but the number of households being supported remains about the same (AIHW 2005a). Nationally, affordable housing strategies have involved more community housing and investment from the private sector (public private partnerships or PPPs).

In alignment with the housing sector, private health sector services have increased dramatically across the period of the National Mental Health Strategy (NMHS). From the commencement of the NMHS in 1992 until 2001-02, there was a 38% increase in private sector psychiatric hospital beds in Australia (DHA 2003) (see diagram 2). In 2002-03, around 29% of separations for specialised psychiatric care in Australia occurred through the private sector (AIHW 2005d). These increases in the private hospital sector have paralleled reductions in the public sector system (DHA 2003). However, commonwealth funding spent on private psychiatry and GP consultations has slightly declined since 1999-00 (see Appendix 17). Subsequently, the third NMHP aims to promote access to private psychiatrists and shared care and

consultation-liaison models between public services and private providers (AHM 2003).

**Diagram 2: Selected Indicators of Change in the Private Psychiatric Hospital Sector (DHA 2003)**



Source: National Mental Health Report 2004 (DHA 2003, p. 36)

Overall, these trends across sectors are consistent with neo-liberalism and new forms of governmentality (Dean 1999). Trends in the mental health sector support Henderson's (2005) argument (based on her discourse analysis of policy) that Australian mental health policy is based upon expectations for non-government and private forms of care. However, public-private partnerships (common in the housing sector) have been linked to both neo-liberal and third way political ideology (Orchard & Arthurson 2005). The second National Mental Health Plan (NMHP) identifies partnership development with community support services as a priority (AHM 1998), whilst the third NMHP aims to increase support for and develop NGOs (AHM 2003). But funding for NGOs has been slowly established under the NMHS, particularly in South Australia (CDHA 2005).

### **5.1.2 Intersectoral linkages, bilateral<sup>20</sup> agreements, and access to government programmes**

A heavy emphasis on 'intersectoral linkages' can be found within separate policies for housing, homelessness and mental health. For example, the National Homelessness Strategy asserts the importance of intersectoral linkages, particularly where it comes to housing people with mental disorders (FACS 2003). Intersectoral partnerships are also promoted across the three National Mental Health Plans, although evaluations of the first two plans acknowledge that these are difficult to develop (National Mental Health Strategy Evaluation Steering Committee 1997; Steering committee for the evaluation of the second national mental health plan 2003). The Commonwealth State Housing Agreement (CSHA) is guided by principles which include linking with other programmes (Government of South Australia 2003). However, the Commonwealth State Territory Disagreement's (CSTDA) focus on intersectoral partnerships has dwindled (Bostock & Gleeson 2004).

Until the advent of the 1992 National Mental Health Strategy (NMHS), mental health policy was largely the responsibility of the states. When the NMHS was introduced it did not explicitly refer to the relationship between other bi-lateral agreements important to mental health, such as the CSHA or CSTDA (AHM 1992a). This was despite the NMHS being introduced after the CSHA had changed significantly from a public housing vehicle for low income people, to a welfare strategy for those with 'high needs', including people with disabilities (McIntosh & Phillips 2001). This was also despite the CSTDA being flagged as the vehicle for considering housing for people with disabilities in a discussion paper prepared for the National Housing Strategy (Sach & Associates 1991).

Advocates for people with a psychiatric disability have increasingly turned to disability (rather than health sector) policy and politics (Beresford et al. 2002). However, Bostock and Gleeson (2004) highlight the lack of coordination between the CSTDA (which they refer to as the CSDA) and the CSHA, a situation which has

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<sup>20</sup> Bi-lateral agreements refer to agreements between the Australian commonwealth and state/territory governments regarding the funding and provision of services, e.g. Commonwealth State Housing Agreement, Commonwealth State Territory Disability Agreement.

evolved only recently

The 1991 CSDA highlighted the importance of consultation with the 'relevant housing authorities to ensure coordination with the commonwealth state housing agreement' (section 6 (4)).

By contrast, the 1998 CSDA aimed to be more 'enabling' and to facilitate variations in service delivery within each state and territory. Consultation mechanisms included in the 1991 CSDA were not replicated in the second CSDA. This means that the second CSDA no longer explicitly requires consultation between disability and housing agencies. Thus, the focus in disability appears to have shifted to non-housing support needs whilst the profile of disability within housing appears to have diminished.

(Bostock & Gleeson 2004, p. 53)

Similarly, Bochel (in Bostock and Gleeson 2004) notes that academic discussions on deinstitutionalisation and community care have not been extended to the role of housing in community care policy and service frameworks. Conversely, the housing sector has not played a major role in community care (Bostock & Gleeson 2004). Despite the CSHA containing a guiding principle promoting partnerships, any cross sectoral partnerships between housing and disability sectors are often initiated by the disability sector (Bostock & Gleeson 2004).

The lack of connection between national bilateral agreements is reflected in people with psychiatric disabilities' general poor access to key community based services. In 1991, psychiatric disability was considered a 'health issue' leading to the inability of people with psychiatric disability to access mainstream accommodation support (Sach & Associates 1991). It was anticipated that this would change with the introduction of the CSTDA (Sach & Associates 1991) however CSTDA resources have not serviced people with psychiatric disabilities as intended (AIHW 2006). Only 8.3% of recipients of the CSTDA resources are people with psychiatric disabilities, who represent 4.2% of people with disabilities under 65 years of age (nearly all of whom have limitations in daily living activities) (AIHW 2006). Conversely, 38.2% of recipients of CSTDA resources are people with an intellectual disability, who represent 2.5% of people with disabilities under 65 years of age (nearly all of whom have limitations in daily living activities) (AIHW 2006).

The commonwealth Supported Accommodation Assistance Programme (SAAP) targeting homelessness initially officially excluded services for people with a mental

illness (HREOC 1993). Nevertheless, the department responsible for this programme claimed that it had become a 'defacto support service' for people with a mental illness even though the SAAP sector was not intended or resourced to provide services to this group (FACS 1999)

The skills required to support these high needs groups are beyond those of the current SAAP workers. Therefore a decision is made about the role of SAAP in becoming de facto carers for clients who have been lost and discarded in other service systems.

(Erebus Consulting Partners 2004, p. 106)

Conversely, the Home and Community Care (HACC) programme planned to support people with disabilities to live within the community independently in order to prevent their admission to institutional care (DHAC 2006). However, there is no information being collected through the National Minimum Data Set on the number of people with a psychiatric disability accessing HACC services (DFC 2006).

### **5.1.3 Competing concepts of health and disability within national policy documents**

Lewis (2005) argues that policy proposals associated with a social determinants view of health were largely ignored in the health sector internationally prior to 2000. Whilst some 'new' ideas of health were incorporated into policy, Lewis (2005) claims that there were no major changes reflected in policy such as resource shifts from medical care to non-health sector areas such as education and transport. She calls this period prior to 2000 'impermeability'. After 2000, some 'transformation' had occurred, evidenced by UK examples where national health inequality targets were set and strategies to address social exclusion were introduced (Lewis 2005).

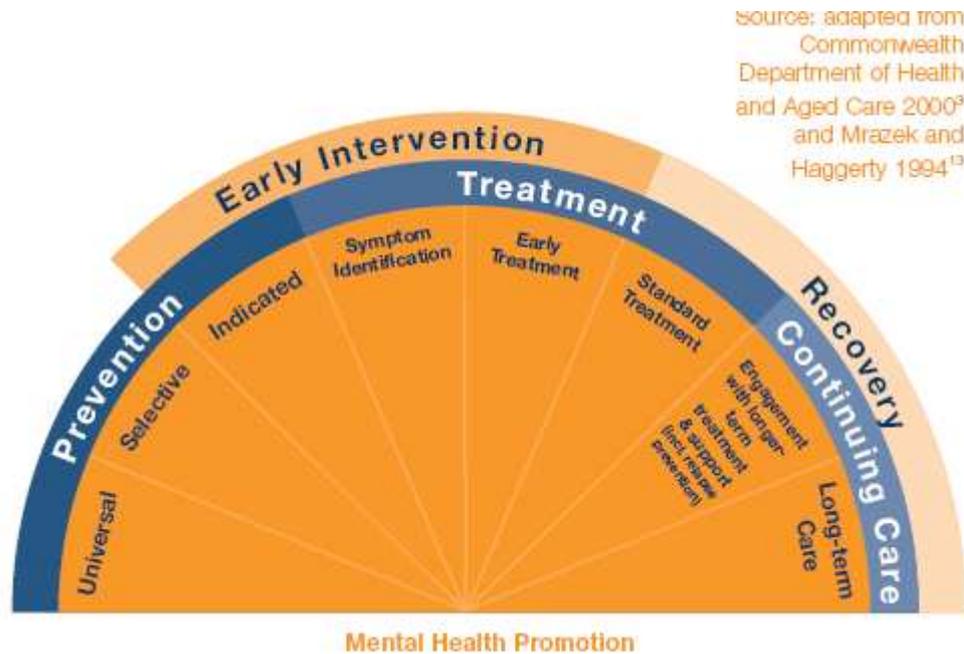
Similarly, Healy (2003) claims that later mental health plans in Australia have adopted a more social explanation of mental health and associated strategies. The second NMHP includes 'social determinants' settings for mental health promotion such as public housing and Supported Residential Facilities (AHM 1998). The ensuing mental health promotion policy generally acknowledges psychosocial determinants of health, listing housing as a key strategic sector for the realization of the plan (CDHAC 2000). However, strategies related to housing are not articulated. Settings for mental health promotion in the housing sector are 'separate services' such

as the temporary accommodation (i.e. for homeless people) and aged and disability services settings (CDHAC 2000). Mainstream public housing where the majority of people living with psychotic illness reside (AIHW 2000) is somewhat overlooked.

Additionally, when the national health promotion plan specifically relates to 'consumers and carers', objectives are contradictory. Housing consistently appears as an important factor affecting the health of 'consumers and carers', and the outcomes and process indicators for this group include social determinants (e.g. unemployment, homelessness) (CDHAC 2000). However, there are no 'national action' strategies related to these outcomes/indicators that mention sectors other than health. Instead, strategies include consumer participation, providing carer support and respite and improving mental health literacy (CDHAC 2000). When it comes to 'consumers and carers', the plan ultimately rests on a medical discourse of disability (Fulcher 1989).

An individualized focus consistent with a medical discourse on disability is also apparent in the third NMHPs focus on 'recovery' for mental health 'consumers' (CDHAC 2000). In the third NMHP (AHM 2003), the word 'recovery' is applied to the last three components of the spectrum for mental health promotion (see Diagram 3). The notion of a 'recovery approach' to mental health is somewhat congruent with Seedhouse's (2002) reasoning on mental health (discussed in chapter 2), as it acknowledges the episodic nature of mental ill health.

**Diagram 3: Spectrum of Interventions for Mental Health (Revised) (AHM 2003)**



Source: National Mental Health Plan 2003-2008 (Australian Health Ministers 2003, p. 9)

In the definition of recovery used within the third NMHP, the onus is on the individual with mental illness, together with families and communities, to change themselves in order to recover as recovery is defined as

a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and, or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability.

(Anthony, in AHM 2003, p. 37)

The emphasis on personal obligations to 'recover' are consistent with critiques of the obligations intrinsic to the 'new public health' (Petersen & Lupton 1996). The recovery approach as defined above is also consistent with the self-governance, individual autonomy and personal responsibility synonymous with neo-liberalism (Dean 1999).

#### **5.1.4 Changing definition of the 'rights' of people with a psychiatric disability in national mental health policy**

Interpretations of the 'rights' of people with a psychiatric disability have changed over the period of the National Mental Health Strategy. Hazelton (2005) observes that mental health policy in Australia has focused on improvements in treatment services, whilst overlooking the rights necessary to participate fully in life (Hazelton 2005). Conversely, Rees (2003) argues that the first National Mental Health Policy (AHM 1992b) focused on human rights, a focus lost in the second NMHP (AHM 1998) (Rees 2003). The Mental Health Council of Australia also point to the absence of a rights discourse in the second NMHP (MHCA 2005).

These observations on the diminishing rights of people with psychiatric disability in national mental health policy were supported by this study. In contrast to the National Health Strategy's (National Health Strategy 1993) discussion paper on participation which focused on 'consumer rights' in the health system, the National Mental Health Strategy initially had a much broader interpretation of the civil rights of users of mental health services and aimed to enshrine rights in legislation. This first NMHP followed the Burdekin report on the human rights of people with a mental illness (HREOC 1993) and the UN's '*Principles for the protection of persons with mental illness and the improvement of mental health care*' (UN 1991). Following these, the Australian government's *Mental Health Statement of Rights and Responsibilities* was developed (AHM 1991). This document included for consumers

the right equal to other citizens to health care, income maintenance, education, employment, housing, transport, legal services, equitable health and other insurance and leisure appropriate to one's age

(AHM 1991, p. 1)

The ensuing first National Mental Health Plan (AHM 1992) advocated a rights approach to consumer and carer engagement in the legislative affirmation of rights, and claimed moderate progress in the achievement of consumer rights through mental health legislation review, anti-discrimination legislation and consumer advisory groups (National Mental Health Strategy Evaluation Steering Committee 1997). Rees (2003) argues that many of the human rights targets of the first NMHP have not in fact been met, whilst SANE similarly claims that rights enshrined in

legislation have not been upheld (SANE 2004).

The latest NHMP reinterprets rights in terms of consumer and carer rights in treatment and related settings (AHM 2003). Across iterations of the three national mental health plans, there has been a change from a focus on broad civil rights, to promoting rights in health care policy, planning and treatment settings. Additionally, when it comes to intersectoral linkages, the focus is now upon policy and services integration, rather than meaningful community participation to develop policy and resources in non-health sectors (AHM 2003).

### **5.1.5 Tension in the way carers are perceived in national policy; as resources or people with moral obligations to care, or people requiring support**

Based upon their UK study, Twigg and Atken (1994) suggest that carers are perceived as resources, co-workers, something to be superseded, or invisible to the formal care system. Far from being seen as contributing to mental illness (chapter 2), families are now seen as 'resources' in the care of people with a psychiatric disability. Henderson (2005) (based upon her discourse analysis of NMHS documents) suggests that within policy, families are responsible for their own maintenance and a 'moral imperative' to care is implicit (Henderson 2005). In Henderson's view, expectations for monitored family care are created through carer participation within, and their provision of, mental health services. Carer rights to participate in treatment services are seen as one mechanism through which the state is able to monitor the family (Henderson 2005).

The definition of 'carer as resource' is apparent throughout the NMHPs. Carer rights outlined in the *Mental Health Statement of Rights and Responsibilities* are articulated in terms of their caring role (AHM 1991). Across mental health plans, carers are considered in terms of 'need' for government resources to support their central role (AHM 1992b; AHM 2003). In the first NMHP, one goal is

To support the development and expansion of Non-Government Organisations to assist carers and promote self-help and consumer advocacy, through information provision, opportunities to participate in mental health service decision-making and funding'

(AHM 1992b, p. 26)

However, the evaluation of the first two NMHPs have indicated that strategies designed to meet the 'needs' of carers are slower to develop than strategies for consumers (National Mental Health Strategy Evaluation Steering Committee 1997; Steering committee for the evaluation of the second national mental health plan 2003). Under its 'increasing service responsiveness' principle, the third NMHP also recognises the 'need' to support carers in their role (AHM 2003).

Carer participation within service and care planning could have an important role in illuminating cross sectoral issues for both people with disabilities and their families, rather than simply being a monitoring mechanism of the state as Henderson (2003) suggests. Alternatively, the absence of a carer voice across levels of mental health services (local/regional/state) may narrow perspectives on or make invisible the role being played by carers both within and across sectors.

#### **5.1.6 Crisis response and lack of political will**

Across sectors, a number of parliamentary inquiries, programme evaluation reports and academic research has noted the need for increased accommodation linked to support (Thomas & McCormack 1999; Health Outcomes International 2002; O'Brien et al. 2002; Parliament of South Australia 2003; Parliament of South Australia Social Development Committee 2003). These recommendations have largely gone unrealized in terms of a systems-wide national or state programme. Given the number of national and state level inquiries pertinent to mental health that were undertaken during the period of interest to this study, the political nature of mental health was apparent (e.g. Parliament of South Australia Social Development Committee 2003; Commonwealth of Australia 2005; Senate Select Committee on Mental Health 2005; e.g. Parliament of South Australia 2006; Senate Select Committee on Mental Health 2006). These inquiries suggested a lack of financial investment for mental health (and particularly housing issues) and crisis rather than planned responses. Some of the key issues raised by national mental health advocacy groups included the lack of accountability for the implementation of the NMHS and associated Plans (MHCA 2003; SANE 2004; MHCA 2005) and the need for a national mental health commission to monitor mental health services (SANE 2004).

##### **5.1.6.1 Political initiatives post 2005**

In 2005 a motion was passed in the federal House of Representatives to recognise the

impact of mental illness and the extent of the problems faced by people with psychiatric disabilities (Commonwealth of Australia 2005). 'Transinstitutionalisation' (or movement from people from psychiatric institutions into prisons and latterly detention centres) was one important issue on both national and state agendas (Commonwealth of Australia 2005; Parliament of South Australia 2006) after being raised by advocacy organisations (SANE 2004; MHCA 2005). Subsequent to the Council of Australian Governments (COAG) meeting in 2006 which prioritised mental health strategies and funding (COAG 2006), funding was allocated to mental health in 2007. Following the privatization trends described above, these funds focused on private clinical services subsidised by the Medicare Benefits Scheme. Just after the COAG funding was announced, the Prime Minister stated that housing for people with a psychiatric disability was a state rather than Commonwealth government issue (Karvelas & Cresswell 2006).

These developments followed an individual 'crisis' which had directly led to the Inquiry into the Circumstances of the Immigration Detention of Cornelia Rau (the Palmer Inquiry) (Commonwealth of Australia 2005) and the subsequent parliamentary inquiry into mental health (Senate Select Committee on Mental Health 2006). This crisis saw the wrongful detention of an Australian citizen with mental illness in a detention centre for illegal immigrants, which also uncovered 201 other similar cases (ABC 2005). Less of a focus were the significant mental health effects of Australia's harsh detention policies (Steel et al. 2004). The Rau case revealed a lack of agreements across governments and sectors on processes for information sharing and managing confidentiality (e.g. the absence of a national missing persons register) and acutely demonstrated the consequences of these failures.

## **5.2 South Australian Mental Health Reform Policy**

### **Context**

#### **5.2.1 Slow progress in National Mental Health Strategy objectives, ongoing review of mental health, reform across sectors**

Based on this study, previous consultations, and national mental health reports, it is evident that South Australia is one of the jurisdictions where the goals of the National Mental Health Strategy have been slow to progress (Brennan 2000; CDHA 2002; CDHA 2003; CDHA 2005). In particular, South Australia has seen a lack of progress in the 'Service Mix' objective of the National Mental Health Policy (AHM 1992a) (see Appendix 16). The service mix objective is to

To reduce the size or to close existing psychiatric hospitals and at the same time provide sufficient alternative acute hospital, accommodation and community based services

(AHM 1992a)

At the commencement of the state Mental Health Reform, 'expenditure on stand-alone psychiatric facilities was 80% above the national average' (Brennan 2000). By 2003, South Australia was the only state not to have reduced its spending on its stand alone psychiatric institution when compared to 1993 (CDHA 2005). Due to South Australia's high number of non-acute beds in stand alone psychiatric institutions, the state maintains the highest number of psychiatric inpatient beds (including beds in both acute and non-acute psychiatric units) on a population basis amongst Australian states (CDHA 2003). Also against the NMHS 'Service Mix' objectives, there was a reduction in the proportion of community residential facilities in South Australia throughout the Strategy (Commonwealth of Australia 1993; CDHA 2003).

Additionally, community based non-clinical mental health services delivered through the mental health sector has received significantly less funding (on a proportional basis) in South Australia when compared to other states (CDHA 2002; CDHA 2003; CDHA 2005).

The mental health sector has been in a constant process of review in South Australia, since the NMHS commenced. The South Australian Mental Health Service was incorporated in 1991 and a review of mental health services was established the

following year in 1992 (SAMHS 1993). After the 'realignment' (or reform) of 1996, further reviews were undertaken in 1998 and 2000, whilst in 2003 the Generational Health Review led to specific reviews in mental health such as a review of legislation (SAMHS 1996; DHS 1998; DHS 2000; DHS 2001; Generational Health Review 2003; Parliament of South Australia Social Development Committee 2003; Bidmeade 2005; Parliament of South Australia 2006). The overall theme of the state reform of mental health services 2000-2005 was on leadership and structural review (Brennan 2000). There was also an emphasis on integrating mental health services (which were already regionalized in the 1996 mental health services 'realignment') into the overall framework for the broader regionalization of health services following the Generational Health Review (Generational Health Review 2003).

Instability of the state Mental Health Unit was affected by both the changing leadership of its Director and the restructuring of the central unit during the entire period of reform. The Unit went from being a small unit to a large unit during tenure of Dr Margaret Tobin<sup>21</sup> (July 2000-October 2003), and then back to a smaller unit at the end of 2005. Initiating government reform in the health sector in 2002 coincided with a change in government. The housing sector also undertook a process of reform in 2005, where governance and legislative review were also a main focus (DFC 2005). The particular regional boundaries in health were not congruent with the geographical and planning boundaries in the housing sector.

Apart from the instability brought about by reviews, the mental health sector is vulnerable to crises (such as the aforementioned murders of two Psychiatrists by a patient and colleague respectively, or coronial inquests into the deaths of patients), and crisis responses such as parliamentary inquiries (Parliament of South Australia Social Development Committee 2003; Parliament of South Australia 2006). This is particularly the case in the absence of clear strategies for the decommissioning of stand-alone institutions. Parliamentary inquiries into mental health have a long history in South Australia, and played a key role in the establishment of the asylums in the first place (Pidcock 2004).

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<sup>21</sup> Former Director of Mental Health Services during 2000-2003

Dwyer asserts that the focus of health sector reviews should be health outcomes, however they are often characterized by a lack of accountability and are often tied to the political process (Dwyer 2004). In support of this argument, the Generational Health Review commenced following the election of a new government and Minister, and the 'First Steps Forward' response of the government to the review focussed upon services, i.e. more efficient management of individual services (e.g. emergency demand at hospitals) and better working across services and programmes (Government of South Australia 2003).

### **5.2.2 Access to resources under bi-lateral programmes**

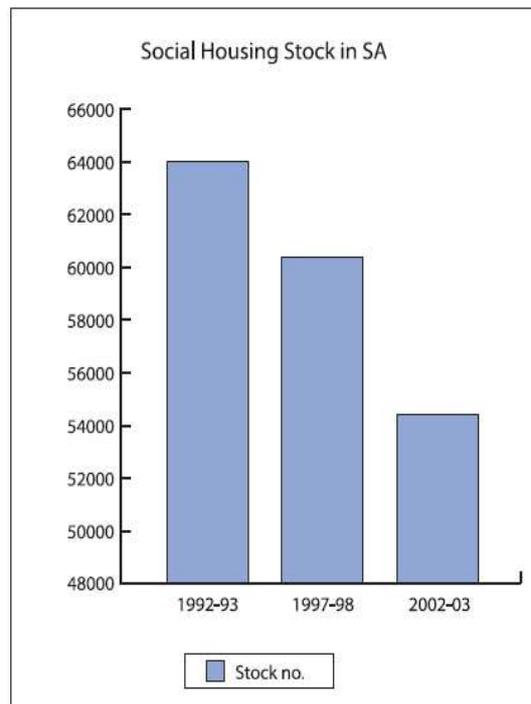
Following national trends, people with psychiatric disability's access to disability support resources (i.e. CSTDA) has been limited in South Australia, reflecting and perpetuating lack of progress in mental health reform. The first national report on the CSTDA showed that only 514 recipients of these funds in South Australia were people with psychiatric disability (AIHW 2002). The majority of people with a psychiatric disability were not able to access CSTDA funds in South Australia until 1st July 2005 when new growth funds were introduced by state government (Interview 4). This failure to follow up national CSTDA for people with psychiatric disability when funds were first introduced may be related to the health and community service bureaucratic distinction between psychiatric and other disabilities, first noted in 1991 (Sach & Associates 1991). Problems with access to both CSTDA and HACC resources for people with psychiatric disabilities have been raised by NGOs (MHCSA 2002; Parliament of South Australia Social Development Committee 2003).

### **5.2.3 Affordable and High Needs housing strategies in state policy**

In 1998, the South Australian Liberal government affirmed the national policy of public housing to be provided on the basis of priority need (Parliament of South Australia Legislative Council 2000). This was part of a series of social housing reforms including a reduction of concentration in South Australian Housing Trust (SAHT) housing, wider dispersion of public housing and increase in community housing (Parliament of South Australia Legislative Council 2000). The segmented waiting list for public housing commenced March 2000. In 2000, SA had twice the

number of housing stock dedicated to public housing than other states (Parliament of South Australia Legislative Council 2000). By 2003, SA's public housing stock had reduced considerably and 8.5% of households were public housing stock in the state compared to 5% nationally (Housing Management Council 2003). Diagram two shows the decline in actual housing stock from 1992-3 to 2002-03 which was in the vicinity of 10,000 homes (DFC 2005).<sup>22</sup>

**Diagram 4: Decline in Social Housing Stock in South Australia (DFC 2005)**



Source: State Housing Plan (DFC 2005, p. 12)

Whilst there has been a decrease in the waiting list for public housing (Stamfords Advisers/Consultants 2005), the proportion of people on the waiting list with 'one or more special needs' has increased (SAHT 2004). However, from 2000/01 to 2003/4 there was a decline in the proportion of new allocations for public housing in South

<sup>22</sup> The population rose by 4.5% (or 65,429 people) between 1991 and 2001

Government of South Australia 2007, *State-wide changes in population growth*, Department of Environment and Heritage, Government of South Australia, accessed 15th June 2007:

<http://www.environment.sa.gov.au/reporting/human/population/changes.html>.

Australia going to people in greatest need (from 48.6% to 40.1%) (Stamfords Advisers/Consultants 2005). The proportion of these households when compared with total households is now below the national average (Stamfords Advisers/Consultants 2005). The state's 'ranking as a provider of new tenancies to low income and special needs applicants has fallen from second to sixth' in Australia (Stamfords Advisers/Consultants 2005, section 1). However, people with identified mental health issues have increased as a proportion of new tenants since 2000-01 (Stamfords Advisers/Consultants 2005). In 2003-04 people with mental illness represented 11.5% of new tenancies, the second highest group allocated new tenancies (SAHT 2004).

The Housing Plan for South Australia (DFC 2005) and Strategic Agenda for DFC Connecting to the Future (DFC 2005) have recently focused on 'high needs housing' strategies. The associated High Needs Housing Unit oversaw a number of *existing* programmes, projects and services (e.g. Supported Housing, Supported Accommodation Assistance Scheme, Supported Residential Facilities). Whilst 'high needs' is not specifically defined in state policy, it appears to be a term used for population groups requiring extra support. People with moderate to severe psychiatric disabilities are one group considered to be a 'high needs' group 'at risk' (DFC 2005). A somewhat competing concept of a 'housing career' was also promoted in state housing policy where tenants, including 'high needs' tenants, were seen as being able to move across tenures and ultimately achieve more 'socially desirable' tenures such as home ownership and private rental (DFC 2005; Smith 2005).

Meeting the current housing needs of an individual with high needs will be progressively seen as a step on the path of social inclusion rather than a solution in its own right. Part of the service plan for that individual will include movement to more independent and socially valued housing options over time (such as unsubsidized private rental and home ownership)

(Smith 2005, p. 12-13)

This concept fits with state affordable housing strategies emphasizing 'alternative financing arrangements' through partnerships with NGOs and private agencies (DFC 2005). Affordable housing strategies involve the sale of public housing stock to community housing organisations, and are partly motivated by the financial deficits of state housing agencies (Orchard & Arthurson 2005).

## **5.3 State level community participation trends**

### **5.3.1 Different cultures of community participation processes across sectors in South Australia**

Table 7 below shows the range of structures and proposed plans for community participation across sectors during the reform period. The review of key documents outlined in Table 7 suggests that community participation processes in mental health services in SA were more unstable than participation processes in the housing sector. The former South Australian Housing Trust established a long history of tenant participation in services, beginning from 1983 (Ottway 2003). However, the level of involvement from users of mental health services or their advocates within housing participation structures is unclear.

**Table 7: Structures and Plans for Community Participation into Mental Health policy and programmes during the period of the South Australian mental health reform (2000-2005)**

Date	Structure/Plan	Role	Status	Membership	Theme
<b>Located in Govt</b>					
1991-Sept 2004	<b>South Australian Consumer and Carer Advisory Group (SACAG)</b>	Input into Mental Health Unit. Recognised as a Ministerial Advisory Group at its establishment in 1991 (SAMHS 1996)	Disbanded and merged into the Interim Committee.	First established following the National Mental Health Strategy to be a state level group informing policy. Representatives were from the Regional CAGs (see below).	Terms of Reference (1995) include assisting the Minister and CEO in the development of state-wide policies and plans and to provide input into the National Consumer Advisory Group (See Appendix 8).
Commenced at various times	<b>Regional Consumer Advisory groups (CAGs)</b>		Ongoing. Unsure of their position in relation to the new regional structure of health services in South Australia as at 2005.	Recruited from clients of mental health services and their carers.	Input into treatment & services at a regional level.
2002	<b>Mental Health Consumer and Carer Steering Committee (MHCCSC)</b>	Assist in the development of a plan to ensure consumer/carer involvement in the state reform.	Ceased, combined with SACAG following the death of Dr Margaret Tobin, former Director of Mental Health Services	Recruitment through advertisements in newspapers (Nov 2001, first met June 2002), selected by government. Paid positions. Group was facilitated by external consultant.	Changing Terms of Reference. Focus was on the development of a new structure for input into policy, rather than input into the mental health reform itself (see Appendix 8). Developed a 'Framework for developing partnership between consumers and carers and the mental health sector (2001)', earlier draft written by govt (Tobin version 5).
2003-2004	<b>Interim Committee</b>	Finalized a plan for consumer/carer involvement progressed by the above group.	Ceased. The document was finalized but never endorsed by Minister.	Joining of SACAG and the Mental Health Consumer and Carer Steering Committee following the death of Dr Margaret Tobin, former Director of Mental Health Services.	Focus was on the continued development of the document outlining a structure for input into the mental health reform.
Around 2002-2003	<b>Department of Health Plan</b>	'Community and Consumer Participation Plan Principles and	Not endorsed by the Minister.		Part of outcomes of Generational Health Review. It was decided that these principles should go into the health service agreements between the

		<i>Framework for Action'</i>			Department and Health Service regions.
2005	<b><i>Human Services Peaks Forum</i></b>	Peaks forum for NGOs. Oversees partnership agreement between the government and the community sector, known as 'Common Ground'.		Chaired by chief executives from the Department of Families and Communities, Department of Health and SACOSS and attendance by NGOs.	One of the intended outcomes is "Continuous improvement in policy development, governance, community and consumer participation and all areas of service development, planning, delivery and management." (DFC 2006). Also, a goal of the partnership is 'public debate about policy'.
2003-2005	<b><i>Carers Ministerial Advisory committee</i></b>  Department of Family and Community Services	SA Carers Report	Document 'SA Carers Report' passed through cabinet with minor changes. At the operational policy level – each department/health service will be required to action the report.	Individual people recruited via advertisements. A position was reserved for a carer representative from the Carers Association of South Australia (CASA).	Established to develop state government Carers Policy.
<b>NGOs</b>					
2001	<b><i>Mental Health Coalition of South Australia (MHCSA)</i></b>		Ongoing. Launched in 2001, incorporated Sept 2002, first AGM 5 <sup>th</sup> Nov 2003. Funded by state government from June 2004. Employed EO around Jan 2005.	Assisted in its development through the SACOSS Mental Health project.  Peak NGO and advocacy group comprised of professionals from consumer/carer and/or service delivery agencies in the mental health field.	Goals include advocating for more NGO services and the quality of NGO services on behalf of mental health consumers, addressing stigma (see Appendix 7).
2002	<b><i>Health Consumers Alliance (HCA)</i></b>	Mental Health Unit has a service agreement with the HCA to provide consumer input into the unit (funded by government).	Ongoing. HCA had just received funding from the state government Mental Health Unit for two 'mental health projects' as at 2004.	First AGM November 2002. Membership of the committee is professionally based, with positions reserved for consumers. No direct links to Mental Health Services or consumer or carer groups as at June 2005. In Feb 2006 a Mental Health Carers Taskforce was established.	Goals include provision of a voice for consumers, enhance the role of consumer and community groups in policy, planning, research and evaluation and services.

1989 Ongoing	<b><i>Carers Association of South Australia (CASA)</i></b>	Providing information, support and advocacy to all carers	Established and ongoing. Receives commonwealth and state (HACC) funding.	Family carers and organisations.	Policy and Advocacy, Information and Service Provision to Carers.
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The seventh National Mental Health Report showed that SA was well below national averages for consumer and particularly carer participation mechanisms in service delivery (CDHA 2002). It is important to note that the state acknowledged that consumer and carer participation in mental health service delivery was inadequate (CDHA 2002). In SA, the development of consumer and particularly carer participation strategies in mental health services stalled as they remained static since the end of the first NMHP (CDHA 2002). Consequently, the focus of this period was the development of strategies/structures to ensure community input in rather than actual community input into policy development. This situation is best described as tokenistic participation, or 'placation' as defined by Arnstein (1969).

The Generational Health Review supported community involvement in health priority setting, however argued that community participation should not occur through hospital boards, where 'corporate governance' should be a focus (Generational Health Review 2003). Communities appear to be partly defined by their lack of skills in corporate governance. 'Problems' with community participation (apparently identified by professionals) included consumer group expectations to be part of regional boards, communities wanting to ensure accountability for funding decisions, the silence of marginalized consumer voices, the co-option of consumers, and health system culture leading to resistance to community participation (Generational Health Review 2003). Separate local community advisory boards were recommended, along with community participation in areas such as workforce development, legislation, leadership, accountability and programmes (Generational Health Review 2003).

Following the GHR, the state government absolved itself of 'direct democratic accountability' (Hill 2005) for service user input into state mental health policy, by contracting a NGO to undertake consultation over policy (the Health Consumers Alliance) (Notes from Consumer Carer Groups). The focus for carer and consumer input became the operational programmes (regional services) in mental health rather than policy, and at a state level, 'tokenistic' participation through 'consultation' (Arnstein 1969) organised through this NGO. A peak advocacy group for mental health NGOs was also successfully established following the GHR (Mental Health Coalition of South Australia).

### **5.3.2 Carer invisibility, carer support and carer recognition**

Carers appear to be excluded from the state housing plan (DFC 2005) and to use Twigg and Atken's (1994) terminology are 'invisible' within this plan. This point is significant because, as the Inquiry into Supported Accommodation (Parliament of South Australia Social Development Committee 2003) indicated, it is carers who are already providing support in the absence of public services. Conversely, SA's strategic plan for the Department of Families and Communities (DFC 2005) (overseeing housing) states the need to recognise and support carers in their role (particularly ageing and young carers). Within this latter plan, carers could be considered 'resources' and 'partners', where the state supports carers through the provision of services such as out of home care and shared care.

A number of 'carer' initiatives were introduced during and immediately after the period of interest to this study, including:

- the State Carers Policy (DFC 2006) and Carer Recognition Act (Parliament of South Australia 2005)
- placement of the Human Rights Monitoring Bill on the political agenda by the Mental Health Reform Alliance 1st in 2005 (Field Diary) (not supported as at May 2007) (Legislative Council 2005)
- the monitoring of carers in treatment services (advocated for through Children of Mentally Ill Consumers)
- and the Carers Association of South Australia being represented on the committee overseeing the Review of Mental Health Legislation in 2004 (Department of Health 2004)

The Carer Recognition Act passed through the Parliament of South Australia, had the following aims:

to recognise and support carers and their role in the community; and

to provide for the reporting by organisations of the action taken to reflect the principles of the Carers Charter in the provision of services relevant to carers and the persons they care for.

(Parliament of South Australia 2005, p. 1)

This legislation was accompanied by the whole of government carers policy (DFC

2006) developed from 2003-2006. This policy document recognises carer choices, including to undertake the caring role, and is more consistent with a 'rights' discourse for carers. It makes a direct link between deinstitutionalisation policies and the increased burden of family care (DFC 2006). Whilst neither carer legislation or policy specifically mention carers role in providing housing or housing stability, the policy claims that carers are maintaining people 'at home' within the community. Neither policy or legislation are linked to resources, however they now require government agencies to report on their activity in relation to carers.

### **5.3.3 Narrow definition of the rights, anti-discrimination legislation excluding psychiatric disability**

The GHR contained a broad definition of human rights, and identified priority groups who have inequitable access to health as a human right, such as people with mental illness. However, strategies to address these were not specific and related to 'ongoing mental health reform' (Generational Health Review 2003). The development of new mental health legislation is one aspect of reform, although consultation for this legislation has not embraced the broad civil rights of users of mental health services. Rather, like national mental health policy, rights pertaining to treatment options have been a focus (Department of Health 2004)

the Act should include an expanded statement of principles in relation to the provisions of treatment and care, involuntary admission and treatment, and rights of consumers in approved treatment facilities.

(Department of Health 2004, p. 17)

[The Act should] acknowledge the rights of consumers and their carers as fundamental and the importance of family and carers in the care and treatment of people with a mental illness'

(Department of Health 2004, p. 14)

Conversely, WHO recommends priority access to housing or the provision of certain types of housing as areas for inclusion within legislation (WHO 2005). Ensuring that people will not be discriminated against in trying to access housing or being placed in poorly located or segregated housing are other recommendations (WHO 2005). These are pertinent points to SA, as (uniquely to this state) protection from discrimination as a result of one's mental illness or psychiatric disability is not included in state anti-discrimination legislation (Parliament of South Australia

1984).<sup>23</sup>

## **5.4 State level programmes and policies for intersectoral collaboration**

### **5.4.1 Project based initiatives and relationships, separate strategic policy networks**

Feedback from the SAAP programme has indicated problems with collaboration across the homelessness and mental health service sectors in South Australia (Rymill 1992). In 1992, SAAP services found it difficult to access clinical mental health services on behalf of SAAP clients, whilst state Mental Health Services expressed a view that SAAP services were resistant to working with people with a psychiatric disability (Rymill 1992). Mental health services claimed SAAP workers' confusion about confidentiality issues versus the need to seek appropriate support (Rymill 1992). In 1994, the Disability Services Office of the state government attempted to develop protocols between disability, mental health and housing agencies although these did not appear to have been implemented. Almost ten years later, participants in Department of Premier and Cabinet's (DPC) Social Inclusion Unit (SIU) consultations raised the difficulty that homelessness services experienced in accessing mental health services, and concerns with the mental health sectors' focus upon acute care (DPC 2002).

Intersectoral partnerships have been largely focused at a project level in mental health services, and at a regional/operation level in the housing sector in South Australia (Smith 2005). There were five main initiatives related to housing and disability support for people with a psychiatric disability over the period 2000-2005;

- DHS Supported Housing/Accommodation demonstration projects, later an ongoing programme managed by the DFC, incorporating 12 projects

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<sup>23</sup> Moves to include mental disorder as a recognised basis for discrimination were made through the Equal Opportunity (Miscellaneous) Amendment Bill 2006.

housing 130 people (Tregenza & Beck 2005). (The only examples of cross sectoral activity mentioned in the 2000 South Australian Mental Health Reform documents)

- Supported Residential Facilities (\$57m) package 2004 (Mental Health Unit 2005)
- DPC Social Inclusion Unit's Exceptional Needs Program<sup>24</sup> and Homelessness projects, and the
- One-off social rehabilitation (\$25m) funds 2005 (Mental Health Unit 2005)
- Supported Tenancies demonstration projects (later a programme) (housing sector)

The above initiatives had varying levels of cross-sectoral activity and involvement from mental health services at a policy, programme or service delivery level, and not all were directly targeted for people with a psychiatric disability. Many of these activities were not the result of cross sectoral activity in the development of policy. They were often initially demonstration projects which may have led to cross sectoral activity in a service delivery environment. For example, the 'Housing Support Coordinator' initiative (one of the Successful Tenancies projects) was first introduced to the SAHT in 2000. The aim was to provide case coordination, advocacy and support to tenancies 'at risk', and it actually led to improved interagency collaboration (Baulderstone & Beer 2003).

Where policy networks existed, they were often confined to particular sectors. For example, the parliamentary inquiries on supported accommodation and public housing occurred simultaneously (Parliament of South Australia 2003; Parliament of South Australia Social Development Committee 2003). They encompassed similar issues and arrived at similar conclusions regarding the need for more supported

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<sup>24</sup> The Office of the Public Advocate South Australia manages 12 individuals deemed to have 'exceptional needs'

Office of the Public Advocate South Australia 2005, *Australian Senate Select Committee on Mental Health, Submission by the Public Advocate*: 30.

accommodation, with different ideas about what this constituted (as did the SIU Homelessness Plan in 2003, see below) (Social Inclusion Unit 2003). There were different participants within these inquiries, largely determined by funding sector. The Inquiry into the South Australian Housing Trust recommended the development of a Memorandum of Understanding (MOU) between a range of services within 12 months, including mental health and housing services. Similarly, the Inquiry into Supported Accommodation recommended the development of protocols for planning and priority setting between disability services, the housing sector and mental health services. At the time interviews and focus groups were being undertaken for this research (2005), an MOU was still in developmental stages.

#### **5.4.2 Responsibility for housing people with a psychiatric disability: intersectoral collaboration and the Social Inclusion Unit**

The Department of Premier and Cabinet's (DPC) Social Inclusion Unit (SIU) is one cross-sectoral structure aiming to develop cross sectoral policy and strategies in areas such as homelessness and mental health. However, the SIU strategies used to address homelessness are not always cross sectoral and the Interagency Group established as part of the DPC Homelessness Strategy did not involve health agencies. The Unit has also run a series of roundtables on effective linkages across government and services (Social Inclusion Unit 2004), however outcomes in terms of housing people with psychiatric disability were not evident. Much of the activity funded through the Unit was project level activity which appeared to be based on a 'crisis model' (targeting people who are primary homeless, see below). For example, two recommendations from the final report of the Homelessness taskforce were for the creation of community based mental health services targeting homeless people and for the psychiatric assessment of homeless people at public hospitals (DPC 2003). One subsequent short-term project monitored homeless people at the state's central hospital, finding that 80% of homeless people admitted had mental health problems (Graham 2005b). However, the SIU did recommend additional supported accommodation places, particularly for people with a psychiatric disability (Social Inclusion Unit 2003).

The government's response to the SIU's Homelessness Strategy was to concentrate

on primary homelessness, which refers to people without conventional accommodation or a roof over their head (e.g. rough sleepers, sleeping in cars, derelict buildings) (Chamberlain 1999; Chamberlain & MacKenzie 2003). Secondary homelessness refers to the movement of people across temporary accommodation (e.g. SAAP accommodation such as shelters and refuges, boarding houses, or living with relatives and friends) (Chamberlain 1999; Chamberlain & MacKenzie 2003). Finally, tertiary homelessness refers to people living in untenured housing which is below community standards and where people do not have their own bathroom and kitchen facilities e.g. some boarding houses and SRFs (Chamberlain 1999; Chamberlain & MacKenzie 2003). Losing and gaining housing in the latter marginal housing sector has also been referred to as iterative homelessness, an important problem for people with mental disorders (Robinson 2003).

Another small project introduced through the SIU was the DPC's Thinker's in Residence<sup>25</sup> Common Ground model. This was based on 'Common Ground' in New York, which provides residential and support services for former homeless people (Government of South Australia 2006). Haggerty's (Thinker in Residence) influential first report to the state on homelessness included recommendation such as; collecting better information about homelessness, focusing on the most chronically homelessness, improving discharge practices from institutions, eliminating 'transitional' programmes and focusing on housing, better accountability mechanisms in governance and political will (Haggerty 2005). Solutions for homelessness included building a system beyond projects, widening the range of housing options and types (reusing existing city buildings, mixed use, mixed income housing) e.g. developing Glenside Hospital and the former Police Barracks at Thebarton (former institutional settings) (Haggerty 2005). Structural issues such as the decline in the CSHA were not addressed as part of the overall strategy to solve homelessness.

In December 2005, a Supported Accommodation Task Force was established in South Australia and consulted the community on an accommodation and personal support services policy and plan and new accommodation legislation for people with

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<sup>25</sup> A state government programme connected to the Department of Premier and Cabinet where experts visit the state to make recommendations on a particular topic

disabilities (DFC 2006). Additionally, towards the end of the period of interest to this study the SIU took up mental health as a priority for programme oriented rather than project activity (following a request by the premier in August 2005) (Social Inclusion Board 2007). The effectiveness of these two initiatives is largely outside of the scope of this study as the focus is the Mental Health Reform period (2000-2005), however recent initiatives in mental health and housing are discussed in the conclusion of this thesis.

## **5.5 Conclusion**

This chapter highlighted the current neo-liberal policy context of this case study across the housing and mental health sectors and levels of government. This neo-liberal policy context is synonymous with diminishing public sector resources, including resources for collaboration. The review indicated new forms of governmentality associated with the gradual withdrawal of public services, in favour of more privatized solutions (Dean 1999). At a national level, the focus has been upon intersectoral linkages in policy and public private partnerships rather than public resource provision (necessary to support intersectoral linkages). Expectations for family care were inherent within state and national mental health policy over 2000-2005, however the role of carers was invisible within current state housing policy (DFC 2005). Neo-liberal discourse can be associated with ‘consumerist’ discourses on participation and narrowing definition of the rights of people with psychiatric disabilities within mental health policy. Latest iterations of mental health policy indicated the rights of people with psychiatric disabilities being interpreted in terms of individual treatment services, rather than broad civil rights such as access to housing. A tension lies between the ‘choices’ assumed by ‘consumerist’ discourses on participation, expectations for family care, and diminishing public sector resources.

Despite overall neo-liberal trends, a mismatch between national and state policy (particularly NMHS and CSTDA) was evident, contributing to the slow progress of mental health reform in South Australia. This has seen a lack of commitment to community based (and NGO) resources directed to psychiatric disability from the mental health and disability sectors. The extreme instability of community participation groups at a state mental health policy level was also identified (which contrasted with the situation in the housing sector). This situation has the potential to further impact upon the development of alliances deemed necessary to support reform (Funk et al. 2005). This situation in South Australia also suggested contextual factors within this policy environment (e.g. particular dominance of neo-liberal discourses, ongoing reform, and community stigma).

Intersectoral collaboration was considered particularly difficult to achieve through the National Mental Health Strategy (NMHS) (Steering committee for the evaluation of the second national mental health plan 2003). The cross-sectoral reform being undertaken in South Australia during 2000-2005 could be potentially impacting upon both intersectoral collaboration and community participation important for this research, and seen as a temporary situation. However, the mental health sector has been in a constant process of reform in South Australia since the introduction of the NMHS, such that attempts to reform represent the 'status quo'. The lack of progress in MOUs is potentially related to organizational instability brought about by such governance reform.

The state's new cross departmental structure, the DPC's Social Inclusion Unit, prioritised homelessness and in the last stage of the reform period, a mental health initiative was announced. The success of and barriers to cross-sectoral and community participation strategies in place across 2000-2005 are explored over the next three chapters. The next chapter specifically considers policy actors' perceptions of housing problems for people with a psychiatric disability, and the current neo-liberal policy context, in order to understand policy agenda setting and change priorities and processes explored in subsequent chapters. These chapters also explore the contextual factors impacting upon the South Australian policy environment.

## **6 Perceptions of housing problems and policy solutions**

It isn't that they can't see the solution. It is that they can't see the problem.

(Chesterton, in Ratcliffe 2003, p. 309)

The solution of every problem is another problem.

(Goethe n.d.)

This is the second results and discussion chapter and considers both how important 'problems' of housing stability and access for people with psychiatric disability were conceived by participants across sectors, and perceptions of policy solutions. It is primarily based upon the thematic analysis of interviews and focus groups with NGOs, consumer/carer groups and professionals. The chapter also considers 'indicators' of problems from the review of the policy context (chapter 5). This chapter relates to all of the central research questions and demonstrates that the way in which 'problems' are conceived is crucial for understanding agenda setting and housing outcomes for people with a psychiatric disability. This chapter is precursor to the next two chapters on community participation and intersectoral action for agenda setting. It plays an important part in establishing that 'problems' identified across policy sectors are not always consistent or reflective of problems expressed by consumers and carers, problems taken up by NGOs or those addressed through policy. It also considers the impact of policy discourses within and across sectors.

This chapter uses policy theory discussed in chapter three to understand the results presented, in particular Kingdon (2003) and Bacchi (1999). As discussed, Kingdon (2003) sees problems as sometimes being separate to solutions, arguing that 'problems may be in search of solutions' or 'policies may be looking for problems'. For Kingdon (2003), matching problems to policies depends upon the degree of integration of the policy network, and policy entrepreneurs' connection to the political stream. Conversely, Bacchi (1999) sees 'problem representation' as essential to all stages of policy processes (e.g. in understanding affordability). For Bacchi (1999), the way in which problems are represented across these stages (including in policy debates) and by whom is crucial to understanding policy discourses, and ultimately what becomes policy.

In this chapter, components of Kingdon's (2003) 'problem stream' are considered to examine the relationship between indicators, evidence, problems, and 'problem representation' (Bacchi 1999). These include the indicators for problems, the way in which problems are categorised, problem urgency, and budgetary constraints and promoters (Kingdon 2003). At the same time as considering these components of problems, the chapter examines the political and cultural ideologies which mediate perceptions of problems (and favour particular policy solutions or the low prioritisation of mental health). These discourses include neo-liberalism (Dean 1999) and various discourses on disability (Fulcher 1989), including a lay discourse based upon community stigma.

## **6.1 How were problems and policies conceived?**

### **6.1.1 Different emphasis on resources or intersectoral links, different perspectives on neo-liberal policy solutions**

There were a range of housing problems for people with a psychiatric disability identified by participants across sectors. Appendix 18 demonstrates both the range of problems identified and solutions which could be linked to these problems. The most often reported 'problems' were resource problems: the shortage of disability support services to maintain people in housing and access to social housing (housing supply) (Appendix 18). Respondents differed in their emphasis on the need for either disability support services or housing access and supply, although in many cases both were considered important issues requiring addressed for successfully housing people with a psychiatric disability. A lack of housing and support options or the failure of public housing system were cited as reasons why so many people with psychiatric disabilities were in and out of the private SRFs and boarding houses (Interview 5, 14, 19 below, 22, 25, 30, Consumer Carer Focus Group).

Well I think housing is a real priority issue but in terms of funding by - I don't think it's been recognized by government to be as an important issue. The recognition of the importance of the issue.

Part of it is housing, but I think the critical issue is actually the support. And so there's not been enough appropriate housing. But there's certainly not enough funding put into the support side. And, you know, there was a fair bit of evidence and that in the supported accommodation, or the SA Inquiry into Supported Accommodation.

Interview 5

The lack of suitable stock is reflected in the number of people still in the SRF sector. And despite the Legislative Council review and the money that was allocated for that purpose the quality of life/access to services, including mental health services, seems to be limited although it's improving.

Interview 19

Not all respondents believed that resource 'problems' were in search of policy solutions (Kingdon 2003). There were different perspectives on the appropriateness of current state-level housing strategies, based upon various perceptions about the need for additional public housing resources. One public servant did not consider housing problems for people with a psychiatric disability to be necessarily related to resources (Interview 23, below)

getting the right supports for those people is a very large issue, but that's not saying that's - I don't think you should assume that it's necessarily a resource problem, it's about better connection to existing services.....To a large extent it's [housing instability's] an issue, because more and more we're becoming what we call a high needs housing provider, so it's about us thinking how we can connect up support services to those houses.

Interview 23

Consistent with 'new governmentality' (Dean 1999), 'community care' in the psychiatric disability sector was associated with drawing back government services or a lack of community support following deinstitutionalisation (Interviews 2, 4, 5, 6, 7, 21, 24, 26, 29, 30 Consumer Carer Focus Group, Advocacy Focus Group). In alignment with neo-liberal trends in national and state policy (chapter 5), policy actors observed responsibility for service provision shifting away from government (to private services and NGOs) (Interviews 5, 6, 23), or something avoided by government (Interview 17). These trends were seen as problematic or desirable, depending upon the respondents' political view and connection to NGOs. Some public servants across sectors held the view that 'communities' should become more

independent and responsible for services (Interviews 6, 11, 17, 23, below). However, exactly who communities referred to (i.e. non-government sector, community housing, private sector, families or 'other sectors of government') was often unclear. Some of these same respondents emphasised the need for additional resources for people with a psychiatric disability such as support (Interview 11) or housing (Interviews 6, 17). Others recognised the shift of responsibility from government to private services and NGOs was not always desirable for the most difficult clients (Interviews 17, 23).

And with the assets the issue to me is does the state need to own the assets or can the community own the asset? Ultimately I think we want the communities to own the asset... Because I think we are heading towards a system where more is pushed out to the community. We want community, and the same with the services. And my reason for going that way is because I think it's the opposite to internationalisation and nationalisation.

Interview 6

Idealistically, personally I think there's a lot to be said for the whole community kind of coming together in some kind of way that enhances the life of the disadvantaged citizens, if you'd like. And a non-government organisation in a sense is such a thing.

Interview 17

I think it's a bit wider than the health service. I think it's actually more of a community responsibility

Interview 11

The 'homelessness to home-ownership' strategy in state housing policy (chapter 5) promoted independence from government and was associated with values of self-reliance and the undesirability of a welfare system (Interview 23). This can be associated with a 'new right' perspective of welfare (Kenny 1994). However, the 'housing career' concept was explained in terms of 'best practice' principles such as the principles used by the Oregon government in the United States (described below) which, on face value, neutralised the inherent new right perspective of welfare (Interview 23, below)

So, we need a housing system that flows, that's got clear pathways for people so they can move from a situation of being in crisis and homeless, through to stable tenure, through to renting in the private sector, through to owning their own home. If we lose sight of those high order goals of what I'd call, contribution back to society and active engagement as a citizen, then you end up

with a welfare system.

...Over time, we might have to - local government and us might be here in that engagement process, in other words we are doing it to them at that stage, but in five years time, if you take the UK principles and some of the other, you know Oregon principles, you will want to hand that back to the community. It allows government to withdraw. Then you can put those resources into a community that is more dysfunctional.

Interview 23

There are six 'Oregon principles' (or core funding areas) which act as a 'Strategic Plan' guiding the activities of the government of Oregon. The Oregon government has the objectives of; greater transparency for government programmes, increased efficiency and accountability, savings from government being reinvested across government, and government services directed to meeting the needs of the most vulnerable members of society (Kulongoski 2005-2007). For each budget submission, government agencies are required to identify the 'Oregon principle' which the proposed programme falls under, provide information on the proposed evaluation, explore the possibility of services outside of government being service providers, undertake a cost-benefit analysis, and outline the potential impact of the programme upon citizens (Kulongoski 2005-2007). The 'Oregon Shines' plan was used as a model for the South Australian Strategic Plan (which adopted the Oregon strategies for accountability) and the leader of the Oregon Shines Progress Board headed consultations for the latest SA strategic plan (Manwaring 2007).

The state government's 'Affordable' and 'High Needs' strategies generally linked in with the Oregon objectives on the reinvestment of government resources across programmes, alternative financing arrangements and addressing people most in need. For example, 'high needs' housing is part of a strategy to meet the needs of category 1 clients (people considered to have urgent housing need: DFC 2005), and the separate affordable housing strategy is intended for those on the waiting list who are category 3 clients (eligible for public housing according to income but not in urgent need of public housing: DFC 2005) (Interviews 2, 6, 16 below).

There are, there is probably a wide range of definitions of high needs so, I guess I don't want to pick any particular one out. I guess, in this context we would define high needs probably as being category one, housing trust tenant. So a group that met a set of criteria that actually defined what their needs were. In general it would actually mean that they have issues that are beyond

affordability, so some sort of support needs. Certainly people with mental health or psychiatric or intellectual disabilities or whatever would be high prevalent in that group.

Interview 16

However, affordable housing strategies (with anticipated investment from the private sector) intended to push the public housing sector to play an even greater role in welfare housing. Along with the 'housing career' concept, these strategies intend to reduce demand on the public housing sector, whilst at the same time meeting the needs of a range of people, providing affordable rental and homes when private rental and home ownership markets are highly competitive. Like the rationale for community care policy (Goodwin 1993), these strategies can be seen as an attempt by government to fulfil a range of interests to ward off crises for the state (Habermas 1976; Offe 1984).

The practicality of the 'housing career' continuum, and particularly the ability of people with a psychiatric disability to achieve home-ownership, was questioned by community housing and other NGO professionals who worked closely with people considered to have 'high needs' (Interview 14, Participant observation notes). Private rental options were equated with poor access to support and housing affordability problems for residents (by housing sector respondents; Interviews 2, 6, 7, 24, Advocacy Focus Group).

Yet the issue to the Minister and others is that we've got a large proportion out there in the private rental sector who are in terrible strife.

Interview 6

I would be more worried about the private rental market than I would about the home ownership market because I think the reality is that people, particularly with severe psychiatric disabilities, are not going to get in home ownership or they're going to fall out of it. They may not be able to make a success of public tenancies. They may be able to access community housing tenancies but a lot of them are in or are going to wind up in the private rental market for some proportion of their time and again, you're going to have the same problem, that there's no housing type support there for them really. There is no organisation that provides that sort of support in a housing sense in South Australia that I'm aware of.

Advocacy Focus Group

The capacities of people with disabilities to move across tenures may rest on the level of public service provision provided in the health and disability sectors as well as private family support available. However, reference to people being 'high need' clients could easily overlook the fact that many people with disabilities used few public resources, relied on private support, found it difficult to access social housing, or were in expensive SRFs where public tenancies had failed (Interview 22). Government 'promoting independence' for people with psychiatric disability was problematic for carers, who saw this as either meaning independence from family carers, and a forced dependency on unreliable services, or as meaning people were left with little support in the community (Consumer Carer Focus Group).

Homelessness to Home Ownership idea of X, the leader of the housing reform, scoffed at. Set up to Fail. People need supports.

Participant Observation notes

I remember reading it and weeping to be quite honest for our client group. This is just ridiculous, it has just gone way beyond and when it does say the community based housing then we're here. You know review the act is our main thing, review the Co-Operative and Community Housing Acts, strengthen the management capacity of community housing organisations.

Interview 14

Independence means providing support though, doesn't it?...And they don't seem to understand that concept.

Consumer Carer Focus Group

Previous reports and research studies support concerns that some points on the state government's 'homelessness to home ownership' continuum are especially difficult for people with psychiatric disability to achieve. In one Australian study, just 14.5% with a psychotic illness were living in their own home just prior to their illness (AIHW 2000). However, based on the findings of one small study, it appears that the proportion of people with chronic and complex needs owning their own home in South Australia is extremely limited (Cooper & Verity 2004). Supported Accommodation Assistance Programme (SAAP) (homeless) clients with a disability are much less likely to come from or exit into private rental accommodation (AIHW 2005b). Private rental housing is often not an option for people with psychiatric disabilities given its affordability to consumers (Thomas & McCormack 1999).

Private rental landlords can afford to be extremely selective in South Australia as recently it has had the lowest rental market vacancy rate in Australia with vacancies consistently under 2% (Real Estate Institute of South Australia 2006). Studies from overseas have shown that stigma may be an additional factor for people with a psychiatric disability obtaining accommodation; in the United States, 40% of landlords indicated that they would immediately reject a rental application on the basis of a person having a psychiatric disorder (Alisky & Iczkowski 1990).

### **6.1.2 Feedback mechanisms and the interpretation of problems: political acceptability of evidence and the national reporting context**

If feedback mechanisms of government are an important source of 'problem identification' (Kingdon 2003), then problems may have been overlooked during the period of interest to this study due to gaps in;

- counting the homeless mentally ill (Haggerty 2005)
- information on supported accommodation shortages for people with psychiatric disability (Parliament of South Australia Social Development Committee 2003)
- information on the profile of disruptive tenants (Parliament of South Australia 2003)
- the housing status and stability of users of mental health services (Appendix 18)
- complaints mechanism in the health and community services sector (introduced in 2005).

Information gaps at least suggested little urgency placed upon housing access and stability problems for people with a psychiatric disability within government. However, this did not prevent problems from reaching the political arena as the parliamentary inquiries into supported accommodation and public housing demonstrated (Parliament of South Australia 2003; Parliament of South Australia Social Development Committee 2003).

Even where there was evidence or feedback mechanisms indicating problems, the

reluctance to use research data or the impact of the politicisation of issues upon reporting was evident (Interview 17, below) (This is discussed further in chapter 8).

I can tell you that nobody in the Department of Health wanted to see it [research] because it contradicted the direction they were going in. Actively didn't want to see it... But mostly, there's a thing you'll see which is supposed to be a feature of private industry, but it's actually every bit as much a feature of the public sector. And that is that you can't afford to know the information or otherwise you're responsible for the outcomes.

Interview 17

Since the 1990s, government reporting has occurred on a national basis through the National Mental Health Reports (CDHA 2002; CDHA 2003; CDHA 2005). There is a heavy focus in reporting upon 'service inputs' and government expenditure rather than client 'outcomes' such as housing stability. For example, national reporting on supported accommodation through the National Mental Health Strategy first occurred in 2005 and focuses upon numbers and expenditure upon supported accommodation places (staffed by mental health professionals on a 24 hour basis as an alternative to institutional care) (CDHA 2005). In June 2003, South Australia, Western Australia and Queensland were the only states that had no 24 hour residential beds to report upon (based on June 2003 figures) (CDHA 2005). One respondent suggested that the politicisation of mental health (and the national reporting context) had impacted upon the way in which public housing services were being reported upon within states (Interview 23, below).

I mean as an example, there's a classic example of how this stuff's politicised, in WA for example, they moved all the public housing and houses with somebody with a mental illness over to the health system and they count as part of health services. So when SA benchmarked against WA in terms of dollar per capita spend on mental health, it comes in really low because they're counting things that South Australia's not counting.

Interview 23

### **6.1.3 Different categorisation of problems and solutions proffered, and overlooking the connections between problems**

Another reason why problems such as housing access and supply may fail to reach the policy agenda, or be unaddressed by policy responses, is the different ways in

which problems are categorised (Kingdon 2003), or problems being overlooked (Bacchi 1999). Within this study, problems were prone to being categorised differently across sectors and policy/political streams of government, or specific evidence or indicators for problems that were mentioned were different across sectors. For example, health sector participants referred to increases in emergency hospital demand and the inability to release patients due to housing shortages (Interviews 17, 19), whilst housing sector participants discussed the turnover in homelessness services (SAAP) and the former public housing body (SAHT) (Interviews 2, 7, 23, Participant Observation notes, Appendix 18).

One problem which appeared to be largely overlooked in the case study was the problem of 'trans-institutionalisation', or people with a psychiatric disability being overrepresented amongst prisons/community corrections sector clients following deinstitutionalisation. Only a small number of respondents mentioned the problem of 'trans-institutionalisation' (Interviews 9, 11, 14 below, 23, 26, Advocacy Focus Group).

The remand centre, their unit managers of each unit in the remand centre for instance, talk of that's how they see their job now, they're just a mental health holding facility and they're openly saying that. They're doing a good job when they can, for security officers dealing with mental health issues, it's a scary thought.

Interview 14

This comment was consistent with findings and commentary regarding an increasing number of people with mental disorders within the corrections system without support services in South Australia (Richards 2003; Office of the Public Advocate South Australia 2005). A South Australian parliamentary inquiry into mental health services and associated corrections services is currently being conducted (Parliament of South Australia 2006).

NGOs and public servants suggested a deliberate failure to recognise the overlaps between a range of problems, including social exclusion, housing instability, the overrepresentation of people with a psychiatric disability in the corrections system and emergency demand in hospitals (Interviews 11, 14, 16, 17, Advocacy Focus Group, below).

I still think there's a long way to go to recognise the intersection between housing, mental health, criminal justice interface and to me we've got to bring that together if we're going to think about the health of our community rather than treating them all as separate things. There's still a recognition there that for us to have a, what's the word, a vibrant society we've got to somehow or other stop compartmentalising or seeing these things as outside the square rather than central to it.

Interview 11

So, if you can, if you can train your disciplines, your health disciplines to understand that, we are complex human beings with multiple needs and you've got to work together... That whole sort of debate is really what's got to happen in all the, sort of disciplines, so that housing workers need to understand the connections, health workers need to understand connections etc, and I think that if health is defined widely professionals understand and have a commitment to join up, that will take it a long way. It doesn't mean that structures don't matter, but I am probably more inclined to say it's a responsibility of all us professionals to not take narrow approaches.

Interview 16

In particular, the health sector was accused of taking a narrow approach, focusing upon the provision of clinical mental health services, hospital emergency demand policies, crisis responses and throughput in service delivery (Interviews 2, 4, 5, 6, 11, 18, 21, 22, 24, 25, 27, 30, Advocacy Focus Group below, Minutes of Consumer Carer Groups). These observations reflected the medical discourse on disability operating in the sector (Fulcher 1989). Mental health services were considered increasingly narrowly focused, creating an even greater need for disability support services (Interview 5, below).

Whereas now, mental health service is becoming more specialised. Tightening up. You've got government putting some small buckets of money into psychiatric disability and just specific types of services too. Because for example, vocational services haven't really got a guernsey, but so you've got more specialists on this end, you've got small buckets of money over here, and so you've got a whole range of people who actually need your service who are now being told, who aren't getting it anymore.

Interview 5

The perceived narrow clinical focus of mental health services, together with these ideas about 'community responsibility' and ownership of problems, supports Goodwin's (1993) analysis that separating treatment and care was part of the rationale for community care

This implies continuing support for medically orientated treatment services, providing

increasingly specialised services that are accessible to a growing number of people. It also implies continued pressure to transfer the responsibility of care onto the community.

(Goodwin 1993, p. 219)

As discussed in chapter 5, in the final year of the mental health reform period, the government funded social rehabilitation resources, which extend beyond clinical treatment. However, these funds are for temporary ‘rehabilitation’ services and based upon expectations for throughput in service delivery, rather than ongoing disability support (Interview 23). Such expectations were considered problematic for people with psychiatric disability who by definition have ongoing needs for support (Advocacy Focus Group, below). One interviewee expressed reservations about these social rehabilitation funds being held by the mental health sector inferring that they would be subsumed by demands for clinical services (Interview 22, below).

I came from a clinical background and just assumed because in the clinical framework the flow through and the pushing people through is the current mantra, and so when I came in and started supervising assumed that that case load or that group of people would move on, and what I quickly realised is that was an incorrect assumption

Advocacy Focus Group

But I don't know how it will pan out in the longer term, you know the fact that the Mental Health Service have got the psycho social rehab money and yet they have all the demands around the clinical. I don't know how into the future how well that's going to work.

Interview 22

### **6.1.3.1 Problem representation of homelessness and homelessness responses**

Previous failure to recognise the overlap between homelessness and psychiatric disability was apparent. For example, one person expressed the view that tertiary homelessness for people with psychiatric disability was a major and somewhat overlooked issue (Interview 5, below). Another public servant (Interview 7 below) commended the South Australian Strategic Plan for tackling homelessness (SA Strategic Plan Audit Committee 2006), whilst noting that s/he had not associated homelessness with psychiatric disability in the past

Well at the moment, government seems to be very focused on people who are homeless and the focus is probably on people who are sleeping rough. But the reality is that people living in SRFs for example, which is part of the - it might not be primary homelessness, it might be tertiary homelessness, but you have people who experience primary homelessness moving through that sector on the one hand, and on the other it's - just because you've got a roof over your head doesn't mean you're actually not still freezing cold, undernourished, you know, that you actually experience getting the sort of care and support services that you require. So, I mean I think there's a lot of work to be done for people to actually recognise it. What the population is that we're actually talking about, whereas all we seem to focus on is small bits of population and develop small programmes and then feel - and we market them as being new-beaut and terrific and that we've met people's needs.

Interview 5

I've been thinking and saying for quite a while within the housing system about the question of our responsibility for homelessness. I've never really given it the same kind of thought about a mental health issue. You know, we complain about it. We whinge about it and say something's got to happen. We've got some good things happening here, but what about the rest? But this one I haven't included and I will.

Interview 7

Whilst state-government homelessness strategies were heavily focused on 'primary homelessness' (as recommended by the government's 'Thinker in Residence' Haggerty 2005), tertiary homelessness was not being 'problematized' in policy responses. Conversely, government strategies were supporting the private SRF sector which received considerable government support (chapter 5) despite their tertiary homelessness status (Chamberlain & MacKenzie 2003).

In this case study, respondents reported a high number of people with mental illness being in the SRF sector, and this was considered less than ideal due to the insecurity of tenure and quality and cost of accommodation in the sector (Interviews 4, 6, 13, 14, 17, 19, 22, 25, 30, Consumer Carer Focus Group, see below). Areas flagged for improvement included; the inconsistency in support provided by public mental health services across SRFs, people transiting across private SRFs regions without timely coordination with GPs/mental health services, conditions and standards within SRFs and the role of private SRFs in the public service system (Interviews 4, 5, 13, 19, 22, 24, 25, 28, 30). The lack of advocacy and support services for SRF residents has also been raised as an issue by the Office of the Public Advocate (Office of the Public

Advocate South Australia 2005). Oversight of SRFs was planned and commenced following the latest state housing plan (DFC 2005; DFC 2006). However some problems would be left unaddressed by simply monitoring the system. For example, the noted incompatibility between the for-profit motivations of private providers and the needs of people with a psychiatric disability, associated with the power of providers to terminate leases and cherry pick clients (Interviews 5, 30).

I think housing is a huge issue for people's mental health wellness. That stable housing I think maintaining one's mental health is a big issue, especially in SRFs and property prices are going up and the attractiveness of selling the property, people left homeless, relocated, put into places like Salisbury in isolated housing. I think it's an issue what the government seriously needs to look at. It's not satisfactory.... Having worked in SRFs, I think the linkages, information, knowledge is extremely poor. I don't think they have any idea of what happens in the SRF, of the sub standard living conditions. When it comes down to quality of food, level hygiene, that staff are not qualified, medication regimes that are not adhered to... But from working with the people in the SRFs, they are the poorest of the poor, the most poorly treated.

Interview 13

I know subsequent to my involvement those supported SRF's in their own right became an issue. Because what started to happen is that even though they weren't necessarily a good thing that was the only option.

Interview 25

Despite these problems, withdrawal from and viability of the SRF sector was a concern of respondents and government (Interviews 13, 19, 22, 24, 25, 26, 30). Both nationally and in SA, private boarding house and SRF proprietors had either withdrawn or were facing closure due to financial viability and land prices which had made the sale of properties attractive (Anderson et al. 2003; Doyle et al. 2003; Quast 2003b; Doogue 2004). Where boarding houses are available, proprietors in SA have indicated they were becoming more selective due to low vacancy rates (Anderson et al. 2003). The political power of the private SRF sector grew in the context of diminishing CSHA resources (see chapter 8).

### **6.1.3.2 Problem categorisation, discourses on disability, neo-liberal strategies and preferred or ideal housing models**

The different 'categorisation' of problems could be tied to various discourses on disability (Fulcher 1989) and housing solutions. Respondents across sectors

discussed the preference and need for a range of housing models and tenures for people with psychiatric disability. The importance of choice in housing and support options reflected a rights discourse on disability was implied (Interviews 5, 6, 15, 16, 19, 22, 23, 26, 28, 30, Advocacy Focus Group, see Appendix 18). However, many of these respondents expressed a preference for a professional assessment of need matched to the 'needs' of people with disabilities (in alignment with a corporate discourse), in addition to consumer aspirations (Interviews 5, 6, 19, 22, 23). Sometimes consumer choices were believed marred, either by the poor range of housing options available, individuals' low expectations and/or community stigma (Interviews 17, 19, 30).

In the health sector where a medical discourse was dominant, there was a focus on either temporary 24 hour high level supported accommodation or temporary social rehabilitation (involving stepped residential care and support packages). NGOs and carers in this study claimed that there was far too much of a focus on costly high level support (24 hour) in supported accommodation models rather than the provision of flexible ongoing and disability support (Consumer Carer Focus Group, Advocacy Focus Group). This claim was on the basis of consumers not wanting or needing such high level support, even when people were considered to have high level disabilities (Consumer Carer Focus Group, below)

Well I knew that with my sons, I mean, they're classed as having very high level disabilities...they don't want 24 hour care. They don't need 24 hour support, which is what a lot of the - you know they do these demonstration models, you know.

Consumer Carer Focus Group

Not necessarily 24 hour support but just options that are appropriate. I think with a lot of that stuff people get hung up on models that are around 24 hour support. It's like you need 24 hour support, but you don't. Like you might need it occasionally but sometimes it might just be a bed that's a little bit more supervised than what you've got at home or meals or whatever.

Advocacy Focus Group

Recent funding spent on such high level care and temporary social rehabilitation, seemingly contrary to the desires of at least some consumer and carer representatives, suggests the dominance of health professional interests in a policy environment (further discussed in chapter 8).

A corporate discourse on disability was emphasised within 'high needs' housing policy which linked a range of housing options/tenures with levels of need (DFC 2005; Smith 2005), although the language of 'high needs' can be associated with a medical discourse. However matching need to housing tenure (and the 'housing career' concept) could also be linked to the new right perspective of welfare and government efficiency (discussed above). Conversely, a rights discourse on disability (Fulcher 1989) was associated with the disability sector (Interviews 4, 5). The charity discourse on disability could also be associated with the Common Ground model, where homeless people with psychiatric disabilities will live and receive a range of services onsite in one building with support from the private sector. Charity models are aligned with service provision in the corporate sector, and 'total' residential institutions and/or non-residential institutions for people with disabilities living and working together (Fulcher 1989, see Table 1). Deliberate attempts to involve the corporate sector in disability can also be linked to neo-liberal strategies of government.

Some respondents across sectors suggested that 'disability specific' housing solutions were unnecessary (Interviews 4, 15). Cluster housing or congregate living (where independent homes are clustered on one site such as in a group of units) were sometimes considered ideal (Interview 4, 21), although two people in the mental health sector bureaucracy believed this model vulnerable to stigma (Interview 27, Field Diary). Some consumer representatives had successfully lobbied for cluster housing, where bureaucrats had expressed a preference for independent homes (Consumer Carer Focus Group, Field Diary). This is an important point as previous studies have highlighted consumer preferences for independent living, away from other people with psychiatric disability (Reynolds 2002b; Arthurson et al. 2007).

The need to weigh up factors associated with independence and the risk of social isolation is important given the problems of social isolation (and stigma) identified, and its perceived relationship to housing instability (Interview 4 below, 11, 13, 17, 19, 21, 24, 28, Consumer Carer Focus Group, Advocacy Focus Group). Linking people to communities, neighbourhoods and vocational and recreational options is important to address social isolation (Advocacy Focus Group).

But one of the key issues in community based support and living for people with mental illness is

loneliness and it's the other side of independence, community, engagement and the rights of people to live an ordinary community life is that people can be very isolated and lonely. So you've got to try and find that sort of right balance. I mean there are lots of people and predominately people either living single or two person households now and so there are lots of people that spend part of their time by themselves. But people with mental illness I think they feel that fairly acutely.

Interview 4

Other factors important to housing people with psychiatric disabilities included tailored, flexible (e.g. episodic or ranging in intensity) ongoing support linked to housing, and ongoing rather than temporary housing solutions (see Appendix 18). NGO professionals and public servants also saw the need to develop independent living and social skills amongst tenants for housing options to be successful (Interviews 9, 21 22, 23 24). The separation of tenancy management and support was also seen as desirable (Interviews 3, 6) and is currently best practice in Victoria and New Zealand (Connellan & Wilson 2004). Conversely, at least one community housing agency had obtained funds from mental health services for providing support where they were already undertaking tenancy management (Interview 7)<sup>26</sup>. Having disability support together with 'manageable homes' was also considered necessary, particularly to avoid being considered 'disruptive'<sup>27</sup> (Interviews 2, 6, 9, 15, 21 see below, Consumer Carer Focus Group).

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<sup>26</sup> This was not related to a planned policy response, but to the quick release of Social Rehabilitation funds combined with the existing networks between government and community housing staff (see chapter 8).

<sup>27</sup> At this point it is important to mention that one behaviour which could be considered 'disruptive', compulsive hoarding, is associated with mental illness and a known symptom of obsessive compulsive disorder

Black, D. W., Monahan, P., Gable, J., Blum, N., Clancy, G. and Baker, P. 1998, 'Hoarding and treatment response in 38 nondepressed subjects with obsessive-compulsive disorder', *Journal of Clinical Psychiatry*, vol.59: 420-425. which highlights the need for support to address this behaviour.

We've had lots of discussions about cluster housing, because I think that is where there's a gap. For single people with mental health problems who don't necessarily need any whopping great big yard. In units or things where there is onsite support and social activities for people.

Interview 21

Because with people wanting to live on their own and often being able to manage to a point, but not being able to keep their front yard or back yard tidy, they stick out in the street, they are unable to shop all the time and that sort of thing. So it's about having that sort of support to get those things in order.

Interview 15

It's probably also, like the style of housing. I mean most of our houses are three bedroom homes, single home, with a yard and that sort of accommodates for a family and that or they're groups of units, like a block of six or four or six units and I suppose our experience has been that people don't cope in either of that type of housing. You can't maintain the yard if you're in a house that's too big or you live in a group of units and then you might be reported for disruptive behaviour yes so I suppose it would be like a worthwhile thing to find out what type of housing actually is most suitable for.

Interview 9

There were mixed views held on the suitability of community housing versus public housing for people with psychiatric disability. These views were often dependent upon one's experience in the community housing sector, experiences liaising with in or working in other public housing agencies, and perceptions about the interests and skills of staff working in public and community housing (Interviews 15, 24, Advocacy Focus Group, Participant Observation notes). (This is further discussed in chapter 8).

#### **6.1.4 The effect and interpretation of budgetary constraints and promoters**

According to Kingdon (2003), an influx of funds can act as a 'promoter' for placing problems higher upon political agendas, whilst budget constraint can have an opposite effect. The lack of follow-up to deinstitutionalisation in the mental health sector was sometimes associated with the state bank debt and collapse (in 1992)<sup>28</sup>

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<sup>28</sup> The State Bank of South Australia was owned and underwritten by the Government of South Australia, and when it collapsed in 1992 it led to the government being billions of dollars in debt, the

and funds being channelled to other areas (Interviews 6, 12) or used as a government saving (Interview 29, below).

The Health Commission decided to close Hillcrest and they left Oakden, but they were so proud that they closed Hillcrest and saved, in those days something like \$20 million dollars, and they handed it back to the government as a saving. It was always obvious that you just couldn't close Hillcrest without reinvestment in community or other services, and from that time onwards the mental health system always struggled. ... they decided to close Hillcrest and yet they didn't have a plan from the rest of the mental health system. It was a disaster, and from that time onwards I think we've been trying to catch up with mental health and we've never got on top it. I mean they wanted to close Glenside without the investment in the other sites. You can't do that, and it's a political problem now. People won't invest before closure, and you can't do that.

Interview 29

Although the state bank collapse may partly explain the low priority of deinstitutionalisation and community housing, this does not explain why the general disability sector did not equally suffer. Interviewees compared the planned response to deinstitutionalisation of the intellectual disability sector with what they saw as the unplanned and unresourced response to the 'deinstitutionalisation' of people with psychiatric disabilities (Interviews 4, 7 below, 15, 22, Participant Observation notes, Advocacy Focus Group). This could partly be related to government failure to channel CSTDA resources to psychiatric disability, and the medical framework dominant in the mental health sector at the time CSTDA funds were introduced in 1991 (Interview 26 below).

You know the disability sector if you like has done it much better...it's pretty clear and easy with these folk [exiting Strathmont] that if you're going to move them into the community you can only move them into fully staffed 24 by 7 group homes. And so you don't do it until you've got the resource commitment to be able to do that. And so people are reasonably well supported you know in moving from an institution to a community. Whereas in mental health there was not that level of planning or resource allocation.

Interview 4

It just hasn't been a planned and integrated process. As a parallel, and you know, a related parallel, de-institutionalisation is occurring around institutions housing people with intellectual

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resignation of the Premier and the subsequent loss of government by the Labor Party.

disability.....And so in disability it's better because there's quite an injection of monies in to actually providing, and in fact we benefited from that too, some projects we've done have been used to house people coming out of Strathmore [an institution for people with intellectual disability].

Interview 7

Well I think because at the time that first [CSTDA] agreement was struck, and we are talking about the early 90s, when we looked into it South Australia was just not positioned to actually make a legitimate case or a bid for how they would use those moneys for psych disability because it was always psych disability without a hearing, it wasn't mainstream in a sense..... I think the mental health sector was actually not positioned to sort of offer anything because it just wasn't a part. It wasn't on their radar.

Interview 26

The existence of 'one off' buckets of funding and short term projects (chapter 5) fit with the observation that one solution to budget constraint is the abandonment of large-scale expenditures (Kingdon 2003). The one-off and project based nature of housing/support interventions (particularly for people with psychiatric disabilities) was considered problematic by a number of interviewees (Interviews 2, 4, 5, 14, 18, 23, 24, 26, Advocacy Focus Group see below), as well as the state's Thinker in Residence (Haggerty 2005). Project sustainability, the level of control exercised by government departments when developing projects, difficulties recruiting and retaining staff, and the minimal resources provided through projects were some problems cited (Interviews 2, 5, 18, 24, 26).

And there is a lot of projects on the go at the moment about supporting people in public housing or in private rental and so on, but they are all projects so we will need to probably focus, move them on from being projects and saying that these are worthwhile programmes that should be funded on an ongoing manner.

Interview 2

And what you'd find is that when you look at the programmes for people with psychiatric disability that there's not a large bucket of money going into those programmes, but they're all fragmented little programmes. So the sort of supported accommodation demonstration projects, which have not, through evaluation, they've written programmes, they've got relatively small buckets of money. They can only take maybe 15, 18 people in the programme.

Interview 5

So we figured we needed to have something along those lines and we sort of tended to basically follow Victoria to a point but we didn't really know still what we wanted, so that's why this idea of demonstration projects and the ...sad thing about that is that there is still demonstration projects!

Interview 26

I mean sometimes those things happen and you have to have the capacity to respond to that but the other problem with that is it's one off. So the issue is that when you have one off moneys coming in it's actually harder to work with that in the sense that you first of all you have to spend it, which you know, and that's harder than people think actually to spend, particularly if what you're investing in is primarily around staff because you've got to be able to recruit, train, place support and then of course once you put them on the ground no-one wants you to take them away and understandably so.

Interview 18

A focus on crisis responses and quick, short term results, rather than planned policy frameworks was associated with the mental health sector and the political need to have quick solutions to problems (Interviews 2, 5, 26 below, Advocacy Focus Group, below).

But because things have deteriorated so badly as a system that politically the tendency was to find some quick fixes, things that would seem to indicate that you are dealing with the issue to just get it off the front page. Rather than sort of say, 'well, look this is going to take us 10 years but systematically these are the things we are going to do and there is a reason for the order for those things and, hold the line'. They would do that for 12 months or 2 years but the first time that anything really difficult comes up again like there is another really bad suicide or a person absconding whatever they would drop the bundle and put up more security fences

Interview 26

One example of this was the release of the social rehabilitation funds through mental health in 2005, which involved quick political decision-making linked to the budget cycle, with the effect that funds were rapidly released by government (Advocacy Focus Group). These funds were declared the result of 'economic growth' (Government of South Australia 2005), rather than a planned policy commitment to mental health. The Senate Select Committee on Mental Health questioned the 'one-off' nature of these funds (Senate Select Committee on Mental Health 2005). The quote below refers to an observed lack of transparency when releasing these and other mental health funds.

Yeah, but that's Mental Health all over. Like pretty much everything they've done that I've seen and that's not a long time but there's been a lot of money go out of that place. I haven't seen anything go through that hasn't needed an exemption by the purchasing board or whatever they are to do it. There's some bizarre approaches.

Advocacy Focus Group

Budgetary constraint or expenditure alone is not sufficient for understanding the rise and fall of policy agendas, as *perceptions* about costs differed. For example, whilst one public servant saw the cost of housing stability to government as a motivator for the Supported Housing projects/programme (Interview 4), others referred to the 'significant' costs of the programme despite an overall 'cost savings' (Interview 3, 5, 26). Other studies have shown the similarity between the costs of homelessness and supported accommodation (Horin 2006). It was unclear exactly why supported accommodation projects (now a programme) and CSTDA resources had not significantly expanded if overall savings to government within the same or 'other sectors' could be achieved.

### **6.1.5 The perceived urgency of problems and what was being advocated for: consumer and carer perspectives**

Across government sectors and consumer/carer representatives, the extent to which access to housing and support was seen as an 'urgent' problem varied (Interviews 2, 23, 26 below). Whilst generally considered as an important issue, professionals and NGOs differed in the extent to which they prioritised housing as a key issue for lobbying<sup>29</sup>

A bit of it I guess people not paying enough attention to the urgency of the issue so we in say the Mental Health Unit might be saying we know it has to be done, pretty big problem, let's not stuff around and on the other hand you say well there's a whole sort of processes and contract procedures and all the different bureaucratic red tape and that caused some tension because every month that went by you were actually losing an opportunity of doing something.

Interview 26

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<sup>29</sup> NGO perspectives are further discussed in chapter 8.

So, yes it's an issue...It's not a new one, it's not over and above what it - when I was working in housing 20 years ago, it's not over and above that. It can be dramatised at times.

Interview 23

Consumers and carer representatives sometimes based their perception on the urgency of housing to their personal situation, did not or could not comment upon housing problems for people with psychiatric disability generally, or based their comments upon knowledge drawn from their representative role rather than personal experience (Consumer Carer Focus Group). Two carer representatives did not rate 'bricks and mortar' housing as an urgent personal problem because they already had purchased a house for their care-recipient (Consumer Carer Focus Group). Three of the four consumer representatives owned or were purchasing a home, and one of these people did not rate homelessness as an important problem within community participation processes despite having been homeless in the past (Consumer Carer Focus Group, Interview 27, below).

So I suppose regretfully of us in the past our assumptions have been that 'where are these homeless people in our area anyway?' I mean apparently people, like I did go from lounge to lounge to lounge and the odd person that you see in the park or the odd person you see in their car; sleeping in their car didn't bring enough noise with them to get to us. So our assumptions were that there were not a lot of homeless people.

Interview 27

Well, I live in my own house. Don't have a mortgage. I'm pretty fortunate like that.

Consumer Carer Focus Group

The two carers who had purchased homes (along with other carers) emphasised the need for 'disability support' to maintain people in their homes. However, they were concerned that professionals' awareness that their care-recipient had a family carer resulted in less hours of public in-home support being provided to them (Consumer Carer Focus Group). Whilst links between the level of public care provided and family care may be difficult to substantiate, the Inquiry into Supported Accommodation indicated that people with psychiatric disability are receiving extremely low levels of support on the whole (Parliament of South Australia Social Development Committee 2003). One carer also spoke about the personal importance of striving for self-sufficiency (see below), suggesting the adoption of a 'familist'

expectation that families should be self-sufficient evident in public policy (Dalley 1996).

Can I just interject here mainly because housing for me isn't such a big issue...if I use just my scenario, with our circumstance, where it comes to housing we've been self-sufficient and tried to make ourselves self-sufficient. We have never relied on government housing, but that has come at a huge burden on me as a carer having to purchase a unit away from the house. And I'm paying for that.

Consumer Carer Focus Group

Families and individual consumer representatives obviously have different capacities to be self-sufficient in purchasing private homes or providing support to their care-recipients. This point was made clearly when other consumer and carer representatives spoke about a range of urgent housing problems they or the person they cared for had experienced, or general housing problems faced by people with a psychiatric disability. These included homelessness, the quality, cost and withdrawal of the SRF sector, lack of support within and the 'ghettoization' of public housing, and cost and access to private rental (Interviews 13, 20, Consumer Carer Focus Group, below).

I was just looking at the question, just access. I mean I meet - because of my brother who ended up homeless because he couldn't pay his Housing Trust rent and he got evicted, even though he was completely off, you know, off his rocker. But it seems to me a lot of people end up in boarding houses, then they pay huge money like \$470, \$480 a fortnight so they end up with \$20 or \$30 a week for their smokes and so they can't buy new clothes, and they just look like shit. And it's not good for people's self esteem. And they wander about. I mean, yeah, 'to what extent?' - most people who don't have families have complete problems with housing stability. They don't have access to appropriate housing or any housing at all. They end up in boarding houses.

Consumer Carer Focus Group

Families were often seen by professionals and consumer/carer representatives as the 'last resort' or one of few options available when it came to housing, and people with psychiatric disabilities without family support faced particular difficulties with housing (Consumer Carer Focus Group, Interviews 14, 26, 28). One health professional believed that disability support services were a greater need than housing, due to the perception that families were willing to provide housing following deinstitutionalisation when public support was also provided (Field Diary).

This was despite this being a form of tertiary homelessness (Chamberlain & MacKenzie 2003). However, carers in this study emphasised their desire to live separately from their adult offspring or parents with psychiatric disabilities, a desire they suggested was also held by their care-recipients (Consumer Carer Focus Group). Another health professional noted a group of families seeking to purchase private housing for their relative, in the absence of options provided by the public system, and wished to support them in this endeavour (Interview 15, below)

I'm seeing a relative, I'm seeing a father whose son has schizophrenia this afternoon. And he's got a plan of a number of people who have [adult] children who have mental illness, and they want to buy a caravan park and build some units. And so, you know, I think this is an initiative that families want to do and if I could actually help them get it off the ground it would be fabulous.

Interview 15

Despite many health, disability and NGO professionals acknowledging families and carers' role in housing (chapter 6), only one public servant in the housing sector mentioned the role of families in housing for this group (Interview 9). Overlooking the role of families in housing may mean that policy actors are overestimating the degree of 'independence' of people with psychiatric disabilities in housing, the extent to which clients are able to access housing, and their ability to move across housing tenures without private support. Failure to consider carers role in housing policy and housing stability was one 'silence' in housing policy discourse and policy responses, which is likely to differentially impact upon women, who represent 77.5% of carers for people with a disability (Edwards et al. 2007).

#### **6.1.6 The influence of crisis events on mental health policy**

Kingdon (2003) states that the urgency of problems may be pushed by crises and events, leading them to arise on policy agendas. However, in this study, crisis events generally had a negative impact upon mental health policy. 'Crisis events' enhanced community fear and stigma, and led to the focus on security and surveillance as a technique of power (Foucault 1979). Crisis events included the murders of two Psychiatrists including the Director of Mental Health Services in SA (the first by a patient, the second by a Psychiatrist with mental health problems) (Interviews 6, 25, 27). One was linked to the rapid closure of the institution Hillcrest in 1992 (Interview 25), whilst the second event was linked to detraction from and the mental health

reform process taking lower priority (Interview 27). Crisis events could also determine what was prioritised in mental health policy, and were tied to policies on tightening security within mental health and the public services more generally (Interviews 6, 18, 27, below). The state's focus on personal safety is exemplified by barbed wire surrounding the courtyard fences of the state's intensive care unit, security offices being used in hospital wards where people with a mental illness are being detained, or people being shackled in emergency departments (Office of the Public Advocate South Australia 2005).

Rather than sort of say, 'well, look this is going to take us 10 years but systematically these are the things we are going to do and there is a reason for the order for those things and, hold the line'. They would do that for 12 months or 2 years but the first time that anything really difficult comes up again like there is another really bad suicide or a person absconding whatever they would drop the bundle and put up more security fences.

Interview 26

I think the perception of safety became a major issue. Apparently there's \$800,000 a year going towards protecting that one building. All of the hospitals in the state have had increased security. And security, in my mind, safety and security became paramount; became much, much higher than the issues for people with mental illness on the ground.

Interview 27

### **6.1.7 The effect of community and institutional stigma, the media and political and government commitment**

Political will and funding commitment was seen as necessary and important for deinstitutionalisation and addressing services for people with a psychiatric disability living in the community (Interviews 2, 4, 5, 7, 11, 15, 21, 22, 26, 29). However, a lack of political commitment was seen as an important 'problem' when it came to mental health funding and planning (Interviews 5, 11, 15 below). Mental health was also considered to have been rated a low priority within the health and former human service departments (Interview 29, below).

See you can't have a five year plan and that's part of the dilemma whereas other states say we're going to roll out \$100m over five years for that purpose, so now you plan and you can fine we'll get on with it, whereas here that commitment has not been made.

Interview 11

We would never get anywhere until cabinet...the Minister of Health on their own cannot make the change. They can't allocate the money. It has to be the whole of government. And we've been told that the Treasurer at times has said that, you know, he's very much an economic rationalist, and wanting to know what are the benefits and sometimes quality of life of people is not seen as an economic benefit.

Interview 15

I think it was more there was a lack of support from the senior executive...from day one X could just not get [their] policies or decisions through, there just wasn't support for anything to be done...Yeah, at senior executive of the Department of Human Services and the Department of Health, and that really meant that mental health struggled to get anywhere. There's this lack of influence.

Interview 29

Institutional and community attitudes/stigma towards people with mental illness evident in public debates were seen to shape conditions for political commitment towards mental health and deinstitutionalisation strategies (Interviews 6, 23 below, 26, 27, 29). Local politicians had sometimes provided barriers to housing projects approved by state government (Interviews 6, below). Similarly, in 2006, a federal labour politician and a psychiatric nurse lobbied through the media against the introduction of a proposed community rehabilitation facility for people with a psychiatric disability (Bowen 2006) (which followed another state Labor politician's petition against the proposal).

On a service system level, I think because of the nature of the condition it becomes a highly politicised issue, and you've got historic responses around institutionalisation and you know, we shouldn't close Glenside and we should let people back. So, one of the major barriers I think is community attitude and the political nature of the beast, because it is highly political and you've seen the debate going on in mental health will be, and health will be a key election issue and it gets politicised. When anything's politicised, to a certain extent, I think you'll have decisions that are influenced by those policies at times.

Interview 23

I mean, they just don't want a public debate and have the Lord Mayor run off and say, 'We're going to have, you know, thousands of mental health people wandering the streets disrupting everybody living in this building.' And he did that with Riviera...Like, even with the old Santos building, I had people at a high level say, "Well, shouldn't we have a separate entrance that goes

out in one of the side streets? Why don't we let the top floors out to the affluent and then have a separate entrance?" And you sort of, "Can't you see the principles here? We are trying to create a community."

Interview 6

In this policy environment, the media had a role in pushing particular representations of problems. Community attitudes reflected in the media were considered a barrier to community housing initiatives or factor contributing to concerns that people with a mental illness were dangerous or disruptive tenants (Interviews 3, 15, 21, 26 below, 27). The media was also cited as being an avenue to promote political agendas resistant to the health reform proposed through the Generational Health Review (Interview 18). Various opinions were expressed through the media on the closure of wards and departure of people from the state's stand alone psychiatric institution (e.g. Bowen 2006; e.g. Reid 2006). The media's influence on public opinion, lobbying and political influence (decision-making) was noted (Interviews 15, 18 below) as was state government monitoring of media (Interviews 27).

The press, everything to do with mental illness is the most stigmatising way of reporting. And all the pictures you see on telly are all the very itinerate disabled people, and that is what the public see mental illness as, and not willing often to give people a chance. So it's terrible.

Interview 15

Yes and politically. I mean you've seen the headlines. As much as government pays lip service to society I mean "What's the priority?" The issue of stigma is still way up there.

Interview 26

The proximity of the politics to the local community is tighter than any I've ever seen. And you add to that a one newspaper town where the media, the media voice runs the public opinion and, you know, that's what the politicians all read because that's their paper and that's understandable...I think that's a very big policy driver here, more so than in other, in my experience in other states or in the commonwealth, because the community is so closely aligned with, like it's so, small state, close to the politicians, the politicians are accessible.

Interview 18

However, there was a 'catch 22' situation identified with regard to the media's influence upon mental health and community attitudes, and the slow progress of mental reform. As the Office of the Public Advocate noted

It seems to this office that community attitudes and expectations and the drivers for mental health reform are still significantly in conflict. In South Australia, the inability of the mental health system to reassure the public that help is available to the mentally ill (and lack of funded community support alternatives) serves to reinforce the very fears which the reform process seeks to overcome.

(Office of the Public Advocate South Australia 2005, p. 12-13)

Additionally, a review of media reports suggested that the media exhibited mixed attitudes towards mental health and reform (Field Diary). Due to both the sheer volume and nature of articles in the local community newspaper, it could be argued that this newspaper saw themselves as having a role in championing issues surrounding mental illness (Castello 2003a; Quast 2003a; Castello 2003b; Quast 2003b; Editorial 2005; Graham 2005a; Lloyd 2005a; Graham 2005b; Lloyd 2005b; Anderson 2006; Gowing 2006). Local newspaper media had drawn attention to the state's former mental health director questioning the extent of government funding commitment to community care (Castello 2003a; Castello 2003b; Editorial 2005; Anderson 2006). National media had also drawn attention to problems surrounding a lack of follow-up to deinstitutionalisation including supported accommodation, trans-institutionalisation and juveniles being in adult psychiatric wards (Kearney 2005; Kearney 2005; Kearney & Cresswell 2005; Wynhausen 2005; Hart 2005a; Hart 2005b; Karvelas & Cresswell 2006; Kearney 2006).

One professional in this study noted the importance of NGOs using the media effectively for lobbying purposes (Interview 12). The Mental Health Lobby Group<sup>30</sup> and a carer representative had used the media effectively as an avenue for lobbying or in the latter case to express a 'voice' on mental health policy in the absence of other alternatives (Minutes from Consumer Carer Groups, Consumer Carer Focus Group). However, there appeared to be 'silences' in media debates when it came to consumer and carer representatives and NGOs, particularly when it came to housing policy debates. Greater scope for NGOs to develop relations with media and engage in public media debates is evident, particularly to challenge negative representations

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<sup>30</sup> A now defunct advocacy network established by the Social Australian Council for Social Services Mental Health Project Officer (discussed further in chapter 8).

of people with a psychiatric disability and encourage commitment to mental health funding.

## **6.2 Conclusion**

In the previous chapter, the role of discourses and stigma in mental health and the mental health policy environment was discussed. This chapter explored conceptions of housing and support 'problems' for people with a psychiatric disability across study participants. The evidence served to critique the notion that there are separate 'problems, policies and politics' streams (Kingdon 2003) as the examples provided illustrated the close connection between different understandings of problems and solutions proffered, and the role of discourse. Different 'problem categorisations' (Kingdon) and the poor overlap between problems identified could be tied to different discourses on disability (Fulcher) operating within sectors (e.g. medical discourse on disability connected to health sector). The way in which problems were represented and by whom (Bacchi 1999) was important to understanding problems and solutions.

It was also evident that there were 'silences' about some 'problems' e.g. silences resulting from a lack of available data on housing problems for people with a psychiatric disability or available data not being used. The lack of recognition of carers role in assistance with housing within the housing sector also suggested a lack of representation of or involvement from carers within this sector, and the strength of 'familist' discourses. The findings also suggested that socio-political factors not only influence the success of proposals (as Fischer suggests 2003), but also problem themselves, as political realities influenced the use of evidence and reporting mechanisms on government programmes. Additionally, stigma appeared to influence perceptions about the appropriateness of people with psychiatric disability living in the general community.

Neo-liberal political discourse and community and institutional stigma also influenced political commitment (and responses to crises) and highlighted the importance of values to 'problem representation' and proposed interventions. In alignment with 'new governmentality' (Dean 1999), principles associated with

increased government accountability and efficiency and private sector investment influenced policy solutions.

Whilst the state Strategic Plan aims to integrate and make government accountable, the range of perspectives on policy problems and appropriate interventions strategies (linked to discourses) pointed toward the fragmentation of the policy network.

Different views on policy problems and appropriate interventions could further influence the impetus for intersectoral collaboration. Policy actors' perspectives on intersectoral collaboration, and the relationship between policy networks, ideas and structures are further explored within the next chapter.

## **7 Intersectoral links, discourses on disability, and the impact of governance reform**

There is a certain relief in change, even though it be from bad to worse...it is often a comfort to shift one's position and be bruised in a new place.

(Irving, in Ratcliffe 2003, p. 60)

I think it will be a clash between the political will and the administrative won't.

(Lynn & Jay, in Ratcliffe 2003, p. 74)

This is the third results and discussion chapter and examines the findings from the case study in light of the first two questions posed by this research: *To what extent have inter-sectoral links between mental health services and the housing sector been developed through the implementation plan of the South Australian Mental Health Reform 2000-2005?* and, *To what extent have these links been effective in improving housing options for people with a psychiatric disability?* The chapter is also relevant to and provides a background for the third research question on community participation. It is based on a thematic analysis of interviews and focus groups with all participants, and a thematic analysis of participant observation and documents from the three NGOs observed. The main focus is the policy/departmental/programme level linkages and their effect upon housing options in South Australia. Perceptions on the extent of intersectoral collaboration across the reform period, and the barriers to intersectoral activity are discussed.

### **7.1 The extent of and barriers to intersectoral linkages**

#### **7.1.1 Mismatch between national and state policy on intersectoral linkages, linkages across departments**

Despite the national policy focus on intersectoral linkages, public servants and NGOs across sectors widely agreed that intersectoral collaboration across the mental health housing (and disability) sectors was undeveloped. Respondents explained gaps in service linkages on the ground by the existence of government silos. State mental health policy did not follow the 'intersectoral links' focus of national mental health

policy, and one housing NGO had been lobbying for cross sectoral links with mental health following deinstitutionalisation (see below).

At a policy level, I don't think there are strong links. There might be some links between national policy around housing and state policy around housing, but - and I wouldn't know the detail of that, but certainly in terms of what I'm aware of, in terms of the work that we do around mental health policy and, you know, policy around people with high and complex needs, there's not a link between the National Mental Health Strategy. And in terms of policy and state...that was some of the work we were going to do. And at that time, I think it was suggested that it wasn't necessarily - it would take too much time to do that work. We would just focus on individual programmes.

Interview 5

I'm not aware of a lot of work within the bureaucracy between Mental Health and Housing. I have the feeling that the Mental Health Services expect the Trust to house anybody that they refer and probably also support them in the private rental market which is just unrealistic at this stage I think. I think the Minister is very aware of the needs, but there's a little bit of danger that there may be a focus on disruptive tenants. I know that there's some moves not to develop high concentrations of mental health clients, particularly in lockups, but that doesn't happen. But we keep hearing about whole of government integrated services, but ...

Advocacy Focus Group

There is no planning we are aware of. We've raised this issue many times in appropriate forums e.g. SACOSS meetings with DHS Executive. Deinstitutionalisation has been done without key stakeholders in housing - it is just cost-shifting. It wasn't properly planned. Support has not materialised as promised. This issue has been raised with the authorities since the 1980's, as far as back as Emergency Housing Office Days.

Notes accompanying Advocacy Focus Group

A lack of 'common view' of problems (chapter 6) was reflected in cross sectoral initiatives such as the implementation of supported accommodation (Interview 19), but more commonly related to a lack of cross-sectoral responsibilities being taken for problems in the first instance. For example, the role of Corrections in mental health was largely overlooked in the mental health reform (Brennan 2000) and the ensuing Implementation (DHS 2000) and Action plans (DHS 2001). Additionally, health, housing and NGO professionals suggested that disability and housing services were overlooked in policy solutions within health (Interviews 5, 7, 11, 12, 15, 22, Participant Observation notes). Conversely, many respondents claimed that non-

health sectors such as housing and disability had not fully taken into account people with a psychiatric disability (Interviews 4 below, 5, 6, 11, 22, 26). The Office of the Public Advocate (OPA) believed that non-mental health sector personnel were generally reluctant to address services for people with mental illness and their families in South Australia (Office of the Public Advocate South Australia 2005).

The disability services programme if you like in South Australia up until now hasn't included psychiatric disability. That's been in a sense unattended to some extent, or to the extent that it has been it's either been through just sort of one-off projects like those demonstration ones or bits and pieces in the mental health sector too.

Interview 4

Some public servants across sectors claimed that the dominant medical/clinical view of health (chapter 6) undervalued the need for non-clinical support services and partnerships (Interviews 4, 5, 11, 12 below, 26). The state's focus on clinical services was also noted in OPA's submission to the national mental health inquiry (Office of the Public Advocate South Australia 2005). However, two housing sector professionals noted that mental health services had recently commenced providing social rehabilitation services and liaising with the housing sector (Interviews 5, 22).

SACOSS had had a longstanding position where we felt that, too much money, and resources were going to the acute sector, in the clinical sense, and that more money, or more emphasis, let's put it this way, needed to be spent in community based services, and that was a subset of the general problem about health service delivery as we saw it

Interview 12

Conversely, despite a national policy focus on 'high needs' housing since 1998 (chapter 5), some respondents believed that public housing agencies had neglected or were reluctant to focus on the needs of mental health clients (Interview 6, 11, 26). This was tied to historical and/or current perceptions on who public housing was for and who should be taking responsibility for its provision (Interviews 6, 7, 11, 26, below). An NGO also supported the view that public housing wasn't currently seen as being for those most in need such as corrections clients with psychiatric disability (Interview 14, below). Even housing sector professionals raised the question 'which sector was taking responsibility for housing for people with a psychiatric disability?'

public housing always excluded people that had the incapacity to live independently for most of

its life. So that was part of its charter, was people had to have the capacity to live independently. So they didn't see it as their role to house mental health people. And the second was the linkages between both mental health and housing have been pretty bad.

... Housing says, "We create the housing." But who is responsible for the community facilities that need to go with that?

Interview 6

I think there's debate in South Australia that's not been had which is what is the role of public housing. Is it for poor, working class families or is it a housing system that's for the population who are unable, so is it about getting people into the private housing market, is it about that, or is it about this group?

Interview 11

Unless someone says, 'why have you got public housing? If it's not for your really hard clients, who is it for?'. So where are they actually meant to go?' Really, I fail to see where a client with the Housing Trust who is disruptive is meant to go. It really baffles me, that.

Interview 14

The State Housing Plan (DFC 2005) was accused of overlooking the commonality between clients and an integrated approach (Interviews 11, 14). Affordable housing strategies in the housing sector had (at least initially) not involved the mental health sector (Interview 22), and community housing agencies also reported a lack of collaboration with the High Needs Housing Unit (Advocacy Focus Group, Interview 24 below). At the time of interviews, senior public servants in the mental health sector reported limited involvement in the high needs housing strategies of the state housing plan (DFC 2005) (Interviews 11, 19 below). This was partly related to a lack of central policy level staff as a result of the regionalisation of mental health (Interview 19 below), further discussed below. Despite the current 'High Needs' strategies, the need for a 'policy base' or better planning for housing for people with psychiatric disability was recognised (Interviews 11, 26 below).

They're very minimal. Most of the involvement [with the housing sector] is – perhaps reflecting the fact that the Mental Health Unit, of course, is now smaller and many of the people working in this area are now out in the regions. So at the moment it's periodic contact with X at the supported accommodation [High Needs Housing Unit].

Interview 19

Yes, I was involved in the Social Inclusion strategies of the State Housing Plan. I think [Minister

Weatherill] really is trying to be you know much clearer about bringing it into a coherent model of housing functions, Aboriginal housing or whatever but there's not a policy base. And I think you should be able to do it in South Australia when you've only got a population of 1.5 million.

Interview 11

*Well there is the opportunity now isn't there, through the state housing plan, High Needs Housing Unit?* Yes. And hopefully some of those ideas have gone into that but they need to come together again with both the NGO sector and the mental health sector and say, if we are doing planning for this population you can guess in terms of prevalence and incidence what sort of demands you are going to have, and so the housing [that] facilitates part of that solution has got to be flexible to be able to adapt to individual needs because otherwise what you will end up with doing is no better than having 160 hostels and SRFs around the place where it's a roof and a bed alright, when we are talking about something much more than that. So I think that's probably the only thing that I would wish that there is some informed discussion about what are some different models that can be flexible, that can be a mix of emergency, transitional, permanent ownership.

Interview 26

*And Community Housing has been lobbying the government to be seen as a high needs housing provider?* In regard to Housing Associations, yes. [*Yeah. What's been the response to that?*]

So far nothing. It's actually quite interesting to compare the Affordable Housing Innovations Unit which is very interactive and open with the High Needs Housing Unit which is almost sort of invisible ... [*Tell me about it.*]

And I don't know what they're doing actually.

Advocacy Focus Group

Some of the supported accommodation stuff, some of the 'high needs' stuff that is coming out of the High Needs Housing Unit. I don't find them particularly collaborative.

Interview 24

Sometimes housing and/or support models were 'within sector' responses which did not necessitate strategic linkages across policy sectors (although service delivery linkages occurred). Two public servants in the health sector highlighted problems with 'within sector' 'case management' models of service delivery (Interviews 18, 26). One of these observed that the policy solution to housing people with a psychiatric disability is often one of improved case management, rather than intersectoral arrangements at a policy level (Interview 18). Even within this study the solution was often seen as one of improved resources and better 'case management' within sectors rather than improved working across policy sectors. When extra psychiatric disability

funds were recently introduced (under the CSTDA in 2006), this led to interaction between the disability and supported housing sectors networks of DFC to develop case management, but notably not the mental health sector (Interview 4, below)

In this year's budget we've got \$2.5 million and it grows to \$5.5 million next year I think it is. And in fact yesterday X who is the Director of this office and myself met with our colleagues from the High Needs Housing Unit of the Department and they had some leadership on the sort of supported housing area and we agreed with them on how we would apply the \$5 million that we're going to have for psychiatric disability, yesterday.

Interview 4

A lack of strategic level co-ordination across public services, public and private services, or public and NGO services, was also seen to lead to poor outcomes for people with psychiatric disability, where examples included;

- community based services' failure to consider the housing situation of a client before s/he became homeless (Interview 27)
- frequent hospitalisation of one client leading a hospital social worker to initiate a change in accommodation, despite the fact the client was already appropriately housed (Interview 24)
- mental health services encouraging a public housing service to evict a client before they would intervene (Interview 21)
- a lack of co-ordination across private GP services and SRFs leading to a person losing their tenure of housing when they changed address (Interview 30)
- a client losing their public housing following hospitalisation (Participant Observation notes)
- poor relationships across service sectors impacting upon the ability of housing workers to refer clients to mental health services (Interview 9)
- overall lack of clear referral pathways between the prison, court and mental health system resulting in a lack of responsibility being taken for organising essential follow-up support following a person's release from prison (Interview 14)

Despite these examples, some respondents believed that intersectoral collaboration across the mental health and housing sectors occurred more effectively in regional services and projects rather than through state-wide policy (Interview 4, 5, 7, 11, 15, 22, 24).

### **7.1.2 Cross sectoral policy network structures, consumer groups and NGOs**

Consumer and carer representatives who had worked at a state level held mixed views about the effectiveness of links across housing and mental health services, or could not comment on these linkages (Interview 20, Consumer Carer Focus Group). Three representatives claimed there were inadequate service delivery and policy linkages between housing and mental health services, including public housing and Supported Residential Facilities (SRFs) (Interview 13, Consumer Carer Focus Group). Conversely, one consumer representative was able to speak about the supported accommodation projects/programme and regional Southern Mental Health and Housing Alliance (SMHHA), reflecting their involvement in this regional network (Consumer Carer Focus Group, below). In the housing sector, tenant representatives from the Public Housing Customer Forum had expressed concern about the failure of housing, police and mental health to exchange information when discussing disruptive tenants (Parliament of South Australia 2003).

This case study included generic high level networks in the policy environment such as the Ministerial Housing Council (Community Sector) and the Department of Health/Department of Families and Communities 'Peaks Group' (DFC 2006). Some NGOs involved in the above structures commented upon the relative ineffectiveness of these networks in terms of policy agenda setting or their poor links to politicians (Advocacy Focus Group, below). The general lack of strategic policy approach to housing for people with a psychiatric disability through a state-wide forum was noted (Interview 22 below).

My feeling is that probably there are high level networks but in terms of actually ... things like the SACOSS Policy Council or the Peaks groups and things like that, but I wonder whether we need to create something that's a bit more cross sector, or..because at the moment I feel like it's ad hoc or it is from my perspective.

Advocacy Focus Group

We [Ministerial Housing Council, community sector] are there to take matters referred to us by the Minister but in five years I've not seen anything referred by the Minister. .... It serves very well as a network for communication for a lot of people who aren't involved in other kinds of housing forms ... I guess for years there's been quite an open relationship between the bureaucrats and the Housing Council with the bureaucrats keeping the Council informed of what's happening. And my eastern State counterparts say that that's really rare. So what the Housing Council's been able to influence directly as a body is pretty limited.

Advocacy Focus Group

*Can you see some of the work that Southern Mental Health and Housing Alliance hoped for and planned for being realised?*

No, I mean ideally that should have been a group that could of done a state wide, provided a state wide response. You've got a fragmented system haven't you? [Yes..]

You've got housing providers in the west who also target people with mental health issues, you've got Roof's<sup>31</sup>, you've got people in the north and they're all just sort of out doing their own thing. I mean the [Community Housing] Council have a disability forum, but that's more about practical aspects of accommodating people who've got a disability, but really I think the issues about having sort of a strategic plan and a strategic response to people with mental illness was really the goals of the Southern Mental Health and Housing Alliance.

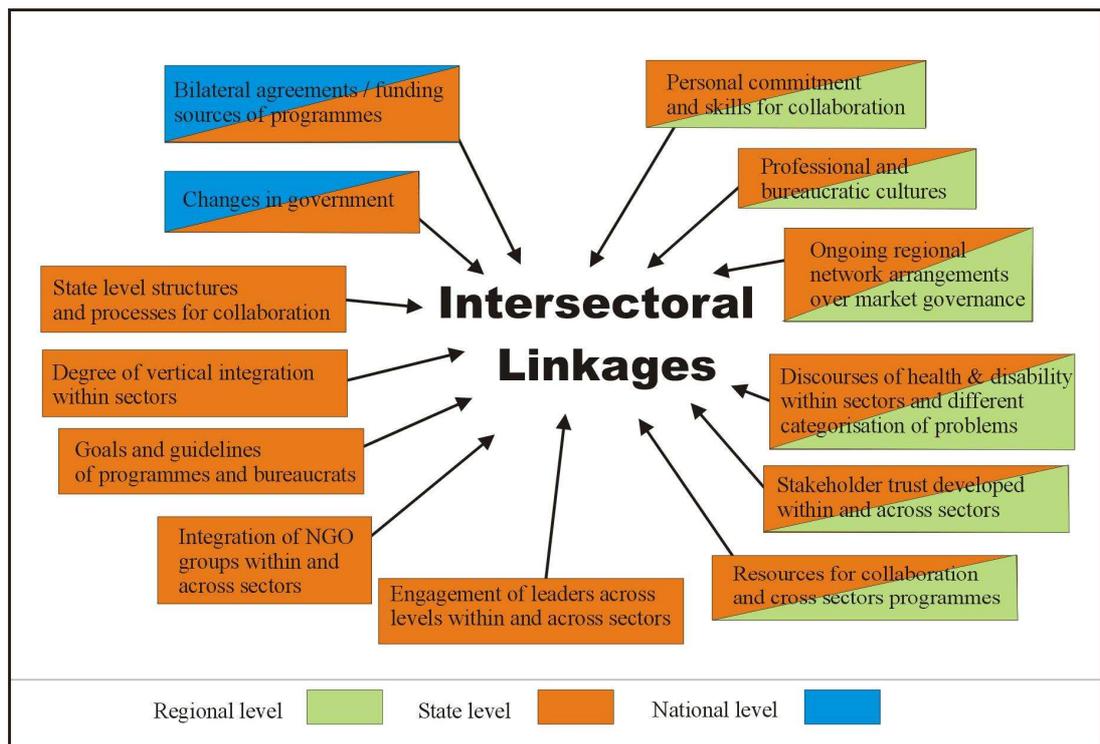
Interview 22

There was no clear connection between existing NGO networks and consumer groups, or between state level housing participation structures and mental health consumer and carer participation structures located within the state's bureaucracy. As noted above, there was little evidence of either cross sector service delivery or policy/advocacy networks across the mental health, housing and disability sectors at a state-wide level, or of links within and across advocacy NGOs during 2000-2005. Notably, one person from a peak housing NGO was unaware of two 'successes' in housing for people with psychiatric disability, namely the Supported Housing programme and the regional Southern Mental Health and Housing Alliance (SMMHA, discussed below) (Advocacy Focus Group).

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<sup>31</sup> A community housing agency for people with psychiatric disability.

**Diagram 5: Factors impacting upon intersectoral collaboration**



### 7.1.3 Processes and resources for collaboration

Diagram 5 (above) indicates the various (sometimes interrelating) factors impacting upon collaboration across levels of government. At a state programme/service level, the Salisbury Supported Housing project (Housing in the North) was consistently referred to as a successful cross-sectoral partnership, due to local leadership and relationships involved, and results produced such as reduced hospitalisations and cost savings (Interviews 2, 3, 4, 5, 11, 15, 19, 21, 23, 25, 26, Consumer Carer focus Group). Within the Salisbury region, processes important for collaboration (Walker 2000) and developing a common view of problems (Benson, in Gray 1989) had been developed, e.g. an attempt to develop a common 'citizenship model' of service delivery and joint planning processes across agencies when applying for funding (Interview 15, below). Despite the success of the local supported housing project, there were still concerns from the housing sector about being unable to refer to the project directly (Interview 21). Similar concerns were evident when mental health agencies were identified as being reluctant to take referrals from Housing Support Coordinators (Baulderstone & Beer 2003).

One of the things that I did when I came out here was try to develop, I set up a meeting with FAYS and Housing Trust, community health, and to look at ways that we could, rather than compete against each other for funds, when they put up initiative bids, to come up with a way that we could maybe jointly put something up so we weren't competing with each other, and it was a way of getting money. We could ensure that we could get some of those funds. And it was developed from that. We went through a process of saying, "What does our service do? What are the needs? What are our challenges?" And got to know what the challenges are for each service. And it really developed from there I think.

Interview 15

Within the Salisbury region, the local leaders of services were both women, whilst women were also instrumental in establishing the supported housing projects (programme) within the bureaucracy (Interview 26) and the regional Southern Mental Health and Housing Alliance (SMHHA), another 'successful' regional network identified. The link between women leaders and cross sectoral collaboration efforts correspond with the finding that the negotiation skills important for collaboration (Walker 2000) and policy entrepreneurship (Kingdon 2003) are associated with women in leadership positions (Stanford et al. 1995). Success in local collaboration efforts could also be explained by women's leadership style being more compatible with 'team based, consensually driven organisational structures' (Appelbaum et al. 2002, p. 49), or to the 'interpersonal orientation' of women leaders (Gardiner & Tiggemann 1999).<sup>32</sup> However, when it came to the introduction of the Supported Housing projects, the DHS had provided an integrated structure to facilitate the development of these projects.

The SMMHA network was established following the leadership and commitment of one community housing organisation, after this organisation was approached by a person from the mental health sector. The peak Community Housing Council of South Australia was also initially involved in a forum which led to its establishment (Interview 22, Field Diary). The SMHHA developed three years prior to the

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<sup>32</sup> However, previous studies have suggested that where industries are male dominated, women and men do not differ in the degree to which they are interpersonally versus task oriented

Gardiner, M. and Tiggemann, M. 1999, 'Gender differences in leadership style, job stress and mental health in male- and female-dominated industries', *Journal of Occupational and Organizational Psychology*, vol.72, (Sep 1999): 301-315..

Supported Housing projects and was a bottom up initiative to introduce a 'strategic approach' to coordination across sectors, in the absence of a such an approach being taken by government following outsourcing of some former public housing services (Interview 22, Field Diary). The network recognised the need for additional housing, not simply intersectoral service delivery linkages, and it subsequently developed two small scale housing projects separate to the supported accommodation projects (Interview 22, Field Diary, Consumer Carer Focus Group). One person involved in this network believed that a partnership approach had been subsequently adopted by community housing agencies, reflected in competition between agencies being diminished (Interview 22, below). However, the broad region which the SMHHA encompassed had not developed Supported Housing projects as successfully as in some other regions, and the extent to which leaders within clinical services involved in these projects were also supporting the SMMHA was unclear.

And I can really only talk about the state wide demonstration projects around the accommodation and flexible support... The other thing I can talk about is a loose alliance called Southern Mental Health and Housing Alliance which started in the year 2000, it's made up of multi agencies. The Housing Trust, Marion and Willunga, the Adult Mental Health Services, Housing Spectrum, Metro Access. I was a consumer representative on there and X was a carer representative on there. Now that loose alliance is a partnership and has actually been successful in getting two very successful accommodation support programmes up and running, despite it was extremely unpopular by the DHS at the time. Because what we were after was transitional housing. And they said "Oh no. You can't have that. Because you'll put people in transitional housing and they'll never move out." So there are actually two very successful projects.

Consumer Carer Focus Group

I think, well I think the partnership approach. I think the other change that there's been over time is that there isn't the competitive environment that there used to be. So, people used to be very reluctant to share information because it was, it was competitive, people would put in bids for sites or whatever and they'd be competing with somebody else, another agency. So, you wouldn't - it wasn't conducive to sharing your ideas, and I suppose I think that's changed so that there's much more collaboration out there, and that people are networking better and they're not competing quite so much.

Interview 22

Despite the success of the Housing Support Coordinators in maintaining people in public housing (Baulderstone & Beer 2003), only two people in this study mentioned the existence of such a role (Interviews 14, 24). Conversely, social worker roles

within the acute wards of some hospitals, which assisted people to link in with community agencies (including housing) were mentioned (Interviews 17, 24). A problem raised was that even when there were these 'linking' roles, successful supported housing projects, or cross sectoral networks, there were few housing resources to refer to (Interviews 14, 15, 17, 22). One housing sector professional underlined the point that resources for public housing had not been prioritized nationally (Interview 7).

#### **7.1.4 Bilateral agreements, programme guidelines and the goals of bureaucrats**

Good 'horizontal' and 'vertical' integration (Stoelwinder 1999) within and across organisations and sectors, linked to strong leadership, is important to successful intersectoral collaboration and policy change. Vertical and horizontal integration has been described as follows

Relationships between organisations may be described as vertical if they exist on the "supply chain". In other words they are interdependent from an input/output perspective...The formal structures created by organisations to control supply chain interdependencies (including availability, quality and cost) are described as vertical integration...Relationships between organisations are horizontal if they compete for the same input(s) or outputs (s). Organisations may seek to improve efficiency through economies of scale or to control market conditions through formal structures as horizontal integration.

(Stoelwinder 1999, p. 17)

The lack of horizontal integration in policy networks was most evident when it came to separate Departmental responsibilities and solutions being proffered to government; there were separate strategies on social rehabilitation and disability support tied to separate departments and programmes (Interview 23, below). The different funding sources of programmes and collaborative projects, the narrow goals of bureaucrats tied to programme goals, separate bidding arrangements for state budgets and the sometimes competing goals and guidelines of government programmes were all cited as barriers to intersectoral collaboration (Interviews 4, 5, 7, 16, 18, 23, 26, below). Whilst joint bidding arrangements for state funding had commenced at a state level, a lack of integrated service delivery plan for clients common to a number of Departments was noted in South Australia (Interview 11).

That [\$25m, one off] fund is like a social rehabilitation for about 600 people a year. When they get out of psycho social groups, so when they are stabilised, we got \$2.5 million this year to support them, that funds about 80 people a year, and what happens to the other 520?... So we got \$2.5 million for the ongoing psychiatric disability after the crisis has been stabilised, so what Mental Health would argue is; we need this money to stabilise people who go into crisis, we've got then - but they might have an ongoing disability, so DFC gets \$2.5 million to look after. Now, just on cost, so just take that example of how an ideal system might work, now what I'm saying is, we don't know how much the government should have invested in rehabilitation versus ongoing support, we do know that just on the raw numbers that both departments have put up, that you are going to have 500 odd people who get rehabilitated and then left to fend for themselves because we haven't got enough money to provide ongoing support for them. Does that make sense to government, and did we advise government when they made that decision about where to invest?

Interview 23

Mainly, there are a lot of barriers but one being the way things are funded, you know they're funded to a department for a specific purpose, but we are getting much better at that and we're bidding now, like in a budget sense we're now bidding for funds, through what are called bilateral bidding processes rather than health going up for money

Interview 18

I guess it typically happens in bureaucracy and the people driven by achieving their goals so that was frustrating because in a sense they couldn't see the forest through the trees, where the success of the projects had to be aimed at - better outcomes for the clients, not better outcomes for the department or the units. So people got a bit entrenched about how they would do their business, rather than sort of focusing on the bigger picture.

Interview 26

Some of the parties clash so, even in one organisation where one side might be trying to run a rental programme efficiently and so if someone doesn't pay the rent there is lots of pressure to deal with that and move someone on. The other one is actually understanding that someone might actually have a reason for the rent not being paid, and so it's just about understanding that those tensions exist and it's got to be worked through. It's complex, it's hard, but people on the ground will tell that every day that it's the joining up that matters.

Interview 16

Funding being linked to a specific department and programme and 'sectoral interests' could help to explain why the introduction of the CSTDA funds (in 1992) did not act as a 'promoter' [Kingdon's term] for placing psychiatric disability support strategies on the policy agenda in SA. Bureaucrats in the disability sector would also have had

an interest in maintaining funds within the sector, as 'programmes agencies and professional careers wax and wane according to their budget share' (Kingdon 2003, p. 105). Two mental health sector interviewees suggested that CSTDA funds had to be 'advocated for' when they were first introduced (1991), and either advocacy efforts were unsuccessful or there was no advocacy in the first place (Interviews 15, 26). Such advocacy (if it existed) would not have been supported by a strong NGO mental health sector at the time (1991) (Interview 25). Conversely, one bureaucrat believed that decisions on the CSTDA resources were influenced by the need to constrain resources in a sector where resources were already stretched and families were strong advocates (Interview 4). The need for more disability support resources was recently raised as an important issue within the NGO mental health sector (Participation Observation notes). However, recent government prioritisation of social rehabilitation over ongoing disability support resources (Interview 23), suggested undeveloped or ineffective advocacy networks between these NGO and government departments overseeing disability.

### **7.1.5 Integrated organisational structures and policy networks**

Collaborative alliances or interorganisational efforts are seen as the ultimate form of collaboration in Walker's (2000) collaboration continuum. In this study, there were mixed views about the dissolution of the former 'integrated' departmental structure, the Department of Human Services (DHS), upon collaboration across departments. Whilst some bureaucrats believed that an integrated organizational bureaucratic structure was not necessary for integrated service delivery (Interview 29) others pointed to the break up of DHS as leading to challenges for departments working together (Interviews 2, 5, 26). Some in the housing sector believed that the larger department did not work (Interviews 6, 7 below), and/or that there was a need to focus on more regional approaches to planning and service delivery (Interviews 6, 23). Cross sectoral initiatives such as the Supported Housing projects/programme had met with some barriers since the dissolution of the Department (Interviews 2, 26, below).

They put it all together [DHS] but it was too big and it didn't work. But, I mean personally I think we've got to reform the public sector, which means you've then got to move away from these functions like health and housing and education. And you've probably got to go to community and regional focus departments.

As you know, we've got fairly intimately involved through Health through the creation of the Department of Human Services. And the Housing became part of that for some time. And there was quite an educational experience for us all round, and I suppose by and large the overriding impression has been that by and large housing overall was ignored in the equation, notwithstanding the goodwill of a lot of people in Health towards us I suppose. But I think we were just not seen as significant really, considering the massive issues they were addressing.

They then split housing and health again so that put people back into their silos if you like, so the dollars for housing came here, the dollars for support came from health, but it was very difficult to pull the policy framework together.

Since the split of the Department...processes that were really simple have become quite difficult and there weren't supposed to be, in changes in the way things operated seamlessly beforehand. But they have because they are two different entities now. And so, whereas prior to the split, you might say to the Mental Health Unit of the Department, we need some money to run this programme, now we have to send an account and wait for that to be paid. And if that money doesn't come, do we fund it? So there is all these administrative things that have become issues, whereas before they weren't issues. So there has been benefits in the split and there has probably been some drawbacks that need to be worked out and while they are being worked out, they have been complicating things.

Some believed that intersectoral collaboration problems across departments were recognised and there was a desire to address these through the Department of Premier and Cabinet's Social Inclusion Unit (SIU) (Interview 16) or the SA Strategic Plan (Interview 7, below). People saw the SIU as the most appropriate avenue to instigate cross sectoral strategies (Interview 26 below) and consumer/carer partnerships with government (Interview 28). Another public servant suggested that the structure of the public service (linked to Ministers) continued to pose problems for this Unit (Interview 6, below). Integrated organisational structures at a state level are unlikely to solve the problems identified arising from the various national-state bilateral agreements (CSTDA, CSHA) tied to different programme goals and funding sources, or issues with professional culture (see below).

One of the things that is really fascinating to me over the past two years as a public servant (I've

been a public servant for much longer than that) was how the state government put in place this South Australian housing strategic plan with targets in a whole range of areas. And the challenge from the Premier and government has been in my view about people in agencies, government agencies, saying, 'Here's a target which I may be able to contribute to, even though it's not necessarily 100% core to what I do, I can do something to contribute to that.' And I think the question has been thrown at us, either intentionally or unintentionally, by saying you basically need to show more initiative around what is your area of responsibility and how you can help other parts of government, if you like, by contributing to those targets.

Interview 7

I think what the Social Inclusion Unit has attempted to do is probably the best example where you bring together and you pull the resources you need to do this. And I think that's the best way to achieve an outcome because if you, the way that we seem to have gone is less and less amalgamation, like you've split off social justice and the criminal justice, housing, health, it's actually created more barriers by doing that, so we have to find away, around mental health in particular, of somehow bringing back into the mix the collective expertise and resources around specific initiatives and that way people don't have to spend half their bloody life fighting red tape and bureaucracies. So I think the model of the Social Inclusion Unit and that's been given some resources and is probably what needs to happen with mental health to be quite honest.

Interview 26

So I think, to get back to your question, the system doesn't change, but nobody seems to sit, and Premier's department I suppose had the function of sitting over and trying to bring the change together. So the Premier has created like this economic development and Social Inclusion [Unit]. But [Chair of Social Inclusion Board, Monsignor] Cappelletti found the way that the public service is structured, which goes right up to Ministers, makes this interaction really difficult.

Interview 6

### **7.1.6 Vertical linkages, stakeholder trust and the impact of within sector reform**

The lack of integration across sectors was not assisted by the integration 'within sectors'. For example, whilst one housing sector bureaucrat was aware of the \$25m social rehabilitation funds released through the mental health sector in 2005 (Interview 2), another public servant in the same sector was unaware of these funds until after their release (Interviews 7 below). Connections across mental health service delivery regions and across private services were also considered one area for improvement, and had sometimes led to poor housing outcomes (Interview 30). The connections within mental health had been particularly problematic in the past due to

resource allocation within regions strictly determining service delivery (Interview 29, below)

That's funny that, because that extra funding came through and we weren't formally advised about it or even informally advised about it.... But there hasn't been, you know, one of the things about government, which you are probably aware is it doesn't communicate as well within itself as it should.

Interview 7

I mean most of it required common sense but people, I don't know why, just wouldn't go that extra mile to make sure that people got services, whether they were in their boundary or not. I mean they took the view that they had a resource allocation and that was precious and sacrosanct, and applied only to that population in that boundary, and Domcare didn't align with community care, with community mental health, but that shouldn't have mattered.

Interview 29

The reform (health terminology) or review (housing terminology) of governance structures was a major focus in both the health and housing sectors (Interviews 23, 25, 27). The housing and disability area of government (Department of Families and Communities) was undergoing a review designed to strengthen the relationship between strategic and operational areas. However, the housing policy focus on legislative and corporate review and common assessment and referral services, at the expense of resources was cause for concern for some NGOs and housing professionals (Interviews 6, 14). One public servant suggested that housing agency managers resisted the 'obvious' need for housing reform for this reason (Interview 6). Importantly, such tension between the perceived 'resources versus reform' focus was less directly expressed amongst public servant interviewees in the health sector. However, resistance to reform was evident within the mental health sector when it came to the closure of the stand-alone psychiatric institution (Interview 29, Field Diary).

Effectiveness in managing policy change was related to leaders' ability to engage stakeholders and engender trust within sectors. Effective leadership has previously been associated with personal qualities of flexibility and adaptability (Dubrin & Daghli 2003). Public servants in this study saw engaging with stakeholders as either important to further (or future) policy agendas, for developing trust essential to

policy change, or for ensuring planning and the best use of resources (Interview 7, 11, 26, 29). Whilst (clinical) leadership was considered important to mental health reform (Interview 26, below, Brennan 2000), the non-consultative leadership style in mental health governance and state government which occurred in the early stages of the reform was considered uncondusive to within sector partnerships and partnerships with NGOs and consumer/carer groups (Interviews 12, 13, 29 below, Field Diary). Government partnerships with NGOs and consumer/carer groups in the mental health reform are further discussed in the next chapter.

Resistance to policy change was exhibited where stakeholder trust was not established and there were industrial concerns within the mental health sector (Interview 29, below). Failure to consult and address culture within the mental health sector was identified as a barrier to both mental health reform (Interview 29) and effective intersectoral collaboration (Interviews 4, 21). A [clinical] leader/manager's tendency to focus on operational rather than strategic issues (Interview 25), and Psychiatrists relatively poor influence within the health bureaucracy were perceived to have affected the progress of mental health reform (Interview 29). Some of these issues may be tied to a lack of well-supported transition from professional/clinical manager (the 'doer' role) to manager/leadership role (Callan 1995), and the 'task oriented' leadership styles associated with male dominated professions (Gardiner & Tiggemann 1999).

I think the clinical leadership however is critical for mental health because dealing with particularly Psychiatrists getting them onboard to support what you are doing is at the end of the day whether you like it or not central. ... So the thing that the clinical leadership provides is the levers to pull around the treatment, the workforce, the access to all of those sort of things. So from that point of view, yes it was critical.

Interview 26

Partly there was the culture of no change, and to achieve change was very threatening. Then subsequently several Ministers talked about closing Glenside, without consulting the staff. That was just like saying well, we're going to get rid of staff. You can't work like that. You've got to engage, you've got to consult and you've got to go through a change management process, and Ministers in particular, again, not just X but others like her, stood up and said these things publicly without considering the impact on staff and without talking to them first. They would read about the closure of Glenside in the paper. You can't do that.

Interview 29

In 2003, the boards of health agencies were abolished in favour of a small number of regional boards overseen by the Department of Health, upon the recommendation of the Generational Health Review (GHR) (Generational Health Review 2003). In contrast to the housing sector reform, mental health sector reform was linked to large regions developing policy rather than this being done by a central mental health policy unit (Advocacy Focus Group, Interviews 25, 29).

So we still have today, we still have this very, very difficult situation where we have a Mental Health Unit in here which is supposed to have policy responsibilities but it has no authority in operational terms because it's now a regional responsibility; so the separation of - and we now have it's still a very disjointed system, we've still got regions doing their business, we still do not have a whole of life integrated mental health system.

Interview 25

And so the whole Generational [Health] Review stuff and the regionalisation of health has probably slowed things down as well because they are trying to get their regions into order as well. Whereas previously we spoke to a central unit, we now have to speak to the Northern Health Service or the Southern Health Service.

Interview 2

As the mental health and housing sectors were reforming 'within sectors' this caused some problems for both vertical and horizontal integration (Interviews 2, 25), (related to different regional boundaries for service delivery or the instability of staff in departments undergoing reform). Reform was focused upon 'vertical integration' (Stoelwinder 1999), making the 'policy stream' (Kingdon 2003) unstable. This would make advocacy coalitions (Sabatier and Jenkins Smith 1999) within sectors difficult to establish. NGOs were advocating for a community senate or community task force on mental health to oversee the implementation of mental health policy (Participant Observation notes, Advocacy Focus Group), related to concerns about public

servants' turnover as a result of mental health reform (Advocacy Focus Group).

### **7.1.7 Professional cultures and ideologies: Leadership and ownership**

The culture of mental health services was considered one factor uncondusive to both reform and cross sectoral relationships. The autonomy and hierarchy associated with the medical profession (Lewis 2005) (including leaders within mental health) was an important part of this service culture. Concerns about mental health professionals' failure to respect the expertise of housing workers were generally expressed by housing sector professionals, even in regions where Supported Housing projects were deemed successful (although not within these projects themselves) (Interviews 2, 4, 21, 24 below). Problems in the early stages of these projects were associated with professional control over clients, paternalistic concerns about patients and the inability to trust non-clinical workers (Interviews 4, 26). 'Ownership' of clients (and professional hierarchy) was exhibited in expectations that housing sector or non-clinical staff were a resource to be directed by mental health professionals (Interview 4). Health professionals' were also initially concerned about the vulnerability of patients living in the community within Supported Housing projects (Interview 26). This situation changed after public servants engaged with mental health service leaders at various levels and nurtured relationships (Interview 26, below).

I mean sometimes, and this is just sort of, generalist talking but, people from Mental Health sometimes don't respect our other experience or intuition that something is really wrong

Interview 21

I can remember for months, every time I walked into X Clinic down there at Port Adelaide, I felt like I had "dick head" tattooed on my forehead....The change was absolutely magnificent but it took me eight months of being treated like an absolute moron before they would treat me with any respect

Interview 24

Essentially I suppose the difficulty we had was that Mental Health Services there saw the rest of us as purely being their agents, saw the rest of us purely doing what they required to be done, because their view was that they were the sole possessors of the secret knowledge about how you support people with mental illness. And so it was very difficult on two fronts, one to just develop a partnership and a partnership needs to be based on respect and respect for the different attributes that each of the parties bring to the table. Well that wasn't terribly present. And secondly that

translated into Mental Health Services thinking that the rest of us were just there to do their bidding and act on their behalf.

Interview 4

The Salisbury project was the stand out example but others have been very slow with different ideas and perceptions of what housing projects should be doing from the housing sector, from support groups and NGO's have had a view about how they should function for clinical groups.

Interview 19

to be fair to them [mental health sector professionals], they saw themselves as the only available support for a lot of these people and didn't want to see their clients be disadvantaged or put in vulnerable situations...that sort of culture shifted once we were able to demonstrate that 'look it is an appropriate thing to do', there is a difference in terms of what we are talking about in terms of support and anxiety separation is ok but just for a very short period of time because people have the capacity to recover and to manage.... It was finding the leadership because what we had at the time was a pretty demoralized workforce ... so it was a matter of working with leadership and that is at all different levels, it's not just your Directors, and that was beginning to take some pretty good hold and suddenly people realized that this was not about saying that 'you're not doing a good job', it's about saying 'we actually want to support you to do all these things'.

Interview 26

Despite the service-level problems with 'ownership' within projects, balancing 'ownership' and 'leadership' across levels of government was considered important for intersectoral activities. The development and success of Supported Housing projects depended upon state-level leadership and ownership of the problem of housing for people with psychiatric disability, as well as the support of local leaders (Interviews 26, above and below). Where a MOU had been slow to develop at a state policy level, the need for one sector (e.g. mental health) to take the lead in overseeing the implementation of the MOU was recognised (Interview 19).

The leadership was there to do it [Supported Housing projects] and that to me is a critical thing. I think for all of X's critics the one thing that s/he had a single minded view about was doing something about providing stable, relevant, flexible housing. So leadership from the top is absolutely critical.

Interview 26

Contrasting comments on the origin of intersectoral strategies and projects by interviewees suggest that where projects are successful, there is a high degree of

ownership by all parties. For example, Supported Housing projects were variously seen as originating from housing professionals recognising problems (Interview 21) consumer groups in mental health services (Interview 15) or public servants as part of state-wide initiatives (Interview 4, Interview 26 above). This example suggests that where intersectoral initiatives originate from may be unimportant where relationships between partners and ownership of the initiative have been established.

### **7.1.8 Relationships, commitment and protocols for cross-sector collaboration**

Good relationships and a 'willingness' or commitment to collaborate at a local level were cited as being necessary to achieve policy level strategy initiatives. The personal commitment of professionals, clinical services and government departments were all part of collaboration efforts to address the housing needs of people with a psychiatric disability (Interviews 2, 5, 16, 19, 22). Memorandum of Understandings (MOUs) and protocols were seen as an answer to concerns expressed by a public servant that personal relationships and networks could not be relied upon for intersectoral collaboration given staff turnover (Interview 22). This is an important point as staff turnover has particularly been associated with insecure working conditions in the mental health NGO sector, which the government is increasingly reliant upon for service delivery (Office of the Public Advocate South Australia 2005). Other public servants doubted the value of MOUs and cross sectoral structures given the role that personal relationships and personal commitment play in collaboration efforts (Interview 11, 16, 21 below). However, MOUs were one tool to confirm linkages across sectors already occurring through regional projects, even where good relationships existed (Interview 21).

We had a round table discussion with X from Mental Health Service and [MOU] agreement has been reached. Now, that's just waiting to be signed off by the new Minister and from our Minister so, I think that that will improve but, it depends what importance Mental Health place on it at an operational level. So I think it's ok to sign something up here, but it really needs to filter right down to the coal face, and I think unfortunately sometimes working collaboratively is based on personalities, and I think you'll find that with a lot of departments. It's whether you've got the will to work together and things click, so to speak.

Interview 21

There was some dispute about from whom and where state level MOUs between

health, housing and disability had originated from across sectors (e.g. two housing public servants mentioned the Inquiry into the South Australia Housing Trust<sup>33</sup>, and two other public servants believed that this had originated from mental health). Whatever the impetus, there were problems with the sign-off, implementation, oversight and publicity of MOUs, and NGOs were clearly not involved in them despite their expanding role in service provision. One housing sector public servant claimed that a MOU had been easier to develop with the disability rather than mental health sector (Interview 2). A draft MOU between disability, housing and mental health agencies was initiated by the Disability Service Office in 1994 (Burgess 1994) and was also either not complete or not sustained, leading to the need for further MOU initiatives in 1998 and 2003. The MOU instigated in 1998 was also not complete and this was blamed upon national privacy legislation and related concerns about information exchange (Parliament of South Australia 2003). Factors limiting the effectiveness of MOUs and intersectoral activity included the turnover of public servants and changes within agencies associated with reform.

Privacy and confidentiality practices were seen as an actual or potential obstacle to working across sectors and common assessment processes (Interviews 2, 3, 7, 21, 23). One housing sector respondent suggested the reluctance of mental health professionals' to share information with other services was related to their interests in advocating on behalf of patients and protecting them from discrimination (Interview 2). The issue of privacy is discussed further in the following chapter in relation to carers and professional accountability.

### **7.1.9 Contracting out and within sector 'market governance'**

The development of contracting arrangements without adequate planning or development of enduring networks across regions and sectors was observed in the case study (Interview 2, Advocacy Focus Group, Field Diary). For example, the SMHHA network was a local initiative developed after mental health services

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<sup>33</sup> Developing an MOU between mental health/housing/justice agencies was in fact one recommendation of the Inquiry into the South Australian Housing Trust Parliament of South Australia Social Development Committee 2003, *Inquiry into supported accommodation: 18th report of the social development committee*, Social Development Committee..

devolved their Community Accommodation Support Scheme services to the non-government sector (Field Diary). Government's focus at this time had been 'market governance' (Lewis 2005) or the individual relationship between government and contractor

Under market governance, relationships are seen as essentially contractual, without reliance on the ongoing commitments and understanding that come from enduring relationships. Network governance, in contrast, relies on ongoing relationships and coordination. It is both a description of the state of the world and a way of thinking about how to better coordinate the splintered components of policy systems and service delivery.

(Lewis 2005, p. 172)

Additionally, the social rehabilitation funds quickly released in 2005 were focused on relationship between government and individual NGOs contracted to provide services. Social rehabilitation funds were quickly released which inhibited the capacity for planning by NGOs and government alike (Interviews 2 below, Advocacy Focus Group). The nature of short term contracts between the housing sector and NGOs in another programme had made it difficult for NGOs to retain staff (Interview 3, below). Market governance arrangements and short-term contracts made both collaboration and the development of trust between NGOs and clients<sup>34</sup> less likely

It's going to be really hard, because of the additional money, one of the things that we are finding is that, I mean, there was a lot of pressure for the additional money to come out... And there was a lot of urgency and need for it to go out and for the services to be developed. But because it happened so quickly, what we are finding with our smaller programme is that they are starting to lose workers, because they can go there for better pay.

Interview 2

the non-government sector was saying to us was, "Look, we need contracts for more than twelve months to hire people, to be able to provide the support. It's not worth you saying to us every twelve months you're going to review our contract because where is the stability?"

Interview 3

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<sup>34</sup> Considered important for housing people with a psychiatric disability in this study, see Appendix 17

## **7.2 Conclusion**

The findings reported in this chapter suggest that cross sectoral activity at a policy level was impaired by the institutional/programme context, events in the 'political stream', and 'market governance' rather than cross-sector 'network governance' arrangements (Lewis 2005). This chapter also provides further evidence for the finding that there is a poor link between national policy on intersectoral collaboration and mental health reform, and local policy and strategies (chapter 5).

In chapter 3, 'policy subsystems' (Sabatier and Jenkins-Smith 1999) were described, and the thesis set out to consider the extent to which policy sectors could be considered separate 'policy subsystems'. The findings suggested that housing and mental health sectors could essentially be considered separate 'policy subsystems' (Sabatier and Jenkins-Smith 1999). The institutional and national policy/programme context (i.e. bi-lateral agreement resources tied to departments, different programme rules and guidelines, lack of joint bidding or contracting out arrangements) supported the notion that there were separate 'policy subsystems' operating. This context impacted upon attempts to create integrated policy through the cross sectoral structure of the SIU as bureaucrats were invested in and constrained by the programme and funding guidelines or planning processes and networks associated with departments. There were very few opportunities identified here where NGOs and consumer groups were tied to cross-sectoral networks (except for in individual supported housing projects or regional SMHHA), and cross sectoral collaboration involving community groups had not been 'institutionalised'. This may have occurred through the new SIU strategies on mental health (largely developed after the period of interest to this study).

Processes and negotiation skills for collaboration (Walker 2000) and leadership were considered important to the implementation of cross sectoral initiatives and state level reform, however these were secondary in importance to the national-state policy programme, institutional and political context. The integrated organisation structure of the DHS had temporarily enabled the Supported Housing demonstration projects/programme which had demonstrated good housing outcomes for a small

number of people with a psychiatric disability in some regions (Health Outcomes International 2002), however these were not fully rolled out and the small number of projects that did exist had reportedly experienced intersectoral problems when the DHS was disbanded. Additionally, despite the SIU and processes such as the SA Strategic Plan, the negative influence of events in the 'political stream' [Kingdon's term] was evident (i.e. change in government leading to reform and organisational instability, impacting upon collaboration). Reform made the 'policy stream' within sectors unstable, lessening chances for advocacy coalitions to form within sectors (Sabatier and Jenkins Smith 1999) and the development of successful collaboration efforts across sectors.

This chapter placed the findings regarding different 'problem representations' (Bacchi) discussed in chapter 6 into the broader national-state policy context. The need for additional resources for collaboration, particularly resources to refer people to following collaboration efforts was recognised across sectors. This highlighted the neo-liberal policy context and the importance of challenging neo-liberal discourse in agenda setting for such resources. Additionally, a lack of common understanding of problems across sectors was reflected in poor cross-sectoral networks (as noted by Kingdon 2003). Discourses on health/disability and professional cultures within sectors were also identified as barriers to collaboration efforts across policy/programmes. The connection between policy networks and 'ideas' or conceptions of problems (Lewis 2005 and Sabatier and Jenkins-Smith 1999) (first identified in chapter 6) was thus illustrated.

The following chapter explores the relative influence of NGOs and consumer/carer groups within policy networks (given the lack of established intersectoral policy and structures) and successes in advocacy and lobbying for housing and support resources.

## **8 NGOs and Consumer and Carer Groups' Influence on Policy**

The broader public policy agenda of the government of the day plays a crucial role in facilitating and/or resourcing community activism in the health policy process.

(Palmer & Short 2000, p. 46)

This is the final results and discussion chapter and considers the relative influence of NGOs and consumer and carer groups on policy and the extent to which the issue of housing for people with a psychiatric disability has reached or missed policy agendas. The chapter relates to the research question: *How have community participation mechanisms (which include state level advocacy and consumer and carer groups) been able to influence the mental health reform process and the development of housing initiatives for consumers of mental health services?* It is also relevant to the sub-question: *Is there evidence of the issue of providing adequate housing for people with a psychiatric disability making it to the policy agenda in the mental health sector?* The chapter is primarily based upon the thematic analysis of policy, participant observation with NGOs, the focus group and interviews with NGOs and consumer and carer groups, thematic analysis of the notes from minutes of state level consumer and carer groups and the Field Diary. The perspectives of health and housing bureaucrats and professionals were also considered in this chapter.

The horizontal dimensions of policy were the main focus here, where policy is understood to be a process involving players beyond government and bureaucrats (Colebatch 2002, p. 143). The chapter is divided into two sections. The first section considers what NGOs and consumer/carers groups were advocating for and how groups prioritised housing and related support issues. It also considers the influence of the current contractual environment on community participation and advocacy activity. In the second section, examples of attempts to influence policy are considered.

## **8.1 Different perspectives on the role of NGOs and Consumer groups in policy across sectors**

In the following section, central themes on community participation were considered (across all participants), before a more detailed examination of NGO and consumer/carer groups' influence on policy. As discussed in chapters 5 and 7, there were few whole of government opportunities to consider policy and programmes on housing for people with a psychiatric disability, limiting the scope of community participation mechanisms. However, there was a great diversity of views expressed in interviews and focus groups on the role being played by NGOs and mental health consumer and carer representatives on policy within and across sectors.

### **8.1.1 Public servants perspective on the role of community groups on policy**

Public servants were much more likely to emphasise state level government initiatives and issues related to the 'political stream' (Kingdon 2003) (i.e. state strategic plan, commitment of government) as determinants of policy, over established government structures involving NGOs. However, policy networks involving NGOs were important to understanding policy influence across sectors. Politicians and bureaucrats sometimes had a role in encouraging NGO alliances to support mental health reform (Field Diary, see section 8.2). A number of public servants interviewed for Stage Three also spoke about their own role or observations about working with community groups in policy agenda setting and change (Interviews 2, 4, 7, 11, 15, 16, 18, 22). These public servants spoke about the importance of advocacy groups raising public debates (Interviews 2, 22), government responsiveness to community views or individual advocates (Interviews 2 below, 4, 16) and/or a more proactive relationship between government and stakeholders in engendering change (Interviews 2, 7, 11 & 15 below, 16, 18, 22, below)

Well that's how we got sixteen [Supported Housing] places in the first place, was through NORCAG [Northern Consumer Advisory Group] writing a proposal. So they actually wrote to the Minister and wrote to, who was it..and he actually came and assisted to develop the proposal.

Interview 15

You develop a rapport with different people, and through that rapport, you get ideas and you are able to bounce ideas off and see people who we think would be successful or worth pursuing. So,

all areas that I have worked in with Housing and Homelessness and Disability and so on, that has always been a useful tool in moving projects and policies along.

Interview 2

I come from a policy activist position where you need to use your stakeholders effectively to get the issues on the agenda and our consumer voices and our NGO's are very, very important so yes they were at every table.

Interview 11

Two public servants in the mental health sector suggested that consumer and carer involvement was central to service delivery (Interviews 11, 19) although the need for greater community involvement (not simply carer and consumer involvement) in health policy and planning was recognised (Interview 18, 19).

In chapter 2, the need to develop public servants skills in working with communities (Skelcher 1996), and the different value placed upon community engagement within policy theory was noted (Bishop & Davis 2002). These points were also made in this study by health professionals and consumer representatives alike (Interviews 1, 13, 18, Consumer Carer Focus Group). Both the lack of general support for community engagement at a policy level (Interview 18, below) and the lack of perceived relevance of consumer involvement at a service delivery level were raised as issues (Interview 1, below).

we've been the ones pushing the consumer engagement, not that others don't but we've been the one who have set up the mechanisms and the structures to make that happen at the policy level.

...I think one of the challenges for us is that it has to be driven by the individuals, like we found, you know, it does come and go, it waxes and wanes this issue of how and where consumers should be engaged and so we fought really hard..Leadership and political issues and we fought very hard...And we fought very hard here to keep that happening at the highest possible level, that said, I think we're facing another watershed in terms of that at the moment because we're coming to the end of another year and people review the structures and go 'well do we really need this, you know, what value is it adding?' and we would say, 'as far as the work of reform is, it's invaluable because it gives us a connection we don't otherwise have' but I'd have to say, you know, people's support for consumer engagement at this, within the department is something that some people don't actually feel is necessary.

Interview 18

But we've done some work, and I won't even tell you the sector. So I'll try and keep it very

general. But I was stunned because we did this piece of research for a client and part of it was to gauge the attitude of these health professionals to consumer participation in their little local service. And a staggering 20% of them said they didn't believe that consumers had any role whatsoever in giving them feedback or advice. Just didn't believe that it was at all relevant. And voiced very strongly. And then another large chunk of them who said "Oh. Well yeah. They might be able to contribute something." You know, you think despite decades of the Consumers Health Forum being around, there being strategies and policies, still doesn't filter down to the people at the interface between consumers and providers. You know, these are people who are providing health care services to consumers who are still saying "Why would we do that?"

Interview 1

However, overall health reform was seen as an avenue for improving public servants skills and promoting awareness of the value and relevance of community engagement (Interview 18).

### **8.1.2 Involvement of Consumer Representatives and NGO groups in reform and policy processes across sectors**

Both NGOs and consumer and carer representatives from the health sector were frustrated with their level of involvement in state-level participation processes, and the progress of both mental health reform and community participation policies (Consumer Carer Focus Group, Interviews 13, 27, Notes from Consumer Carer groups, Field Diary). They were particularly cynical of the ongoing 'reform' in mental health and the engagement process for reform (Advocacy Focus Group, Interviews 13, 27). Consumers and carers were often considered more effective in regional governance and community participation structures and local services which were removed from strategic policy processes (Advocacy Focus Group, Consumer Carer Focus Group Interviews 13, 27).

The emergency demand management policies, we did those locally and had an input locally but during the framework development I don't think we were involved in any policy review or policy per se apart from the [consumer carer] framework that we felt would become policy.

Interview 27

Some consumer representatives in mental health had been involved in recent strategies for the overall process of health reform. A network of NGO and professional organisations was established through the health reform process (Health Reform SA), with one platform being consumer participation and engagement in

services. This included at least one consumer representative from mental health (Interview 18). The government also separately established two implementation and advisory groups for reform which included mental health consumer representatives (Interview 18, below)

In fact we asked the Health Consumers Alliance to nominate four people [to advise on health reform] and they were all mental health consumers or advocates as it turned out.

Interview 18

Involvement in service delivery and general health reform policy processes did not necessarily translate to a political voice for mental health consumers and carer representatives, or influence in mental health policy specifically (Interviews 5, 13, 25, below).

I don't think the mental health consumers have ever had a political voice. There was one and I think that it's essential that they're involved, and I don't think they are.

Interview 25

It's probably got a long way to go. I think on the ground in service delivery, there's probably some good stuff happening, but at a policy level, I wouldn't think it's that terrific.

Interview 5

We could talk about the shortcomings in mental health services and how it was failed and the need for funding, but actually consumers and carers had never sat at a decision making table

Interview 13

This lack of influence at a policy level could partly be explained by government partnerships with NGOs, and NGOs themselves, being slow to develop in South Australia (Interview 12). Conversely, some public servants believed that mental health NGOs were unskilled/inexperienced in lobbying activity or simply not influential in the mental health sector when compared to professional associations (Interview 11, 25).

There was greater consistency from respondents in NGOs and the public service (housing sector) in their belief that NGOs (and sometimes community members) were more involved in the development of housing policy and services (Interviews 7, 9, 16, 22, Advocacy Focus Group). For example, whilst an Aboriginal housing sector

professional was not aware that mental health services had actively involved or consulted the Aboriginal community, Aboriginal community members were centrally involved in the management of an Aboriginal housing service (Interview 9). Another housing professional claimed that there was greater scope for improved relationships between community housing NGOs and health departments when discussing community rehabilitation centres (Interview 24 below)

Look, there is so much goodwill and so much good intention, but policies are made in government and there is no consultation with anybody else, or if it happens it is too far down the track. So we have a situation where the Community Recovery Centre business is starting to happen. So people go from Glenside, three to six month stays and then they get discharged into the community. So first problem, no thought as to where these people are going to go once they are discharged.....I just would like them to come and talk to us and listen to us. And I would like the invitation to be extended for us to go and talk to them and listen to them

Interview 24

However, there were mixed views held across government/NGOs about the relationship between housing NGOs and government (housing sector) departments when it came to negotiating contracts and developing state housing policy (Interviews 7, Advocacy Focus Group, Participant Observation notes). Even where NGOs were involved in consultation over policy, one problem identified by NGOs across sectors was Ministers waiting for politically opportune moments for policy sign-off (i.e. when there was public interest in issues) (Advocacy Focus Group). This provided some support for the influence of Kingdon's (2003) 'political stream' upon policy.

Tenants groups located within the bureaucracy were believed to have had little influence upon policy, apart from the Inquiry into the South Australian Housing Trust and disruptive tenants' policies (Interview 3). However, the extent to which mental health consumer and carer representatives were sources of feedback on these or other housing issues was unclear. One carer in this study expressed concern that public debates on disruptive tenants had not recognised the importance of support for public housing tenants with mental illness (Consumer Carer Focus Group, below). Tenants groups in government did not explicitly include people with psychiatric disabilities, their carers or representatives, and people with disabilities or carers who may have been tenant representatives were not necessarily identified as such

(Interview 3). Unsuccessful attempts had been made to involve the mental health sector within tenant forums (Interview 3, below). Despite having contributed opinions on people with psychiatric disability in public housing at a national level (Alberton et al. 2003), tenant representatives were not necessarily considered to be appropriate commentators on such issues due to their lack of expertise (Interview 3).

we have made efforts in the past to try to engage in the mental health sector and to find representation on OPAC. But that has been totally unsuccessful.

Interview 3

The issues that I know the Housing Trust have had with people who have been very unwell and the trashing of their houses, you know, we've heard it in the media of late. You know, they want to actually charge them for, you know, and my first issue there is, you know, were they supported in the first place? Was anything going on, you know?

Consumer Carer Focus Group

### **8.1.3 What were NGOs and consumer groups participating within or advocating for?**

Housing and support issues for people with a psychiatric disability were generally acknowledged as being important issues by NGO groups in this study (see Table 8). However, lobbying and policy input regarding these issues were either only sometimes undertaken or not engaged in at all. Table 8 shows the specific recognition of housing problems by respondents from various NGOs. Table 9 indicates NGO and researcher identified limits to advocacy or policy level activity regarding housing linked to support.

Charles & DeMaio (1993) argue that recognition of the social determinants of health has challenged the medical dominance of health care decision-making and been one impetus for consumer participation in health. Conversely, in chapter 5 it was noted that people with psychiatric disability were being promoted as 'health service consumers' in policy or people with rights and interests in relation to treatment services. In only around one third of transcripts (11 out of 30 transcripts)<sup>35</sup> were the rights of people with a psychiatric disability mentioned, and half of these referred to

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<sup>35</sup> There were 29 transcripts and 39 participants for interviews and focus groups

consumer rights in treatment services.

**Table 8: NGO recognition and prioritisation of housing issues**

<b>Type of Agency</b>	<b>Recognition of housing and housing stability issues</b>
Health Consumer peak group	<p>It's [housing] kind of been generally recognised as one of the key areas...but no, we haven't, the time that I was involved ... we haven't spent any time.</p> <p>you need a leadership for the organisation that has a social view of health, and you need to have enough capacity to be able to work on those broader social health issues at the same time as you're doing the more bread and butter stuff</p> <p style="text-align: right;">Interview 12</p>
Mental health NGO (non-peak)	<p>Firstly, I answered in terms of accommodation support which obviously comes up all the time - 100%, however, for our other groups ....Accommodation is definitely in the forefront of conversation with a lot of members...</p> <p>....Prior to that you've spoken about ROOFS [Community] Housing and the work that went into ... there was a lot of lobbying work to actually get that up and running.</p> <p style="text-align: right;">Advocacy Focus group</p>
Housing Peak group	<p>Maybe it's an indictment on us but we haven't really raised it with members and I think it probably would be a good idea for us to, but certainly stable housing is so important because the problem is if you worry about where you're going to sleep tonight you're not going to address your mental health problems as a first priority. The other thing is that we're aware that so many of the SAAP services feel like they're defacto mental health services.</p> <p style="text-align: right;">Advocacy Focus Group</p>
Housing service delivery & peak agency	<p>I would say that housing stability is quite an issue for people with mental illness. I would say that accessing housing in the first instance is one of the major difficulties that they face, simply because of lack of supply in the social housing sector and their inability to access and maintain private rental.</p> <p><i>Do you think you have generally been involved at that level, policy and programmes?</i> Not really at a state-wide. I mean Homelessness SA I guess has been quite bogged down with the whole SAAP funding thing and that has been something that they have been concentrating on in terms of advocacy and lobbying</p> <p style="text-align: right;">Interview 24</p>
Disability Advocacy Sector NGO	<p>I did quite a lot of advocacy in relation to issues on housing, I also had quite a lot to do with the South Australian Housing Trust. Such as unsuitable accommodation for clients, I also attended hearings with the Residential Tenancy Tribunal in relation to clients who were being threatened with eviction. I also worked in conjunction with HASSA <i>So housing instability would come up a fair bit?</i> It did actually, inappropriate housing, having clients in inappropriate housing and then of course getting into strife when they're unwell.</p> <p style="text-align: right;">Interview 28</p>
Corrections Sector NGO	<p>The lack of support mixed with the fact that there's not any or so few appropriate housing options. At present there are no pathways or very few pathways for people leaving prison to go into accommodation of any kind unless they've got family and friends. So I think the community perception is that there'd be a pathway that meant that someone being released from prison would have a house; that's just not the case.</p> <p style="text-align: right;">Interview 14</p>

**Table 9: Researcher summary on the reasons for limited NGO advocacy and policy participation activity regarding housing and linked support**

Reasons	Explanation
'Problem Representation' within sector or NGO Perceptions about Core Business, associated with medical and consumerist discourses.	The way people with a psychiatric disability were being represented by NGOs within the health sector, e.g. as health consumers contributing to service issues (see Table 8). Perceptions about core business/responsibilities of the organisation not including housing (e.g. Interview 14). Medical discourses of health and disability and dominant 'consumerist' discourses within the health sector has contributed to such 'problem representation' (chapter 6).
Contractual Environment & Service provision vs. advocacy function	NGOs, including representative groups, may have been contracted to provide specific services to government. The increasing role of NGOs in service provision or workforce development (Participant observation notes) conflicted with an advocacy role. NGO staff may have an interest in expanding the service delivery role of organisations in terms of mental health services (Participation observation notes).
Capacity of NGOs	The lack of capacity of organisations or individuals (Field Diary, Interviews 11, 14) and some advocacy services not being funded for 'systemic advocacy' (e.g. Interview 28).
Consumer representation & proximity to a range of carers and people with psychiatric disabilities	The extent of and effectiveness of people with psychiatric disability within NGOs across sectors determined how the urgency of and perceptions about housing issues for people with psychiatric disability (e.g. no mental health representatives in the housing sector participation processes at a state level, carer representatives who had the capacity to purchase housing on behalf of individuals who did not see housing problems as urgent).
Degree of political and community support for mental health/NGOs	There was longstanding advocacy regarding the development of a peak mental health NGO (Field Diary, Interview 5). Having no mental health peak NGO in SA for some time appeared to contribute to the lack of advocacy activity and the development of NGO services.
Structures and processes for intersectoral linkages not well established	Structures and processes for NGO networks were generic and not specific to mental health and housing issues (Advocacy Focus Group). Social Inclusion Unit initiative on homelessness not significantly involving the mental health sector (see chapter 5).

Conversely, state-wide consumer/carer group had commented upon the developing Supported Housing demonstration projects and had prioritised lobbying for more supported accommodation resources (in consultation with SACOSS), along with respite and recreational activities (Minutes of Consumer Carer Groups). Consumer representatives were concerned with the rundown of public housing stock, the shortage of supported accommodation, and access to housing for refugees (Minutes of Consumer Carer Groups). However, these issues were not progressed through state level consumer participation groups. Opportunities for input into (pre-existing or draft) policies were limited to 'health consumer' issues (Minutes of Consumer Carer Groups). These included emergency demand policies, the review of mental

health legislation and structures and processes for consumer and carer participation (Minutes of Consumer Carer Groups, Interview 27). The focus on security in public services (chapter 6) was also reflected in *repeated* concerns about the locking of ward doors for *voluntary* patients at the stand-alone psychiatric institution (Minutes of Consumer Carer Groups).

#### **8.1.4 NGOs and the contractual environment: advocacy and service provision roles**

Rein (1983) suggests that some interest group leaders may pursue their own personal interests and be focused on the expansion of organisations (Rein 1983). In the case study there were examples of efforts toward organisational expansion; firstly, community housing organisations were promoting their role in affordable housing, and servicing people with high needs following deinstitutionalisation, and secondly, a mental health peak NGO expanded its membership to include generic service provider NGOs some of which were new to providing mental health services (Participant Observation notes).

NGOs now operate within a context where they must participate, represent, provide services, and be monitored in all of this activity. The conflict between these roles is firstly illustrated by one NGO which advocated on behalf of people with psychiatric disabilities who had complaints about other NGO service providers (Interview 28, below). Secondly, the selectivity of community housing and other NGOs in choosing (or resisting taking on) clients was raised as an issue (Interview 17, Consumer Carer Focus Group). These findings correspond with claims that in the United Kingdom a smaller public housing supply has led to social housing landlords being more selective and avoiding taking on people with high support needs and homelessness histories (Sampson 2005).

What happens for a lot of consumers is that they're serviced by a lot of different areas out in the community who think that they are all providing service to the best interest of the client but they're not, but the consumer actually doesn't always get their voice heard. And so having an advocacy group that is not connected to any of those services is often the way that they can actually service the consumers, who are not affiliated with any of the mental health services and the community.

Interview 28

Much NGO advocacy work entailed advocating to a particular sector for additional resources (that would lead to organisational expansion). Considerable time was also spent on negotiating contracts (Advocacy Focus Group, Participant Observation notes, Interview 24). This activity could detract from involvement in other policy development activity. However, whilst NGOs were sometimes instrumental in broad policy agendas, mental health sector NGOs felt excluded from policy implementation processes (Advocacy Focus Group). Conversely, negotiations about community housing contracts were evident, but sometimes considered one-sided or inflexible (Advocacy Focus Group, Participant Observation notes, below).

A few members of the group expressed some concerns about the new proposed 10 year agreement with SACHA, [considered] a 'one-sided', top down agreement. No information had been sent out about the bottom line funding. SACHA can alter the agreement, but the other partner can't.

Participant Observation notes

No, the response was we have to be fair and we have to be consistent and therefore everybody gets the same within one of those three bands. It's a very sort of inflexible ... it was almost ethical - we're the good guys because we're saying 'right everybody gets the same and it's good', and they couldn't actually see that there might be some differences between different organisations and who they were housing and this organisation over here might need twice the funding than that one did over there. Or it might need a different form of funding; it might need a different form of staff...It's a very insensitive approach.

Advocacy Focus Group

Contractual relationships with government could also impact upon what NGOs were advocating for, their relative influence on policy, and the nature of advocacy activity (Interview 12). The importance of maintaining independence in lobbying and the limits of 'networking' (as opposed to other forms of lobbying) for smaller agencies who had less political/bureaucratic connections was recognised (Interviews 12, below), although one interviewee considered that a balance between political lobbying activity with using one's networks for influence was desirable (Interview 28). One person saw the SIU as an opportunity to develop networks with government, hoping that its newly developing mental health strategy processes would establish a 'voice' for consumers and 'street-level' workers alike (Interview 28, below). The currently limited networks of smaller NGOs was evident where one NGO service provider spoke about being unaware of processes for contacting the

appropriate individuals for lobbying purposes, or where another emphasised the need for the right 'audience' for lobbying (Interview 24, 28). The importance of lobbying for smaller NGOs was highlighted where pre-existing networks between government and NGOs determined who received funds within a non-transparent tendering out processes for psychiatric disability funds (Advocacy Focus Group, below).

I think it's important to be able to reach people who actually make these decisions, there's no point in being out there in the community and talking about these issues if you don't actually get the right people to listen to your concerns. But I think there's ways about doing that, I mean, there's many people who are out there and doing that but they are very vocal and who tend to take this lobbyist profile but actually all they really do at the end of the day, and I'm not saying all of them but a lot of them, all they do is make noise but they go about it in a way that can be antagonistic and so therefore, the key players who should be listening switch off.

...But I think it's about ensuring that the right people hear the issues that are a concern for people out in the community and I'm hoping, I'm hopeful that the Social Inclusion Board is one of those arenas where workers on the ground level [and] consumers and carers can actually express their concerns, with the hope that these concerns are taken seriously and some real changes are put in place.

Interview 28

...Well, I mean there's always a pretty important role for networks, isn't there, whether it's open or closed, but I suppose it strengthens the argument somewhat, I think, of those that argue that's the way you do things. I'm still not convinced that's right because I think you can only get so far by having cups of tea with powerful people.

...We took seriously the invitations to go to things where they [politicians] were at, and we were involved in the issues that they thought they were important, and we kept, we had good relations and good contact with the senior department people, and I think that's important. I don't want to discount that. The question, though, is if that is your only strategy, I think you'll run into problems for a whole range of reasons...I think you need more than one string to your bow if you're going to be an effective and independent NGO.

Interview 12

No, I think it's a mix of things, like part of it was the surprise of them [the department] actually getting the money but also getting it in such a way that they had to get it out the door in a big hurry and then it was just the sorts of people that were involved in handing it out and their personalities dictated how they did it and the contacts they have and their own prejudices in a sense of what they wanted to fund. But then there was also like the people they tapped on the shoulder did have some capacity to say this is the sort of service we want to do, but it was a bizarre process in terms of ... if you tried to analyse it from a planning sense it would be very

interesting.

Advocacy focus group

The tension between NGOs and consumer groups maintaining independence and receiving government funds was evident within this study. NGOs inferred a 'double bind' when it came to lobbying and having a contract with government to provide services (Advocacy Focus Group). During the course of this study, one advocacy organisation had its funding cut by the Australian government after 17 years of operation, with corporate mismanagement being cited as the reason (Doolan 2006). Some individuals within this organisation felt that their role in systems advocacy influenced the fate of the organisation (Field Diary). Whatever the impetus, the dissolution of the organisation had led to a gap in individual and system advocacy, significant due to the tension between NGOs service provision and advocacy roles (Interview 28). In Maddison's (2004) survey of 290 NGOs in Australia, 70% of organisations believed that their contracts with government influenced their ability to speak out (Maddison et al. 2004). The political climate as well as NGOs sympathies with the current government (Participant Observation Notes) could also potentially affect lobbying.

## **8.2 Examples of successful and unsuccessful lobbying activity regarding housing and related support**

The following section specifically considers the three organisations involved in the participant observation stage of the case study; the Community Housing Council of South Australia (Disability Forum), Shelter SA and the Mental Health Coalition of South Australia. After generally considering their activity in terms of housing and support advocacy, four specific examples of successful and unsuccessful lobbying were examined. The fourth example included lobbying by a professional/NGO alliance. These examples were tested against the components of Kingdon's (2003) 'multiple streams framework' which helped to explain what missed or reached policy agendas within sectors (see Tables 10-13). However, Bacchi's (1999) 'what's the problem?' approach also enabled an understanding of what problems reached the political agenda and how policy debates shaped policy preferences. The connection

between Kingdon's (2003) and Bacchi's (1999) approach are explored further in the following chapter.

### **8.2.1 Community Housing Council of South Australia and Disability Forum, and Affordable Housing Strategies**

The CHCSA was advocating to the Ministerial Housing Council for community housing to play a greater role in housing people with high needs such as a psychiatric disability. The CHCSA also advocated for people entering community housing to have a disability support plan and funding linked to individuals (Community Housing Council of South Australia 2003), the model used in the Supported Housing programme (which involves public housing). The CHCSA identified professionally run Housing Associations to be the most appropriate avenue for so-called 'high needs' clients (over Housing Co-operatives and public housing), due to their ability to sustain tenants, their client-focus, the stability of their workers, and the resources attached to them when compared to Housing Co-operatives (Advocacy Focus Group). One small scale evaluation of two community housing organisations claimed the suitability of this tenure for people with complex needs, based on workers' feedback and the social contacts of individual tenants (Kilner et al. 1998).

Conversely, within the CHCSA Disability Forum, there were expectations that volunteer Housing Co-operatives should play a role in housing people with psychiatric disabilities (Participant Observation notes). Members of the Forum were concerned that some volunteer Housing Co-operatives were restricting access by using eligibility criteria and making decisions about the capabilities of prospective residents, although many were already housing such clients (Participation Observation notes). One Housing Co-operative justified gate keeping based on the need for skills for reporting, linking this argument to findings from a South Australian Parliamentary Inquiry which had concluded that the co-operative sector needed to develop more robust reporting (Parliament of South Australia Legislative Council 2000) (Participant Observation notes).

**Table 10: Example of successful lobbying within sector using Kingdon's (2003) multiple streams framework: Affordable Housing**

Problem	Lack of affordable housing Low rental market vacancy Diminishing Public Housing
Politics	Championing more privatized solutions – CRA & FHOG
Policies	State Housing Plan (DFC 2005) looking for alternative \$ Private Rental Programme (accessible by community housing organisations)
Policy entrepreneurs	Affordable Housing Consortium (Groups of community housing + CHCSA)
Window of opportunity	Political interest & change of Minister – State Housing Plan (DFC 2005), Affordable Housing Unit established

The CHCSA had advocated for home-ownership strategies and alternative financing for the social housing (public and community) and private rental sectors, in order to provide more affordable housing (Community Housing Council of South Australia 2003; Community Housing Council of South Australia 2003). However, as discussed in chapter 6, some people in the CHCSA Disability Forum were concerned that strategies to enhance home ownership via the sale of public housing were unrealistic for ‘high needs’ clients (Participant Observation notes).

The CHCSA appeared to be influential in pursuing affordable housing strategies through the state housing plan (see Table 10 above). Following diminished public housing funds provided through the CSHA, an amalgamation of community housing organizations, the Affordable Housing Consortium had formed (this involved the CHCSA and other community housing organisations, and was set up by these groups). This group acted as a ‘**policy entrepreneur**’ using the ‘**political window of opportunity**’ (Kingdon 2003) of the new state government’s State Housing Plan (2004) consultations to progress the plans of the consortium. It was claimed that policy makers had readily adopted the plans put forward through the consortium and that there were open processes for consultation regarding the development and implementation of affordable housing strategies (Interview 22, Advocacy Focus Group). The establishment of an Affordable Housing Unit was one aspect of the state housing plan.

I just think it was the right time, you know it was a point in time and it was the right time, because we were also, I don't know if you know this but we were also, and I think it's been

interesting how it's rolled out, but in 2000 I think it was...we got together to look at developing an Affordable Housing Consortium, because affordable housing wasn't on the agenda in South Australia and we were, there was a group of us saying, "Well we've got a bit of clout between us", because we were primarily the large organisations, so you had MACHA, Women's Housing, Housing Spectrum, Northern Suburbs Co-op and we started to look at developing, and in fact did develop a constitution to set up an Affordable Housing Consortium, and that was about opportunities out there, outside your mainstream public housing so SACHA and The Trust had opportunities where you could provide accommodation to people, but a different structure. And then what happened of course is, well MACHA withdrew, Housing Spectrum then withdrew and the State Government took it over, took it on as a big initiative.

Interview 22

However, affordable housing strategies which sought alternative financing were complementary to the neo-liberal '**politics**' and '**policies**' of national and state governments. The strategy was premised on the continuation of the national Private Rental Programme and community housing associations' access to the programme (Interview 16).

### **8.2.2 Shelter SA and Resistance to Changes to Disruptive Tenants Policies**

Shelter SA focused on operational rather than strategic issues at board meetings, and a separate strategic planning meeting was not attended by the researcher. However, housing affordability issues were often raised across these meetings, but not specifically for people with disabilities, a group rarely mentioned within meetings. After one meeting, the problem of high numbers of people with a psychiatric disability in SAAP services was discussed in an informal conversation (Participant Observation notes). Conversely, the speaker at the AGM in 2005 suggested that peak housing organisations needed to increasingly focus on special needs groups in advocacy activity (Participant Observation notes), as had occurred in the UK (Sampson 2005). Subsequently, Shelter SA co-organised a forum on mental health and housing in 2006 with the Mental Health Coalition of South Australia (Field Diary).

Within one board meeting, reference was made to people with 'high needs' being in 'inappropriate housing' that may be more suited to low income families (Participant Observation notes). As noted in chapter 6, the notion that the best use of public

housing resources was not occurring was widely held. However, there were different opinions across sectors about the best use of public housing (i.e. focus on high needs versus low income families).

There was evidence for Shelter SA's consideration of people with a psychiatric disability in (housing sector) submissions to government. The organisation had noted that deinstitutionalisation had been excluded from the first state housing plan discussion paper, and advocated for ongoing support for people with a mental illness (Shelter SA 2003). A later submission recommended adequate community based support for people with a psychiatric disability (Shelter SA 2003). The submission to the Inquiry into the South Australian Housing Trust (Shelter SA 2002) did not specifically mention people with a mental illness however emphasised the rights of public housing tenants and challenged stigma towards people in public housing (Shelter SA 2002). However, Shelter SA had responded to the disruptive tenants debate preceding and surrounding the Inquiry into the South Australian Housing Trust (Parliament of South Australia 2003) (see Table 11).

**Table 11: Example of successful lobbying to resist policy change using Kingdon's (2003) multiple streams framework: Difficult and Disruptive Tenants Policy**

Problem	Disruptive Tenants Concentration of 'high needs' customers in public housing without support
Politics	Disruptive tenants raised as an issue by public housing tenants Influence of media pressure and general community debates Government responding to disruptive tenants debate in the community Questioning the legitimacy of 'community living' Competing concepts of Supported Housing across sectors
Policy	Increased targeting of CSHA Proposed change to Difficult and Disruptive Tenants Policy
Policy Entrepreneurs	Housing Sector NGOs (when it came to outcomes of the Inquiry)
Window of Opportunity	Inquiry into the SAHT 2003 Strong public interest at this time led to development of a service agreement across agencies (which was flagged in 1998) Other problem generated: 'no support, no housing (gate keeping of public housing)

Tenants in one state level housing participation structure had initially identified the **‘problem’** of people with a psychiatric disability not being supported within communities (Interview 3). Housing Trust tenants, particularly in high density housing, were sometimes assisting people with a psychiatric disability by contacting services (police, housing trust) for them (Interview 3). Fear was associated with living close to people with a psychiatric disability, particularly for older tenants living on their own (Interview 3). These problems could be linked to what one carer called the ‘ghettoization’ of public housing, or the increasing targeting of public housing through the CSHA (Consumer Carer Focus Group).

The ‘problems’ of a ‘lack of support’ for people with psychiatric disability living in the community and shortage of ‘supported accommodation’ was subsumed by wider ‘disruptive tenants’ debates. Concerns about disruptive tenants were taken up by the media and a politician, which ultimately led to a **‘window of opportunity’** to examine problems through the Inquiry into the South Australian Housing Trust (Interviews 3, 15, 21, 27, Field Diary). The **‘politics’** surrounding this inquiry included public debates on disruptive tenants, associated with community stigma expressed through the media, in particular the talkback programme of one local radio personality (Interviews 15, 27, below). Media and political pressure combined with public opinion characterised the ‘community mood’ (a component of Kingdon's (2003) **‘political stream’**). The impact of the media upon the disruptive tenancy statistics (i.e. media resulting in more reporting) was noted in the inquiry (Parliament of South Australia 2003).

I think the biggest influences on the government and its policy is Leon Biner; it's the media, the media, the media, and then from the media, the public perception of what's going on. Like psychotropic, knife-stabbing schizophrenic; the media, the media, the media, the portrayal in the media....People ring the radio to have a bitch and away you go. And the politicians listen, that's all tracked apparently and documented.

Interview 27

There was a heavy focus on mental disorder in the Parliamentary Inquiry into the South Australian Housing Trust and assumption of the relationship between mental disorder and disruptive tenancies. Despite the fact that information had not initially been kept on the nature of disruptive tenants, one Psychiatrist believed that the ‘disruptive tenants’ problem had meant that deinstitutionalisation of people with a

mental illness had gone 'too far'

Prof. Goldney: I think that the issue of old-fashioned asylum should be considered an appropriate way to accommodate some people with severe mental disorders, rather than trying to accommodate everybody in the community. It seems that the pendulum of public opinions swings with this and it seems that the pendulum has swung too far towards community care and I think it will come back because of community pressure, just as there has been community pressure in the UK. That would mean in a sense having a new attitude towards asylum, recognising that some people need long-term care, and the optimum long-term care is in a good asylum or institution where there can be monitoring of problems.

(Parliament of South Australia 2003, p. 151)

In the absence of available indicators, the Inquiry appeared to support the view of this psychiatric expert, rather than a public servant's (in the housing '**policy stream**') explanation that disruptive tenants should not be equated with people with psychiatric disability. Later data collection by the state housing agency indicated that these people were not overrepresented amongst what were considered to be 'disruptive tenants' (Parliament of South Australia 2004). However, recommendations of the Inquiry were influenced by political acceptability of the psychiatric expert interpretation, consistent with Fischer's (2003) notion that evidence must be socially and politically acceptable to be taken on board. They were also influenced by *who* was representing problems and *how* problems were being represented in public debates (Bacchi 1999).

The Inquiry supported the view that the onus was on support agencies rather than the Housing Trust to support tenancies, whilst the Trust should have a greater role in eviction (Parliament of South Australia 2003). There was also a strong 'law and order' approach in the Inquiry exemplified by a '3 strikes and you're out' eviction recommendation (Briton 2003) (see below). This 'law and order' approach has been a noted priority of recent state government (Office of the Public Advocate South Australia 2005). However, one member from the Public Housing Customer Forum did not support the 'law and order' approach taken, but instead believed that early intervention strategies were necessary to address disruption (Parliament of South Australia 2003). The Inquiry also recommended that public housing is inappropriate for people with a psychiatric disability (Parliament of South Australia 2003), despite it being used for the existing successful supported housing projects/programme.

There were competing concepts of what ‘supported housing’ constituted (i.e. medically based care delivered through the mental health sector or the existing partnership based programme where tenants used public housing).

The Committee felt a three strikes approach to tenancy management would provide a clear enforcement framework for both the Trust and its tenants. A three strikes policy would work in a similar manner to that in force in a workplace. In particular, the Trust would have the power to issue warnings and impose sanctions and ultimately if breaches of the Conditions of Tenancy were not rectified, the Trust would be able to issue an enforceable notice of eviction. In extreme cases the Trust would be able to issue an eviction notice immediately.

(Parliament of South Australia 2003, p. 143)

There are so many people homeless now; you cannot be forcing people into a homeless situation. There has to be a better solution to this problem than just eviction because, at the end of the day, you get the revolving door syndrome and they come back to the Trust again.

(Parliament of South Australia 2003, p. 138)

A group of NGOs acted as ‘**policy entrepreneurs**’ by lobbying to resist policy change regarding the 'disruptive tenants' outcomes of the Inquiry. Such NGO activity appeared to counter problems that arose where certain voices were apparently ‘silent’ within policy debates and processes. Mental health consumer groups and representative NGOs had not been a part of the parliamentary inquiry or policy processes on disruptive tenants until drawn into processes by Shelter SA (Field Diary).

Shelter SA’s consultation for and ensuing submission regarding Difficult and Disruptive Tenants Policy (Shelter SA 2004) recognised that examples of 'serious disruption' could be symptoms of mental illness and responses to these may be based upon fear and a lack of understanding of mental illness. Lobbying by NGOs was influential in the development and final implementation of this policy (Field Diary, below). Ultimately, consultations regarding a new proposed 'Disruptive Behaviour Strategies' for housing trust tenants were being organised by Shelter SA in 2007 (Field Diary).

The policy was influenced and softened. Turns out the Trust Board had approved the really harsh version some months BEFORE the Inquiry's report was tabled, but did not intend to implement it until later.. When one group saw the differences between it and the Inquiry's recommendations, some of the organisations got together, and drafted up a "complaint" about it. Jay Weatherill

[Minister for Housing] heard about it and asked the group to come in for a meeting. As a result, the Trust had to soften their policy. The group had pointed out that a complete 12 month ban from ANY kind of help from the Trust would just disadvantage people further, and put them at risk of homelessness.

Field Diary

### **8.2.3 Mental Health Coalition of South Australia, Psychiatric Rehabilitation Support Services and Supported Accommodation**

Housing issues were raised in meetings of the MHCSA (Participant Observation notes), but were overshadowed by a focus on the new organisation's recognition and development as a peak body (Field Diary). The MHCSA was also largely advocating to their particular funding sector. Members had raised particular issues with housing within meetings however it was unclear if they had been taken up by the peak body, e.g. the closure of SRFs and NGOs advocating on behalf of mental health clients to prevent eviction from public housing (Field Diary). The MHCSA had attempted to invite housing policy staff to one meeting but they had been unable to attend and this invitation was delayed as the relevant government department was undertaking a process of restructuring (Field Diary). The MHCSA had raised the issue of the lack of integration across portfolios in letters to and meetings with Ministers (Participant Observation notes), and inadequate access to HACC funding and the CSTDA for people with psychiatric disabilities (MHCSA 2002). .

A combined SACOSS/Mental Health Coalition of SA consultation and submission to the Parliamentary Inquiry into Supported Accommodation was undertaken. However, the outcome of the Inquiry in terms of increased housing options was considered negligible (Interviews 5, 12, 19). Advocacy for supported accommodation in 2003 did not necessarily match up with the **'politics stream'** or 'community mood' (Kingdon's 2003 term). This was dominated by the public debates on disruptive tenants, and lobbying by SRFs (see Table 12).

**Table 12: Example of unsuccessful outcomes in lobbying using Kingdon's (2003) multiple streams framework: Supported Accommodation**

Problems	Few supported accommodation places for people with psychiatric disability
Politics	NGOs lobbying for supported accommodation NGOs through SACOSS/MHCA submission to the Parliamentary Inquiry into Supported Accommodation 2003 and SACOSS Mental Health Lobby Group Feb 2004 (media on 'Call to Action' campaign)  Disruptive tenants debates in public housing (expressed through the media) – but Parliamentary Inquiry into SAHT also recommended supported accommodation (not affiliated with public housing)  SRFs lobbying government (media reporting)
Policies	Funding focus on stand alone psychiatric institution  Slow follow-up to Mental Health Reform 2000-2005 and GHR 2002  SIU report recommended the development of supported accommodation  SRF strategies supported in housing
Policy entrepreneurs	SACOSS/MHCA organised wide consultation with a number of NGOs, consumers/carers and professionals. Professional associations were not involved in this. Mental Health Lobby Group organised through SACOSS lobbying for supported accommodation (ceased operating 2004)
Window of Opportunity	National Level Interest in mental health came following the dissolution of the Mental Health Lobby group and HREOC/MHCA 2004 consultations

NGOs in the mental health sector had been lobbying for some time for non-clinical psychiatric disability support services within the community with little success, including through the GHR (MHCSA 2002). Consultation processes for the GHR confirmed mental health as a priority issue (Generational Health Review 2002). Subsequently, two years after the GHR consultation, SACOSS formed an alliance of mental health NGOs and consumer groups to lobby for such services. The ensuing Mental Health Lobby Group (consisting of 22 organisations, both NGOs and smaller consumer/carer groups) prioritised supported accommodation in its advocacy platform. Shortly following the Mental Health Lobby Group's 'Call to Action' campaign, the MHCSA was recognised as the peak mental health NGO in South Australia. This enabled the state to finally take up its vacant seat on the Mental Health Council of Australia (the lobby group ceased as a result of this). One consumer representative saw this new situation resulting in the break-up of the policy network (Interview 13).

Whilst lobbying activity by the Mental Health Lobby Group appeared to result in the development of the MHCSA, success in lobbying for supported accommodation in 2003 were less evident. This was despite a number of different networks

simultaneously recommending supported accommodation in 2003 (in different ‘**politics**’ and ‘**policy streams**’), for example the Inquiry into the South Australian Housing Trust (Parliament of South Australia 2003) and SIU Homelessness Strategy (Social Inclusion Unit 2003). The separation of networks by sector, and different understandings of supported accommodation (by sector and ‘political or policy stream’) contributes to an understanding of this policy environment.

A failure to follow-up supported accommodation contrasted with the success of SRF lobbying which resulted in the Mental Health Unit's funding of \$57million for support services to SRFs in 2004 (Mental Health Unit 2005). The SRF sector had lobbied state government regarding support for people with a psychiatric disability and viability of the sector, through the local media (Quast 2003a; Quast 2003b). The main issue highlighted by SRFs were the lack of subsidies for boarding houses. Whilst the Ombudsman in South Australia was unsupportive of private proprietors receiving such subsidies (Quast 2003b), SRFs were made exempt from land tax in 2005 (Foley 2005; Government of South Australia 2005). Supported accommodation did not get the same public airing through the media as the 'disruptive tenants' debate or SRF closures, and did not have the political, media or public servant advocates which characterised these other debates. The stark difference in the success of private sector versus NGO lobbying was noted by a health sector professional (Interview 26, below). However, it was noteworthy that NGOs across sectors had also been involved in lobbying for SRFs and boarding houses (despite their ‘tertiary homelessness’ status) (see below)

The main flaw in that was the capacity and engagement of the NGO sector wasn't paid proper attention even though we talked about it, it was dominated by the SRFs. What they were saying is 'we are going to go under unless you give us money, we are going to kick all your clients out'. So it became a political thing. But nothing happened for a good 3 years in terms of growing the NGO sector.

Interview 26

Shelter SA recommends that more well-managed boarding houses be established in SA, including in certain areas in Regional SA, and that where possible such boarding houses be managed by non-profit organisations.

(Shelter SA June 2003, p. 73)

There's Supported Residential ... the SRFAC [Supported Residential Facilities Advisory Committee], so we're part of a few committees and councils that take on that lobbying work.

Advocacy Focus Group

### 8.2.4 Mental Health Reform Alliance and Social Rehabilitation Resources

Despite the Mental Health Coalition of SA's recognition as a peak mental health body in the state, another group known as the Mental Health Reform Alliance<sup>36</sup>[2nd], was established in 2004. This was comprised of generic NGOs and professional organizations (e.g. ANF, AMA). This group did not directly include the MHCSA as peak body (however parent body SACOSS was involved) or consumer and carer groups. However, the group was successful in playing a 'policy entrepreneur' role (see Table 13), which could partly be explained by its strong links to government and professional networks.

**Table 13: Example of successful lobbying using Kingdon's (2003) multiple streams framework: Social rehabilitation support services 2005**

Problems	Few non-clinical community based services
Politics	Lobbying for psychiatric disability support services. Mental Health Lobby Group Feb 2004 Mental Health Coalition of SA recognized as peak June 2004. Mental Health Reform Alliance [2nd] 2004
Policies	Funding focus on stand alone psychiatric institution. Mental Health Reform 2000-2005 not supported financially (Generational Health Review 2002 consultations)
Policy entrepreneurs	MHRA organised through ANF, involving SACOSS Mental Health Lobby Group organised through SACOSS
Window of Opportunity	2004 National Level Interest HREOC/MHCA 2004 consultations

The nursing profession was identified as one important component of the MHRA [2<sup>nd</sup>], with the ANF believed responsible for instigating the Alliance (Interview 11, 25, below). The profession had a strong link to the 'political stream' (Kingdon

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<sup>36</sup> Another 'Mental Health Reform Alliance' was developed prior to this network being established, but this did not involve professional organisations.

2003) in the form of the current state government; the previous leader of the local ANF was a member of government and former parliamentary leader of the Inquiry into Supported Accommodation, and current Minister overseeing mental health in 2006 (Field Diary). Government also appeared to have a role in promoting this initiative (Field Diary).

*[But do you think there were, I mean I know that the NGO was very new but do you think they were actually successful in getting the issue on the table in the first place?]* No...It's a shame really, they were very young and in the early stages...It wasn't them. It was everyone else. ANF Uniting Care, all the big church based, all the big philanthropic, they did all the work.

Interview 11

And the ANF became very seriously involved in mental health. And it's very interesting that they see themselves now as the key reformer, the ANF. *[Of mental health services?]* Like it was only late last year when they did all that stuff and got all this new money for mental health. I think the Mental Health Coalition I think it's called. *[The Mental Health Reform Alliance?]* That's ANF basically.

Interview 25

Public interest in the topic of mental health was boosted in 2004 by national level interest (part of the **'political stream'**); the follow-up to the Burdekin Inquiry (HREOC 1993), resulting in the *Not for Service* report (MHCA 2005). This shift in public interest combined with the political connections of the Mental Health Reform Alliance [2nd] and helped to explain the release of the social rehabilitation funds in 2005. Thus networks, events and connections in the **'political stream'** (Kingdon 2003) were all significant to agenda setting for the social rehabilitation resources.

As discussed in chapter 7, one respondent saw that the success in lobbying for these funds was at the expense of funding being provided for ongoing disability support (Interview 23). The 2005 policy focus on temporary 'social rehabilitation' funds (over disability support) can be explained by health professional dominance in policy networks (and linked medical discourse on disability Fulcher 1989) and the separation in **'policy streams'** (disability and health policy networks). The MHCSA, which had lobbied for psychiatric disability support, was not explicitly involved in the MHRA. Lobbying that occurred within the mental health sector for such resources did not appear to involve the mainstream disability sector, i.e. non mental

health NGOs or the government sector overseeing disability funds (CSTDA).

Following the release of social rehabilitation funds, a 'politics of implementation' (as described by Rein 1983) arose where NGOs lobbied to have a say in the administration of funded programmes they would be involved in delivering. This contrasted with community housing NGOs experience with affordable housing initiatives.

I think it's fair to say that on the large issues, like broad brush issues that we've lobbied on we can be successful, but when it comes down to the processes for getting things out and the process for developing new programmes we're not in there at all, and the structures that have been set up, like we participate in heaps of them, they don't get there at all either .... But, we could actually play a productive role in the Minister, the Department and us or against the Government trying to get more money for mental health. At that level we're able to work very closely with them

Advocacy Focus Group

These four examples illustrate that private providers and professional groups were more successful than NGOs in policy agenda setting, particularly when supported by events and connections in the political stream (Kingdon 2003). The way in which problems were generally being 'represented' and by whom (Bacchi 1999) was also crucial to understanding policy agendas within sectors (e.g. 'social rehabilitation' versus 'disability support'). Community debates on disruptive tenants (considered undeserving of resources) conflicted with efforts for lobbying on supported accommodation. Importantly, the private and one-off strategies which succeeded in policy agendas were in alignment with neo-liberal trends and strategies of government (e.g. affordable housing, public funding going to private SRFs, and temporary social rehabilitation funds including private initiatives such as GP shared care). Thus successful strategies could be considered to be politically acceptable, an important factor for furthering policy agendas (Fischer 2003).

## **8.3 Consumer and Carer Participation in mental health policy and services**

### **8.3.1 Changes in the 'political stream' affecting community participation**

Compared to NGOs, there was a greater focus in state level consumer and carer participation mechanisms on the structures and processes for participation. Consumer and carer representatives were concerned about being inadequately supported and educated to participate, having poor access to timely information, groups being 'facilitated' by external consultants (and the subsequent control of agendas), government expectations that groups would 'do' policy rather than be consulted, and the skills and attitudes of public servants toward participation (Interview 13, Consumer Carer Focus Group, Field Diary, Notes from Consumer Carer Participation Group).

Many potential opportunities for consumer contribution to mental health were also frustrated by the turnover of participation structures and processes, largely the result of a change of government, Ministers and senior bureaucrats changing, and various agendas or preferences for community participation (Interviews 11, 18, 27).

Processes for developing structures were time consuming and diverted attention from feedback on policy (e.g. consultation forums, processes for recruitment, discussing frameworks for participation and negotiating with bureaucrats and Ministers). One professional believed that consumers in one state level participation structure had contributed to this focus on structures and processes (Interview 1, below). However, at the time this occurred in the context of competition over participation strategies and resources. There was resistance to a peak NGOs' development (Interview 12, below) and a mental health government leader had tried to encourage a separate 'consumer and carer only' lobbying group separate to NGO processes (Field Diary). However, one consumer had also felt that consumer participation was not supported in mental health reform (Interview 13, below).

I kept on trying to shift the agenda so that we had, you know, areas on the agenda for discussing policy. And to some extent, the group was its own worst enemy because it got bogged down in the process and the structures.

The Mental Health Coalition as being kind of an idea that was even earlier probably, but had stumbled along for a long time, and there were all sorts of reasons. I mean, in my opinion, partly, certainly under X [senior mental health bureaucrat], she was antagonistic to the idea of a coalition....when she was around she, well, I can't say she worked against, but she certainly didn't support anything that would assist in the people that wanted, what became the Mental Health Coalition to form. She spent more of her energy, not more of her energies, but a lot of energy in a process of trying to get ...[The framework together]...the framework, and then out in the field, she put energy into getting, picking consumers to go on the steering group.

Interview 12

X [senior mental health bureaucrat] absolutely *demolished* any form of consumer and carer and participation, she regarded us as *fools*...so we were not involved in any way.

Interview 13

Ultimately, NGOs succeeded in the establishment of a peak mental health and consumer body (through a 'window of opportunity' brought about by new government and the GHR), whilst consumer participation structures and processes disbanded. In chapter 2, it was noted that trust was important to intersectoral relationships (Sako 1992; Crane & Warnes 2000; Walker 2000; van Eyk & Baum 2002). In the case study, trust was impaired by the instability of structures and processes for consumer participation, associated with the abandonment of plans which consumer and carer representatives had worked upon across time (Interview 13, 20, Consumer Carer Focus Group, below). Representatives had either withdrawn from participation processes following the turnover of groups, had not been 'elected' to new groups which used professional processes for recruitment (even when they wished to contribute), and/or were disillusioned with processes for participation. There was silence from professionals in the health sector regarding the effect of the instability of groups and the importance of trust and rapport building with consumer groups. Conversely, one public servant in the housing sector expressed concern about diminishing trust between government and community groups due to consultation without follow-up (Interview 3 below)

I think government and the HCA and the Mental Health Unit have lost consumers and carers goodwill.

Interview 13

this is my resignation and I said why I joined SACAG and why I wanted to be chair, well I didn't

particularly want to, but took it on, and I said that "My decision to join was on my strong support for the National Mental Health Plan," etcetera. And then I'd said "However, I regret to advise that recent events have led me to the conclusion that DHS lacks an appropriate level of philosophical and practical understanding of the process in achieving consumer and carer participation."

Consumer Carer Focus Group

So in a sense, a lot of the hard work you *do* do, you feel like it's tokenistic. You know, you feel that you're being used, and there's nothing wrong with being used, but there are what I would consider better respectful mechanisms that need to be put in place than what [there] were, and I think are.

Consumer Carer Focus Group

But if you're going to call people together and at the end of the day nothing is going to be achieved and you don't get any outcomes or any clear expectations, again you are just building up people's expectations. And we do that really, really well in the public service. We keep asking people and they keep telling us and we do nothing about it. And that just builds a level of mistrust. You know, "I told you this three years ago. But what have you done about it?"

Interview 3

### **8.3.2 Consumer and carer representation vs. accountability**

Associated with the turnover of state-level participation groups were consumer, carer, NGO and government claims that individuals or groups involved in these had not been representative. Co-option into political discourses was suggested by the immense focus on 'representativeness' of NGO versus consumer groups (a debate which NGOs and consumer and carer representatives engaged within). Prominent themes included the desirability of and capacity for NGOs to represent consumers, for carers to represent consumers (and vice versa), and for individual consumers to widely represent each other given the pursuit of personal interests (Field Diary, Consumer Carer Focus Group, Interviews 1, 13, Minutes of Consumer Carer Groups). Individuals who were involved in community participation mechanisms were accused of not representing the diversity of the community (Consumer Carer Focus Group, Minutes of Consumer Carer Groups). Carer representatives had played an important role in this debate, as some preferred to be represented by a NGO rather than other individuals (Consumer Carer Focus Group). Prominent consumer representatives who were not on one state-level consumer committee had been instrumental in making complaints about representation (Consumer Carer Focus

Group), whilst NGOs responded to the 'representation' argument when excluded from the development of a state consumer group (Field Diary).

Some professionals and carers in the health sector raised the problem of personal agendas being pursued through community participation (i.e. a personal 'health service user' perspective: Charles & DeMaio 1993). This provided a rationale for NGO groups over consumer led participation groups (Consumer Carer Focus Group). There were expectations (of some carer representatives, NGO groups and government) and examples of NGOs also providing actual representation in 'direct democratic' (Hill 2005) policy processes, rather than individual consumer or carer representatives (Field Diary). However, two consumers expressed concern with the peak mental health NGOs' involvement within participation processes due to its membership being limited to NGOs (Interview 13 below, Consumer Carer Focus Group)

Well it's all to do with process really, but the coalition can be represented by NGOs but it can't be represented in consumer matters because it's not been nominating or representing consumers, so it really can't represent consumers.

Interview 13

Being discouraged from one's 'personal agenda' was felt to be the norm by a mental health consumer in a housing participation structure, even though personal views may reflect community ones (Interview 20). A tension between managing the personal agendas of consumers and professional agendas was also noted, along with the recognition that personal issues were often widespread and potentially related to the public good (Interviews 3, 20 below).

Sometimes I get frustrated being a housing tenant on the regional board because we - it's not a place to air your personal points of view, and sometimes I think that can be, your personal point of view can be something that's a general issue. But it doesn't really work like that, so that is ok, but I like it because I feel like I'm giving some real information. Sometimes you are in the public system but you don't know the ins and outs sometimes, and even if you ask no ones going to tell you; and then from say Club 68<sup>37</sup> from point of view, being a consumer [support] I really prefer

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<sup>37</sup> Club 68 is a social support and recreational group for people with mental illness connected to one regional mental health service.

that because it's people with real issues, even if it's just daily issues.

Interview 20

The 'representation argument' was seen by one professional as being useful for government in order to discredit participation and consumer representatives' legitimate role in making governments and services accountability (Interview 1, below)

I think people use the representativeness argument to - in a not very fruitful way. You know, my view is that to have a consumer and carer perspective at the state level is really important. And, you know, the reality is one individual, it doesn't matter whether they've been elected by people, they are not representative.....And there's a difference between a representative and having a constituency that people generally use as a proper constituency. And that's about accountabilities, not about representativeness. So I think there's also a muddle up between people saying "I want someone to be accountable and I want them to be representative." Because you can actually be accountable without being representative, do you know what I mean?

Interview 1

The lack of 'representativeness' of politicians and senior bureaucrats was overlooked in debates about representation and accountabilities. The assumption of representative government and associated expectations for top-down form of 'political accountability' (Hill 2005) may be one explanation for this focus. The theory of representative bureaucracy

holds that the demographic composition of the bureaucracy should mirror the demographic composition of the general public. In this way, the preferences of a heterogeneous population will be represented in bureaucratic decision making.

(Ricucci & Saidel 1997, p. 423)

The 'unrepresentativeness' of the most senior bureaucratic leaders has been considered to be the most problematic aspect of representative democracy (Ricucci & Saidel 1997). Conversely, the election of politicians from minorities does appear to ensure substantive political representation for minority groups (Haider-Markel et al. 2000).

### **8.3.3 Professional accountability and consumer representation**

In chapter 3, the relationship between policy development and accountability mechanisms was discussed, with various forms of accountability outlined (Hill 2005)

Within this study dominant accountability mechanisms included political (accountability to elected politicians), direct democratic (accountability to the public), professional (accountability according to professional principles) and bureaucratic accountability (includes elements of political, hierarchical and professional accountability) (Hill 2005).

Professional accountability mechanisms were well established when compared to 'direct democratic' processes and community participation structures (Field Diary). Professional accountability strategies included a state-wide clinical senate (established as part of the Mental Health Reform) and a national accreditation process. Lipsky (1980) suggests that professional accountability should encompass client's perspectives on professional work. Mental health services aim to do this through accreditation processes. However, this study provided some support for Charles and DeMaio's (1993) observation that consumers can defer to professionals points of view, as some consumer consultants involved in accreditation processes had not conveyed central issues for consumers using services (Consumer Carer Advocacy Group, below). The way in which such consultants are representing others is worth considering given their susceptibility to co-option and requirements for professional accountability (Interview 1, below) and the power differentials between professionals and consumers. Additionally, rather than lay decision-making holding professionals to account (Charles & De Maio 1993), one consumer representative saw her role in terms of learning what was 'acceptable' within participation structures (Interview 20, below)

So there's a real seduction that goes on. And people that are not meaning to be underhanded by being nice and welcoming, but people then stop being so challenging. Because they're on a payroll, they have deliverables...they've got to do things. They don't want to put their bosses off side, so they're probably not as critical as they perhaps should be, or as challenging at they should be and they get comfortable. And it's my view that..and it ends up being one person who benefits, not the many.

Interview 1

And so when the summation came, we went along to see it to see what they had to say, you know, and all they were saying was how fantastic everything was in the west. And we went "What? What happened [consumer consultant]?" And he said "Oh, all those things that we talked about, they will be there."...And so we're waiting to see the report, but the overall things – everybody

was clapping themselves on the back saying “What a fabulous job we are doing.” And I said “Look, I think it’s fabulous that everyone needs a bit of encouragement and some things are really good that are happening, but surely there’s got to be acknowledgement of that sort thing? That there are gaps and some things aren’t working well,” you know?

Consumer Carer Focus Group

Oh, I was a team player and a good listener, and I was always learning exactly what I could do.

Interview 20

### **8.3.4 Bureaucratic and political accountability**

Consumer participation mechanisms located in the mental health bureaucracy operated within strong professional, bureaucratic and political forms of accountability (as described by Hill 2005). There was evidence for the political and bureaucratic control of state-level participation structures in mental health. For example, bureaucrats led processes and agendas for participation (Field Diary, Consumer Carer Focus Group, Interview 1). Ministers and bureaucrats were pushing for some participation structures and NGOs to become more accountable, meeting bureaucratic standards for reporting and financial accountability (Field Diary, Interview 13). The notion that bureaucratic compliance and subordination is essential to democratic, representative government (Kaufman, in Rein 1983) could explain why consumer groups located within the bureaucracy were faced with the expectation that they be accountable to government (Field Diary, Notes from Minutes of Consumer Carer Groups)

Palmer and Short (2000) argue that success in consumer participation should be equated with consumer representatives being chosen by and accountable to a constituency of consumers (Palmer & Short 2000). Within one consumer group, bureaucrats hand picked representatives, decisions were made by government rather than the consumer groups, and a public servant withheld information from other consumer representatives (Consumer Carer Focus Group, below). This situation conflicted with consumers’ independence and role in making government services accountable (Interview 1, Consumer Carer Focus Group), and consumers' own accountability to their constituencies.

No, because the people who made the decisions on SACAG were people on SACAG, not the department. So it [the Consumer Carer Steering Committee] was different in that respect.

Consumer Carer Focus Group

I would phone X. I said "I need to talk to you about the consumer and carer steering committee." He said "Can't talk to you," he said "You're not a member." I said "Well I'm a South Australian tax payer and we pay your wages and you've got to talk to me." No. He wouldn't talk to me. Secret stuff. Not on the committee so...

Consumer Carer Focus Group

Despite health reform initiatives aimed at increasing participation, professionals, NGOs and some consumer representatives suggested that the state government had not encouraged consumer participation or provided the necessary resources for participation structures (Interviews 1, 12, 13, Consumer Carer Focus Group, below). Despite this and other problems with consumer groups being located in bureaucracy (discussed above), one professional consultant felt that consumer group independence from government was not desirable due to the administrative support provided by government to groups (Interview 1, below).

And I don't know why it is, but in mental health, the consumers in particular, no so much the carers, but certainly the consumers and to some extent the carers, seem to want to move into this sort of independent state where they're in control of their own resources, they're in control of their own destiny. And that's a double-edged sword. Because once they remove themselves from that sort of bureaucratic, secretariat type support and want to run it themselves, it gets complex. And it's my view that it was somewhat to the undoing the state CAG. The notion of independence was very attractive in theory. In practice, I think, it was part of their downfall.

Interview 1

Finally, two interviewees emphasised state level party politics when explaining the lack of development in community participation strategies in South Australia (Interviews 12, 13 below). Government failure to ensure community participation in mental health at a broad policy level, despite the GHR (Interview 18, above) could be explained by fears about dissenting views on policy and services.<sup>38</sup>

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<sup>38</sup> However, the government had attempted to consult more widely on its latest strategic plan Manwaring, R. 2007, 'The 'new social democracy' and Labour government community engagement

I think you can characterise the Labor State Government as one which just tends to be the driver and sees participation as being at best an adjunct or maybe something that's a good idea, as long as it doesn't get in the way of people doing what they can do in managing. The State Labor Government is a risk adverse, relatively controlling organisation that is not comfortable with open dialogue, I don't think.

Interview 12

It's all quite political. I'm a member of the Labor Party but under Liberal consumer and carer participation was far better supported. We had regular communication with [Liberal Health Minister] Dean Brown, we had more responsibility...and under [Labor Health Minister] Lea Stevens we saw her once in a three year period.... I don't think, this government speaks under the Labor's principles and philosophy of fairness and equal say, but even under our [South Australian] Equal Opportunities Act, mental illness is excluded. I actually don't think this government supports consumer and carer input or participation. It's very disappointing actually because we had great hopes when Lea Stevens became Health Minister.

Interview 13

### **8.3.5 Carer involvement and perspectives in participation processes and professional accountability**

Some public servants believed that consumer and carer representative structures and NGOs in mental health were dominated by carers, and implied that carers had competing interests or needs separate to those being cared for (Interview 26, Field Diary). However, all carers in this study expressed their motivation for participation in terms of a desire to represent and see better services for their care recipient, especially where their disability may have limited their 'voice' (Consumer Carer Focus Group). However, another carer was aware of concerns which some carers had regarding one NGO promoting separate 'carer' interests rather than pursuing service options for their care-recipient

They say "Oh well, what X's doing is supporting carers. We want support for our sons and daughters. We don't care about us." Obviously we do, you know, but the main issue is the consumer. And so our issues are mostly consumer issues. You know?

Consumer and Carer Focus Group

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and consultation strategies: emerging findings from South Australia', *Australasian Political Science Association Annual Conference*, Monash University, Melbourne.

All carer representatives in this study expressed frustration with their level of input into mental health services and the progress of reform (Consumer Carer Focus Group). However, carers' influence within NGOs and upon the development of carer policy and legislation and mental health legislation was evident (chapter 5, Field Diary). The involvement or support of a carer NGO appeared crucial for the development of some initiatives (Field Diary).

Carers' concerns featured significantly in MHCSA submissions to government<sup>39</sup>, with a focus on recognition of the carer role in treatment settings and increased services for carers (SACOSS/MHCSA Inquiry into Supported Accommodation Submission 2003, MHCSA 2004). The MHCSA submission on mental health legislation argues the need for carers to be recognized and involved in care planning and the problems arising out of strict confidentiality criteria in treatment (MHCSA 2004). Carer representatives in this study had also advocated for care plans for their care-recipient in local services (Consumer Carer Focus Group). Carer participation in treatment services could not necessarily be linked to government imposing a 'moral imperative to care' (as suggested by Henderson 2005). Carers were strongly advocating for involvement in care plans due to their interest in optimum treatment and to ensure that any children of patients were being appropriately cared for (Consumer Carer Focus Group, below).

Carers also advocated regarding privacy and confidentiality practices. These had the potential to reduce professional accountability as it affected carers' access to information, treatment partnerships or guardianship arrangements (Consumer Carer Focus Group below, Field Diary). Adherence to privacy legislation and confidentiality practices not only affected carers but was also cited seen as impacting upon the proper care of patients (Interviews 17, 21, Consumer Carer Focus Group). Such practices (and lack of agreements for information sharing) were seen as both a right of people with psychiatric disability and as something working against their interests. A common sense approach to privacy and confidentiality had been advocated by mental health service leaders (Interview 17, Consumer Carer focus

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<sup>39</sup> The Chair of the MHCSA Board is Executive Officer of the Carers Association of South Australia

Group). A working group has previously been established to provide guidelines on confidentiality and privacy in South Australia, however documents produced by this group have not been released (Office of the Public Advocate South Australia 2005).

I've had a lot of people who've come before the Guardianship Board and if the question – if you dare to raise the question, you know, is their family involved here? “Oh no. It he doesn't want to know about it. He doesn't want the family to know anything about stuff.” You know? And you've read in the notes at other places where the family are really concerned and really want to know information and you can tell they've been excluded...So they've still – that still is it. But now after today, we've now got a policy. A care and involvement policy.

...I was going to say, you know, you've got 'what barriers were there to influence from our perspective?', our comment, privacy and confidentiality is the biggest silly barrier that there is.

...And that's what we're advocating for. If, you know, a parent is hospitalised and they're not asked “Have you got children?” Maybe they were hospitalised during school hours. For goodness sake, the kids might be at home. Where's the common sense there? Why should, you know, if the parent is unwell or can't communicate, you know, that kind of information may need to come from a carer.

Consumer Carer Focus Group

Housing issues such as carers' role in providing or accessing housing, the effect of people with disabilities being discriminated against in housing and legislating for access to housing and housing support were issues not taken up by NGOs. Lobbying by carers on housing appeared to be limited to the Inquiry into Supported Accommodation in 2003 (Parliament of South Australia Social Development Committee 2003). The extent to which housing was taken up as an issue could partly be explained by the extent to which individual carer representatives involved in NGOs personally experienced problems with housing (chapter 6).

## **8.4 Conclusion**

This chapter explored the relative influence of NGOs and community groups within policy processes or when lobbying for or resisting policy change on housing and support issues. There was very little evidence for groups' influence upon housing and support resources or ameliorating housing instability. The dominance of professionals and industry groups within policy networks within the health sector

was apparent. Non-government organisations and service user groups in the mental health sector were largely excluded from policy networks. Conversely, NGOs in the housing sector were more integrated within housing policy networks (which excluded tenants groups) and implementation processes.

There was a considerable focus upon the establishment of processes for ‘consumer’ participation in mental health across the 2000-2005 period, and state-level community groups located within bureaucracy were deflected from contributing to policy content and ultimately disbanded. The dissolution of such groups appeared to be surrounded by debates regarding their representation and accountability. These discussions appeared to overlook the community’s role in ensuring the accountability of government. Conversely, state-level consumer groups operated within strong political, bureaucratic and professional accountability mechanisms as described by Hill (2005). Additionally, the co-option of consumers employed by mental health services, in addition to privacy and confidentiality practices, could actually diminish professional accountability.

Following broader neo-liberal trends, processes for ‘consumer participation’ were contracted out to an NGO (leading to government control of participation processes involving NGOs). Non-government organisations (established for mental health NGO and consumer representation) were new and focused upon becoming established. Their nascence could help to explain their exclusion from policy networks.

Compared with the mental health sector, NGOs and service user participation processes were more developed within the housing sector. This could be partly attributed to the different culture and values of sectors when it came to community participation and the political context of mental health policy. However, there was little specific advocacy or representation when it came to housing for people with a psychiatric disability. Although some community housing NGOs were influential in influencing affordable housing strategies, they did not specifically link this issue with problems facing people with psychiatric disability.

Non-government organisations were not limited to ‘within sector’ concerns, however lobbying largely occurred ‘within sectors’ (largely related to service provision).

There was little representation of people with a psychiatric disability in ‘other sectors’ such as housing and disability (partly due to the nascence of mental health groups). Success in lobbying could be affected by broad public debates and *how* problems were being ‘represented’ (Bacchi 199) in the ‘political stream’ (Kingdon 2003), i.e. lobbying on ‘supported accommodation’ coincided with public debates flagging concerns regarding people with psychiatric disability being ‘disruptive tenants’ Additionally, neo-liberal discourses, including ‘consumerist’ discourses on participation, appeared to affect what was being lobbied for or what issues ‘health consumers’ contributed to.

Non-government organisations across sectors were increasingly subject to political and bureaucratic accountability, as neo-liberal trends and contracting processes affected NGOs role in service provision (and the nature of service provision due to performance measures). NGOs role in service provision created tensions for their advocacy role, influencing the way lobbying occurred and what was being advocated for. Smaller NGOs were excluded from policy networks, which larger NGOs may have had access to. Analysis of these results is continued in the following conclusion.

## 9 Conclusion

Recognition of consumers in the theme "Count me in" is excellent. However we are in danger of looking at the micro level of service delivery and not directing our attention to the larger picture of public policy towards the mentally ill.

(Justice Action Australia 2007)

The first part of this chapter summarises and brings together the research findings from the previous four chapters and discusses these in relation to the research aims and questions and policy theory. The findings are then broadly considered in terms of previous research and theory and generalisability. The implications of this research for theorizing about policy agenda setting and policy change are discussed. Scope for future research is also explored, and recommendations for policy change are made

### 9.1 Summary of findings

#### 9.1.1 Intersectoral collaboration questions

The research went beyond local level and project based partnerships to consider opportunities and obstacles in the development of state and national policy shaping housing options. It particularly took this level of analysis because of the problems which people with psychiatric disability faced in accessing and maintaining housing following deinstitutionalisation (Sach & Associates 1991; HREOC 1993). Although prior research indicated that intersectoral collaboration is crucial for the housing stability of people with mental illness (O'Brien et al 2002), intersectoral collaboration had been considered to be one of the most difficult aspects of the National Mental Health Reform (Steering committee for the evaluation of the second national mental health plan 2003). It was partly for these reasons that the research considered the questions: *To what extent have inter-sectoral links between mental health services and the housing sector been developed through the implementation plan of the South Australian Mental Health Reform 2000-2005?* and, *To what extent have these links been effective in improving housing options for people with a*

*psychiatric disability?*

The study indicated a lack of strategic policy coordination between the health and housing sectors and a number of barriers to coordination activity. Respondents also reported a shortage of accommodation and support services for people with psychiatric disability as a major housing problem (chapter 6, Appendix 18). This situation was explained in terms of the following main issues in the policy environment;

- The broad neo-liberal policy context related to a decline in public housing resources through the CSHA and focus on private and NGO services. State housing strategies were consistent with wider neo-liberal policy trends and focused upon primary homelessness and supporting the private sector, including private rental, Supported Residential Facilities and boarding houses.
- The political context, where community and government stigma reflected in the media was seen to affect resourcing for services and programmes for people with a psychiatric disability. The political context also saw the quick development of specific housing projects as a result of political decisions, which contrasted with the planned development of strategies through the SIU and government reform processes.
- Disparate policy networks across sectors and levels of government (tied to commonwealth-state agreements), with some examples of regional level service networks unconnected to policy initiatives.
- The mental health sector was generally tied to a dominant bio-medical view of health and disability and often overlooked social determinants such as housing and disability/social support. Conversely, the housing and disability sectors had not prioritised housing and support for people with a psychiatric disability despite national policy contexts.
- Contributing to the separation of policy and service networks was reform within sectors associated with a recent change in government, however there had been ongoing reform within the mental health sector, highlighting the political nature of this sector. .

This study suggested that a multi-dimensional approach to intersectoral collaboration needs to be considered which takes into account a number of factors including national-state policies and programmes (funded departments and programme guidelines) and politics across levels of governments. These factors contributed to issues arising at a state level (e.g. the perceived responsibilities of public servants and their lack of commitment to collaboration) and within regional services. State governance arrangements and reform processes also impacted upon collaboration efforts. At a regional service delivery level, the existence of collaborative networks, leadership and professional/service cultures were factors important to consider in the implementation of cross-sectoral projects/programmes (chapter 7).

The national and state policy, departmental and resources context were primary factors enabling or inhibiting collaboration. Disparate national-state policy and agreements on housing, homelessness, mental health and disability contributed to the separation of policy networks by programme and department. To use Sabatier and Jenkins-Smith's (1999) language, the health and housing (and disability) sectors in this study could be considered separate 'policy subsystems'. As discussed in chapter 3, policy areas' status as a 'policy subsystem' is dependent upon their level of legal autonomy and integration (Sabatier and Jenkins-Smith 1999). In this study, bureaucratic and NGO interests were tied to commonwealth-state funded programmes and guidelines and administrative arrangements by sector. These separate networks and interests could help to explain why mental health is sometimes not seen as the responsibility of 'other sectors'. It could also help to explain the perception that CSTDA resources overseen by the disability sector had to be 'advocated for' by the (mental health) department in order to meet the needs of people with a psychiatric disability within South Australia. Additionally, it could contribute to an understanding of why the SIU found it difficult to pull these separate sectors and interests together.

Policy change and reform within sectors, tied to changes in government and governance, was sometimes unproductive for cross-sectoral collaboration and housing outcomes. There has previously been an understanding of the political impetus for health governance reform, and criticism of a lack of focus on 'health

outcomes' in reform (Dwyer 2004). The instability brought about by ongoing reform in the mental health sector (and turnover of key government personnel) had a negative impact upon the implementation of NMHS goals on both intersectoral collaboration and community participation.

Where intersectoral projects had been instigated as a result of integration at a policy/departmental level, the study suggested that developing the skill of leaders in negotiation, collaboration and developing stakeholder trust within sectors is important for policy/project implementation, however is not necessarily consistent with the clinician specialist's 'doer' role (Callan 1995). Where there was evidence for successful service level integration (e.g. through local networks and projects), collaboration was supported by processes and skills (e.g. negotiation skills and networks) (as identified in other studies, e.g. Walker 2000). Supported accommodation projects required the support of clinical leaders and commitment of local level partners for their successful implementation, which was more likely where partners were involved in pre-existing networks. The study suggests the importance of policy makers utilising existing regional alliances to support the introduction of larger policy initiatives and engender the support of clinical leaders. Problems that sometimes occurred across collaborative projects were related to expectations for medical authority, a lack of respect for and (mis)trust of non-clinical expertise, and paternalistic concerns about the vulnerability of people with psychiatric disability. Establishing the delineation between and awareness and respect for the expertise of different professional roles was important at a service delivery level.

### **9.1.2 Housing for people with psychiatric disability on policy agendas**

One sub-question of this thesis was: *Is there evidence of the issue of providing adequate housing for people with a psychiatric disability making it to the policy agenda in the mental health sector?* Kingdon's (2003) argument that policy fragmentation lessens the chances of policy agenda setting was presented in chapter 3. In this study, the lack of strategic integration of policy networks across sectors (including across NGO) could help to explain lack of progress in developing policy and advocacy for cross-sector resources. The findings indicated a number of small

projects for housing people with a psychiatric disability rather than strategic policy responses. The state-level DHS had provided the integrated structure which enabled combined resources for supported accommodation projects. However, housing for people with a psychiatric disability was not strategically developed beyond these demonstration projects<sup>40</sup>, and the department itself disbanded. Another problem regarding agenda setting were the perceptions about who was responsible for housing this group (issues tied to national agreements as discussed above, as well as discourses on public housing). Despite the CSHA targeting those most in need from 1998/99, there were different discourses across sectors regarding who public housing was for (i.e. low income or people with disabilities).

In the last year of the Mental Health Reform (2005), there were a number of initiatives within sectors which had not involved the ‘other’ sector in their development to any significant degree. This situation could be partly attributed to factors such as the national policy/bilateral agreement context, the split of the local DHS into separate health and housing departments, and lack of integrated planned policy level responses. Housing did not reach the policy agenda of mental health until after the 2000-2005 period, through the activities of the Department of Premier and Cabinet’s Social Inclusion Unit (SIU).

### **9.1.3 Community empowerment as determined by influence upon policy processes and outcomes**

The third main question for this thesis related to the influence of community groups upon policy: *To what extent have community participation mechanisms contributed to the development of policy or programmes on housing provision for people with a psychiatric disability?* Associated with this main question was the sub-question: *How have community participation mechanisms been able to influence the mental health reform process and the development of housing initiatives for people with a psychiatric disability?* The study found that the undeveloped NGO mental health sector in SA across 2000-2005, and the dominance of a bio-medical view of health<sup>41</sup>

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<sup>40</sup> although the projects were later called a ‘programme’.

<sup>41</sup> This ‘medical approach’ is increasingly incorporating cognitive-behavioural approaches through

and interests in the health sector as a whole, contributed to housing for people with psychiatric disability not being on the mental health policy agenda. The slow development of peak NGO and consumer organisations and alliances in mental health helped to perpetuate dominant interests within local policy networks and hindered community participation in policy implementation or advocacy activity. Where consumer groups existed within bureaucracy they made little contribution to policy development, and their stability was affected by changes in government. These consumer groups could be considered to be an ‘end’ in themselves, and not a ‘means’ to empowerment.

The lack of psychiatric disability support funds being allocated to psychiatric disability (following the introduction of the CSTDA) appeared to suggest a ‘hierarchy of disability’ where other non psychiatric disability groups were seen as more deserving of resources within the disability sector (Borsay, in Fulcher 1989). It also suggested that psychiatric disability consumer groups and NGOs did not have an ‘enunciative position’ within the disability sector, at least at the time the CSTDA was being introduced. However, problems in ensuring the distribution of these resources could also be tied to other factors, including 1) the way in which the CSTDA funds were tied to the disability sector, 2) the notion that funds had to be ‘advocated for’ within bureaucracy, 3) a ‘medical discourse’ operating in the mental health sector such that non-clinical resources were not prioritised within policy, and 4) lack of robust mental health NGO sector when funds were introduced.

Consistent with neo-liberal policy trends (discussed in chapter 5), mental health and housing NGOs not only accepted, but actively pursued a greater role in service provision and lobbied or interacted with a funding sector for sector-specific services. NGO participation in policy processes could be seen as a ‘means’ to advocate and develop resources within a sector. The study also found that greater focus upon NGOs as service providers leads to increasing tension between the NGO service provider and advocacy roles. NGO’s role in service provision led to their accountabilities tied to a funding sector and NGOs felt that they were limited in their

advocacy by their government contracts. This finding supported Muetzelfeldt's (1999) argument that contracting is one method that governments use to control policy.

Additionally, the political environment, both at a state and federal level, was seen to discourage community participation and advocacy.<sup>42</sup> This could lead to a situation where larger NGOs had closer connections to government (through service provision contracts) and were likely to use networks for influence established through service provision, (which smaller NGOs had less access to) rather than other lobbying strategies.

In chapter 3, it was proposed that changes within bureaucracy would differentially impact 'policy subsystems'. In this study, changes in government, linked to reform processes and changes in governance arrangements within each sector, contributed to the separation of NGO and consumer groups within the health sector, and led to network fragmentation across sectors. The breakdown of the DHS affected cross-sectoral projects initially developed under this integrated structure, however the change in government and subsequent reform processes particularly affected the development of NGO and consumer participation mechanisms in mental health (in both positive and negative ways).

#### **9.1.4 Discourses within community participation groups and processes**

The research sub-question pertaining to community participation was: *What evidence is there for various discourses operating and being negotiated in community participation mechanisms?* The research set out to consider the extent to which consumer/carer participation mechanisms were challenging consumerist discourses on participation (Beresford 2002) and medical discourses on health and disability (Fulcher 1989; Baum 2003; Lewis 2005). The mental health policy context was

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<sup>42</sup> However, at a federal level, so called 'gag clauses' (where the previous federal government reserved the right to censor the public statements of organisations) have recently been lifted by the new federal government

Franklin, M. 2008, *Labor to lift gag on critics*, The Australian: 1-2..

commensurate with both a medical discourse on health and disability when it came to strategies for 'consumers and carers', and consumerist (as opposed to citizen) perspectives on participation. There was little mention from the respondents in my study of the connection of people with psychiatric disabilities and their carers to emancipatory social movements or 'other sector' participation structures. There were also few opportunities for the 'democratisation of discourse' (Fischer's 2003 term), or mental health service users expressing their concerns in policy debates and critiquing their social reality. The research highlighted the connection between the consumerist approaches to participation within mental health which delimited what participants were contributing to, the lack of intersectoral collaboration in policy networks, and the failure of housing for people with psychiatric disability to reach the policy agenda.

Consumerist philosophies of participation and medical discourses often limited individuals' participation and rights to health sector planning and treatment services, or developing legislation where rights were narrowly defined. The focus for consumer/carer participation was often the operational policies and services in mental health rather than policy development (e.g. emergency demand policies or local services). The use of individual consumer and carer representatives within bureaucratic participation structures and policy processes, without support or unconnected to NGOs, confirmed the consumerist approach taken. This situation contributed to professionals controlling agendas, the likelihood of 'personal agendas' arising and accusations of consumer representatives being 'unrepresentative'. At a state level, there was also 'consultation' over policy and legislation through NGOs, which Arnstein (1969) refers to as 'tokenistic' participation. NGOs, consumers and carers were often not critical of dominant 'consumerist' discourses, and strategies to promote community development and health activism using a social determinants approach were undeveloped.

NGOs in health have also contributed to 'consumerist' perspectives by focusing upon people's role as health service users, rather than the general experience of people with psychiatric disability as a population group. NGOs across sectors often challenged 'within sector' solutions tied to a strictly medical discourse on disability (Fulcher 1989), such as a narrow focus on clinical mental health services. Some

NGO groups were advocating to the health sector bureaucracy or health policy networks (e.g. GHR) regarding the need for housing/disability support services. However, there were no identifiable state level bodies specifically representing and advocating for the interests of people with psychiatric disabilities as a population group on social determinants of health such as housing, except for the transitory and now disbanded Mental Health Lobby Group established by SACOSS, and the Mental Health Reform Alliance, dominated by professional groups (discussed below). However, housing has recently been taken up as an issue by the state's peak mental health body, the Mental Health Coalition of South Australia, and by the Carers Association of South Australia

In chapter 3, the notion that powerful policy networks were involved in policy agenda setting was introduced, and NGOs and consumer groups' role within larger policy networks were considered in this study. There was little evidence for mental health service user's involvement within policy networks and debates. However, chapter 8 discussed one NGO's role within the Mental Health Reform Alliance, largely a professionally based advocacy network, where it appeared that medical discourses on housing solutions were dominant, leading to many preferences for clinically based interventions and 'separate' mental health sector housing solutions. Conversely, consumers, carers and mental health NGO representatives in this study asserted the need for ongoing, flexible and non-clinical support options and (along with professionals) noted the isolation that many people experienced within existing public housing.

This leads to the point made by Bacchi (1999) regarding the impact of 'voices and silences' in policy debates. The lack of involvement of service users and carers and representative NGOs within policy debates and networks in the mental health and housing sector contributed to certain issues being initially overlooked, such as affordable housing strategies specifically taking into account people with psychiatric disability. A lack of mental health representation may have contributed to the connection being made between disruptive tenants and people with a mental illness in the Inquiry into the South Australian Housing Trust, as there was no obvious resistance to such connections being made.

### **9.1.5 The impact of carers upon housing issues for people with a psychiatric disability**

Another research sub-question was *To what extent are carers' views incorporated in community participation and advocacy efforts for housing provision for people with a psychiatric disability?* Carers were well represented amongst the state level consumer/carer groups and NGOs, and there was evidence that 'carer issues' were progressed over the time of the case study. However, a silence about carers' role within housing was evident, particularly within state housing policy and processes. This may partly relate to the extent to which housing is an issue prioritised by NGOs. There were mixed opinions expressed by consumer/carer representatives' regarding the extent to which housing was an urgent matter for individuals, despite it generally being considered an important matter to be addressed (and personal examples of homelessness or purchasing homes on behalf of care-recipients).

### **9.1.6 Professional and bureaucratic control over participation**

The final research sub-question pertaining to community participation asked: *Is there evidence of professionals controlling the agenda of community participation mechanisms and bureaucratic processes for participation making genuine participation difficult?* There was little explicit evidence for mental health NGOs' involvement in policy planning processes, and there were complaints from mental health NGOs about the lack of transparency for contracting and tendering processes. This suggested a 'hierarchical model' operating between mental health bureaucracy and NGOs.

There was more evidence for planning and partnerships between government and NGOs in the housing sector, particularly when it came to affordable housing and larger community housing NGOs. However, even when there were planned negotiations over contracts these were sometimes considered unequal rather than 'empowering'. In particular, community housing NGOs felt disempowered where the particular needs of population groups were overlooked within contracts for service provision, which they attributed to a bureaucratic imperative for consistency (Rein 1983). The fact that such individual needs were overlooked did not support the argument that there is now a 'new contractualism' operating, where individuals' needs in programmes and services are addressed (Yeatman 1998).

For much of the 2000-2005 period there was a great focus upon methods for 'consumer participation' processes, and the turnover of consumer groups within government, linked to changes in government. Both government and consumer groups had a disproportionate focus on the 'processes' for selecting individuals and establishing groups, and the 'representativeness' of consumer participation, rather than the content of policy and issues such as housing. In alignment with a 'consumerist' discourse, individual consumers were often 'hand-picked' by professionals and unsupported by constituencies or NGOs, or not attempting to be representative. Mental health groups and individuals located within or associated with the bureaucracy were subject to dominant (particularly, professional, political and bureaucratic) accountability mechanisms, over direct democratic accountability (as described by Hill 2005). State-level consumer groups in mental health were also deflected from contributing to the 'content' of policy (e.g. through changing Terms of Reference), leading to a situation where the community participation could only be described as 'placation' (Arnstein 1969).

Former consumer/carer representatives within the mental health bureaucracy did not want to 'do' policy, but rather expressed a desire for what Lister (1997) might call the 'resources' for citizenship. These included educational resources, support for contributing to policy, and financial support to attend meetings (particularly if living in country areas). This support was also important in order to prevent elitism within community participation (and only NGO experts contributing to policy). Such support was lacking which made it difficult for representatives to fulfil 'political' and 'bureaucratic' accountability expectations e.g. providing regular reports to government.

When consumer groups in bureaucracy were disbanded and peak 'consumer' and 'mental health' NGOs were finally established, tension arose between NGO (professional) and individual consumer 'representation'. In some cases, a peak mental health NGO was not seen to be providing support for service users' representation and input into policy and plans, and the organisation itself had a conflicting mission to 'represent and promote the interests of NGOs' and the objective of 'advocate for people with a mental illness'. These tensions are discussed further below.

Overall, the situation when it came to community participation processes could be described as a form of ‘non-decision making’, where power is exercised through the shaping of values (in this case ‘consumerist values), preventing grievances from arising (Lukes 1974). Power was also reflected by forms of ‘non-decision making’ where items did not get onto the agenda (Bachrach & Baratz 1962), or were not implemented (Delaney 1994).

### **9.1.7 Governments’ role in terms of preventing stigma and discrimination**

Finally, this thesis set out to consider the extent to which the state was acting on behalf of mental health consumers and families, or responding or contributing to discrimination and stigma. SANE has previously suggested that institutionalised community stigma can not be overlooked in explaining (Australian) government failure to address service gaps for people with psychiatric disability (SANE 2004). Whilst there was a national anti-stigma programme during the course of this study (e.g. *Beyond Blue*<sup>43</sup>), the many state and federal government reviews on mental health (particularly parliamentary inquiries from 2003-2006) suggested gaps in services for people with a *psychiatric disability*. At the state level, mental health was considered by participants within this study to have had a low priority within health bureaucracy (across 2000-2005). The state government had not readily provided support or resources for mental health NGOs or alliances between government and mental health advocacy groups which are important for mental health reform (Funk et al. 2005). NGOs had lobbied for some time for funding and the establishment of a peak mental health NGO and in order to fill the state’s vacant place on the Mental Health Council of Australia. South Australian legislation did not include ‘mental illness’ or psychiatric disability as a basis for discrimination in its equal opportunity legislation. A Senate Select committee on mental health conducted consultations in Adelaide in February 2006, which led to commentary by the former state Director of Mental Health on SA’s ‘unbalanced’ mental health system making it to the media

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<sup>43</sup> The federal government supports ‘Beyond Blue, The National Depression Initiative’ a bi-partisan programme supported by national and state governments which aims to promote awareness about and reduce the stigma associated with depression.

(Anderson 2006).

Overall, during the 2000-2005 period, the national and state government did not appear to be acting on behalf of people with a psychiatric disability and carers when it came to co-ordinated housing and support to address the needs of people with psychiatric disability, despite a number of small projects or initiatives. After the period of interest to this study, the federal government COAG funds focused upon mental health, however, housing was an area which was largely overlooked and declared a responsibility for states (Karvelas & Cresswell 2006; Kong 2008), despite the CSHA being the main source of funding for housing. Despite the GHR prioritising mental health as an issue, it was not until 2005 that state election pledges led to the social rehabilitation funds and the Premier's pledge to tackle mental health through the Social Inclusion Unit (SIU). Through the latter initiative, supported housing projects were funded through the mental health sector (discussed further below). A Ministry for Mental Health and Substance Abuse was established by the government in November 2005 and by March 2006, the mental health system was clearly an election issue and topic of public debate (ABC 2006).

## **9.2 Generalisability and consistency with previous theory and literature**

### **9.2.1 Findings consistent with previous research**

This research supported the findings from O'Brien et al (2002) which emphasised the role of support (including social support and community engagement) in housing stability, and the desirability of houses being close to community facilities. O'Brien's et al. (2002) study found that half of respondents interviewed rated informal support as significant forms of support in accessing housing and staying housed. This study also identified carers assisting people to access housing (including the purchase of homes and living with relatives) and providing support.

The costs of housing, identified as a risk to housing stability in O'Brien's (2002) study, was also identified as an important problem in this study. Like O'Brien's et al. (2002) study, risks to housing stability identified also included the reactions of

neighbours. Within this study, housing workers emphasised the importance of proactive communications between professionals and neighbours and families for either preventing problems arising or ensuring appropriate care (including for any children or pets) when people are hospitalised. The O'Brien (et al 2002) study placed less emphasis on the importance of these informal connections.

### **9.2.2 Findings consistent with policy theory**

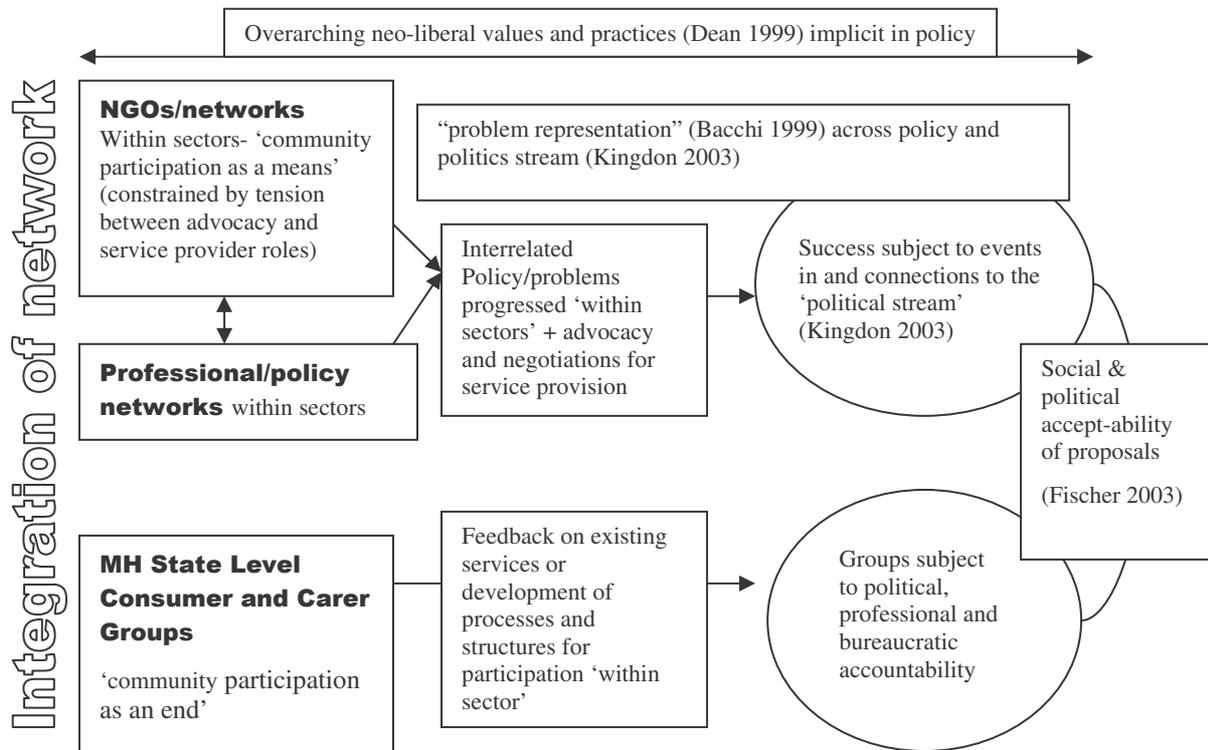
This study built upon the O'Brien (et al 2002) study which emphasised the importance of and need for additional housing and support resources. It did this by considering the barriers to developing such resources at a policy level, and utilising policy agenda setting theory to understand these barriers.

The findings from this study on privatisation trends across sectors, NGOs greater role in service provision, and consumerist discourses on participation fit with previous theorising on neo-liberalism and new forms of governmentality (Dean 1999).

However, in alignment with various theories on policy networks (e.g. Sabatier & Jenkins-Smith 1999; Kingdon 2003; Lewis 2003), this study also recognised the capacity for unified policy networks to influence policy. Additionally, it appeared that what was being advocated for was influenced by broader neo-liberal discourses and values.

Kingdon (2003) alludes to the relationship between the integration of policy networks, the success of policy proposals and 'community mood' (part of his 'political stream'). The importance of this constellation of factors to policy was also supported by this case study. What successfully reached political agendas not only depended upon the advocacy and integration of policy networks, and the ideas put forth, but also the political interest in issues. Factors such as community stigma were influential to public debates in housing, and shaped political commitment to this policy area. Theorising about the role of stigma in mental health (e.g. Goffman 1963) and the existence of a 'hierarchy of disability' (Borsay, in Fulcher 1989) was entirely consistent with this study's findings regarding stigma in public housing debates and the low priority of psychiatric disability within the disability sector (where deinstitutionalisation of people with intellectual disabilities has occurred more rapidly). Diagram 6 (below) compares the relative influence of NGO and consumer groups in the policy environment.

**Diagram 6: Comparing NGO and state level Consumer Groups' influence on policy**



Study findings also corresponded with previous policy research which has noted the links between ideas, networks and power in the health sector (Lewis 2005). The importance of ‘problem representation’ (Bacchi 1999) to policy agenda setting was suggested where policy networks ‘within sectors’ favoured particular views of problems and needs, or advocated for more of the types of services they often already provided or wished to provide (in alignment with neo-liberal trends). The way in which in which problems related to housing and linked support were 'problematized', and by whom (Bacchi 1999), were factors important to understanding policy agenda setting and what was funded. For example, a bio-medical view of health in the health sector traditionally favoured ‘temporary’ solutions where clinicians played a central role in service provision. When political commitment to supported housing was recently made, health professional dominance in policy networks favoured ‘mental health’ sector interventions. Latterly ‘psychiatric disability rehabilitation’ and ‘supported accommodation’ (overseen by clinical services) have been successfully advocated for (over ongoing disability support and ongoing housing linked to such support). These strategies do not essentially conflict with health professionals’

central role in service delivery, and assumptions about the turnover of clients with ongoing psychiatric disability identified within this study.

### **9.2.3 Findings in the thesis that did not fit with available literature or theory**

#### **9.2.3.1 Housing studies and rights discourses on disability**

In alignment with other studies (Thomas & McCormack 1999; O'Brien et al. 2002, Arthurson et al. 2007), the findings highlighted the importance of taking into account the particular desires of consumer representatives being housed, and the need for consumer choices in housing. However, previous (housing) studies have sometimes claimed general consumer preferences for independent living, away from other people with psychiatric disability (Reynolds et. al. 2002, Arthurson et. al. 2007). The distinction should be made between congregate living (separate homes on one site which allow for privacy) and shared living in boarding homes and residential facilities (where there may be a separate room with common facilities). The main problem appears to be living in a group setting with other residents without privacy (Horn, Juriansz, Mulvaney, Owen et al, Lambert et al, in O'Brien et al 2002).

In this study, some public servants across sectors suggested that 'disability specific', congregate housing solutions (where people with psychiatric disability are one site) were unnecessary or undesirable, particularly as they were vulnerable to stigma. However, some consumer representatives in the case study had successfully lobbied for a congregate living model (separate homes on one site), where bureaucrats had expressed a preference for independent homes. Additionally, one supported housing model evaluated in SA which involves independent public housing (and linked services) concluded that an exclusive focus on independent housing is 'too restrictive' due to issues of social isolation and loneliness (Health Outcomes International 2002). This study suggested that due to the experience of social isolation, the ideology of 'independence' (consistent with a rights discourse on disability: Fulcher 1989) in housing for people with psychiatric disability should be met with caution. Future housing strategies for people with a psychiatric disability would ideally be part of service frameworks which consider vocational and recreational options and the community networks of residents.

### **9.2.3.2 Findings divergent from previous policy agenda setting theory**

Overall, when it came to policy agenda setting theory, this thesis suggested that elements from a range of policy theorists could help to explain the policy environment (diagram 6). During the case study period, the policy environment could be better understood when considering the intersection between a range of factors including; overarching neo-liberal discourse influencing governance (Dean 1999), discourses on health and disability (Fulcher 1989) across sectors, discourses on community care, policy level sectoral interests and the integration of policy networks, public debates in the ‘political stream’, and the social-political acceptability of policy proposals.

This research concluded that agenda setting was not simply about the *integration* of the policy network or Kingdon’s (2003) ‘multiple streams’ coming together. The under-representation of mental health advocacy groups in housing sector policy debates and dispersion of the policy network within and across sectors only partly explained barriers to agenda setting regarding the provision of housing for people with a psychiatric disability. One of the limitations of Kingdon’s (2003) ‘multiple streams’ approach appears to be the lack of consideration for the ways in which community groups represent problems, and the close link between problems, policy networks, and policy proposals.

This study suggests also that ‘community mood’ is not an amorphous and unpredictable part of the ‘political stream’ (Kingdon), but a factor which may be manipulated (e.g. by or through the media) or which may interact with factors in the policy realm. There were also different ‘lay discourses’ within the community which may have complemented expert opinion. For example, a lay discourse on disability (Fulcher 1989) was tied to concerns about ‘disruptive tenants’ expressed in public debates, and this was complementary to a Psychiatrist expert questioning the legitimacy of community care in the public housing inquiry, and proposing housing models where there is 24 hour supervised medically based care. However, lay perspectives where consumer and carer representatives saw the need for accommodation and support services (not 24 hour care) were less influential.

### **9.2.3.3 Contextual factors of policy**

One contextual factor of this study related to intersectoral collaboration where

‘within sector’ Australian commonwealth-state agreements are tied to funded sectors and programmes, however this should not prevent common service frameworks from being developed at a state level. Issues from this study that were particular to South Australia included the ongoing reform of mental health services since the introduction of the National Mental Health Strategy, the ‘demonstration’ project based responses to supported housing, the slow development of mental health reform and National Mental Health Strategy objectives on ‘service mix’. Changes in governance arrangements historically occurred very frequently in the mental health sector, and there had been a number of changes in senior bureaucrats across the Mental Health Reform period. These issues were tied to a lack of political commitment, slowly developing NGO advocacy on the issues, and the political nature of mental health. The death of Dr Margaret Tobin was another contextual factor of the policy environment which led to a greater focus on security in public services.

The close relationships between the media, the community and politics, and ultimately politics and policy were evident here. In this study, the media played an important role in influencing public opinion and contributing to ‘problem representations’. Whilst these were partly attributed to the small size of the community and government responsiveness to the media (where the Premier was a former Journalist), there have been some suggestions of a close relationship between politicians and the media (talkback radio hosts) at a national level (ABC 2004). Political candidates were recruited from the media for South Australian seats at the last federal election campaign. Whilst Kingdon (2003) refers to the media when he talks about policy networks, the general impact of the media upon ‘the community mood’ is little explored.

#### **9.2.3.4 Accountability issues**

Literature on ‘community participation’ rarely discusses the issue of different *forms of accountability mechanisms* within bureaucracy (Hill 2005), whereas this study found that groups located within the bureaucracy were strongly influenced by such forms of accountability, which differed according to sector. The study also suggested that there were few mechanisms to consider the accountability of services, particularly in terms of the housing stability of people with a mental illness. Whilst

one small supported accommodation project indicated better health outcomes and cost savings from supported accommodation (Health Outcomes International 2002), accountability measures across services were not well-developed in this area.

#### **9.2.4 Findings in the available literature or theory that did not appear in the thesis**

##### **9.2.4.1 Discourses on participation in mental health**

This research highlighted the extent to which discourses on participation and partnerships may differ both within and across sectors, including when it comes to NGO participation in the development of policy. In a recent South Australian based study, Baulderstone (2006) claims that partnerships now exist in the form of planning between government and NGOs, and that the state has moved beyond the hierarchical purchaser-provider relationship. Notably, Baulderstone's (2006) study did not encompass community service organisations in the health sector (but included other community agencies). Another South Australian based case study (centred upon the community health sector) claimed openness to community development and health activism in South Australia, and the existence of a powerful discourse on participation (Tesoriero 2002). In this case study, the discourse of 'partnerships', health activism and community development was not developed within the mental health sector and there was a greater diversity in discourses and practices than previous recent case studies suggest. The development of health activism amongst people with psychiatric disability through NGOs was suggested an important area for future endeavour.

##### **9.2.4.2 Trust, intersectoral collaboration and community participation**

In chapter 2, the importance of trust to intersectoral collaboration was discussed, and contractualism and competitive tendering processes were seen to undermine the trust important for collaboration (Walker 2000). In this study, trust was a word that was rarely mentioned in relation to intersectoral collaboration at a policy level. At a service delivery level, cross-sectoral collaborative networks had been established within regions, and issues such as professional authority (and mistrust of non-clinical workers) and the need for support from leaders at different levels (policy/service delivery) arose as factors in intersectoral collaboration. Overall, trust in and across professionals appeared to be an issue that was secondary to broader policy and

political processes. Although a loss of trust in bureaucratic participation processes and political commitment to participation was clearly an important issue for consumer/carer representatives, there appeared to be a commitment to continue to try to affect policy change processes through ongoing involvement (e.g. in NGOs).

### **9.3 The role of the researcher**

My values and experience correspond with valuing empowering forms of participation and seeing the relevance and importance of housing for people with psychiatric disability and their family members. For these reasons I recognise the importance of intersectoral linkages across the housing and mental health sectors. I have benefited from the experience as a professional in both the health and housing sectors and learnt from personal experiences. As indicated in chapter 4, my values and prior experiences have shaped the topic of the research. Prior work and voluntary experiences may have enabled access to perspectives, individuals and organisations which would otherwise have been difficult to access (and a more intimate knowledge of issues in community participation for mental health consumer and carer representatives). Having prior contact with the Carers Association of SA may have led to more carers (who had also been representatives on state-level consumer-carer participation groups) being involved in the focus group, however this was balanced by interviews with consumer representatives. My role as participant-observer at NGOs and identity may have pushed the agenda on housing within groups (although there was little discussion on housing for people with disability at these groups, and where there was discussion, there was divergent opinion on whether public and community housing was appropriate for this group).

In some sense, I may have played a ‘policy entrepreneur’ role in regard to contributing to problems relating to participation and housing for people with psychiatric disability being higher upon policy agendas in the future. One interviewee suggested that simply asking questions about housing for people with psychiatric disability had placed this issue higher upon their agenda, as the research was being undertaken when housing reforms were being developed. Another interviewee mentioned that mental health was not represented at a state level in the

housing sector, and briefly discussed plans to ensure this occurred. Additionally, there was no state-level mental health representative group when this research commenced, although a specific mental health group was later established (by a group which was invited along to one participant-observation meeting I attended). Just after the Mental Health reform period, around April 2006, some activity between mental health and housing NGOs involved in this study was undertaken, and later, a Mental Health Carers Housing group was established by the Carers Association of SA. Some research activity was still being conducted just prior to the March 2006 state government election, when services for people with psychiatric disability were a more public issue of concern.

#### **9.4 Limitations**

Before considering the implications of this thesis, I firstly turn to the limitations of this study. Although there were a large number of participants in this primarily qualitative study, resource constraints prevented everyone in the mental health/housing/disability sectors being involved. A main focus was participants in mental health and housing policy programmes and services, and not the disability sector (as resources directed to this sector had been limited). There was also limited access to public housing tenant representatives with identified mental health problems (as this representation did not exist, although one service user had experience in a representative role in both sectors), or tenant representatives connected to the public housing sector (the perspectives of carers and professionals working with these groups was relied upon). Two interviewees in the mental health sector also withdrew from the study so these transcripts were not used.

The study originally planned to involve a small number of consumers, carers and local mental health workers from two regional services, to more closely consider the relationship between national/state policy and what was occurring at a regional service delivery level. Senior staff from regional services were in fact interviewed (accessed directly), as were a number of NGO staff (managers of regional services) and consumers and carer representatives formerly working at a state level (who were connected to regional services). However, there were significant ethical issues in contacting people with housing problems through regional mental health services. At the time the study commenced, there was no central mental health research

committee or body that could give project/ethics approval, and it would have been necessary to obtain approval from separate mental health regional services. This would be in addition to the other approval stages required through the university and housing department and scholarship application<sup>44</sup>. Approval to access consumers and carers through one service region's ethics committee was sought, with a number of problems associated with gaining such access. Due to this experience, the main focus was upon state policy, programme and NGO networks.

The actual role which service users and people with a psychiatric disability were playing in policy, particularly cross sectoral policy, was limited and undeveloped in the case study. The nascence of NGO groups (health consumers and mental health) helped to explain the current policy environment in SA. In other contexts (including in other states of Australia), such groups are more stable and developed (particularly in Victoria). However, opportunities to explore and develop NGO/consumers' views on housing policy may have been possible through the activities of the state's Social Inclusion Unit, which subsequent to this research being conducted, developed a plan for mental health (Social Inclusion Board 2007). The study could have benefited from examining NGO/consumer roles in this new policy initiative, particularly when it came to housing, and particularly the involvement of consumers or tenants within these policy processes who had experienced difficulties in housing. The study generated knowledge in regard to the barriers to policy agenda setting and successes in 'within sector' policy change, and issues for intersectoral collaboration.

## **9.5 Implications and Recommendations**

### **9.5.1 Policy networks: Government partnerships with NGOs and community groups, and cross sectoral lobbying networks**

In this study NGOs contractual relationships appeared to affect both 1) the nature of

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<sup>44</sup> The project had already gone through three levels of ethics approval; the NHMRC scholarship process in 2005, the Flinders University ethics process in 2005 and the DFC research approval/ethics process in 2005.

advocacy and 2) what was being advocated for. NGOs accountability to government through their contract for service provision sometimes led to NGOs focusing upon negotiating their contractual arrangements over other advocacy activity. This resulted in 1) the imperative for intersectoral collaboration being lost as services advocated for resources or met 'within sector' accountability requirements and 2) tension between advocacy and service provision functions of organisations.

#### **9.5.1.1 Strategies that may be employed to overcome the tensions between NGOs advocacy/service provision role & accountability to government**

Tension between advocacy and service provision roles and the experience of community groups within bureaucracy suggested the importance of cross-sectoral advocacy networks developed outside of government structures and contracts. The findings suggested the need for developing *cross sectoral* alliances to support agendas on housing for people with psychiatric disability. In particular, the development of cross sectoral, community based policy networks and participation strategies, i.e. (cross sectoral forums and policy debates). Future advocacy initiatives would ideally not only 1) engage with disability policies and politics (Beresford et al. 2002) and focus on the rights of people with psychiatric disabilities, but 2) look outside the 'sector' which organisations are funded by. Cross sectoral advocacy networks could;

- help to highlight issues overlooked within policy, including carers role in seeking, purchasing or providing housing to adult offspring, the provision of disability sector resources to people with a psychiatric disability, and service frameworks with consider housing, support and community engagement,
- challenge general public debates and opinions not conducive to mental health reform, and
- develop cross sectoral learning about appropriate networks, resources and strategies to target in 'other' sectors.

The study findings also suggested that there needs to be a lead agency or resource committed to developing advocacy alliances.

This study indicates that people with psychiatric disabilities are currently in a “catch-22” situation when it comes to state-level representation; one generic health ‘consumer’ organisation comprises members who are directly health service users, whilst another is a peak mental health organisation whose members are NGOs. Currently there is no member based peak organisation in SA who are involved in policy processes concerning priorities such as housing, whose members are *directly* people with psychiatric disability and their carers. Whilst the mental health peak NGO comes closest, consumer and carer voices may be dissipated where NGOs are direct members. However, this research underlined the need for professional support for mental health consumer/carer representation within the housing sector, where there was currently none, and where community members may be advocating against the interests of people with a psychiatric disability living in public housing. The importance of developing health activism amongst, and the priorities of people with psychiatric disabilities within NGOs, lies in the ease with professional (government and NGO) interests and agendas actually dominate participation/policy processes, the inevitable tension between NGO service provider and advocacy roles, and the stigmatising public debates about people with a psychiatric disability when it came to housing

### **9.5.2 Policy change, cross sectoral policy networks and public forums**

Both a bio-medical view of health and dominant views about public housing (i.e. who it is for) has led to the housing needs of people with psychiatric disability being overlooked. This study found very few opportunities where experts across sectors and people with psychiatric disabilities and carers could interact in public forums or discussions about housing (and forms of participation). There was some disagreement about ideal housing models (when research participants were asked about housing), but there were few opportunities to discuss housing and the various models of housing for people with a psychiatric disability, and the consequent implications for intersectoral collaboration. There were few opportunities to consider negotiations on competing discourses on disability and solutions within policy forums, and there was little evidence for public debates on the interactions between various discourses, ideas and values. Respondents suggested the need to make the connections between problems such as ‘disruptive tenants’, ‘emergency department

hospital demand' and 'supported housing shortages'. Participants also suggested a role for open policy debates regarding the role of NGOs (versus government) in the provision of services to the most disadvantaged.

Policy debates and policy processes are potentially important for developing the social trust important for policy change (Fischer 2003) or for the exchange of beliefs and values (Costongs and Springett 1997). Developing social trust is particularly important in this policy context given questioning of the legitimacy of community care and existence of community stigma. Involving experts and service users within policy forums early on in the development of housing initiatives may prevent professional resistance to the introduction of initiatives and counter dominant professional interests and beliefs (Fischer 2003). Research has shown that contact with the subject of discrimination is successful in addressing stigma (Read et al. 2006). Therefore demonstrating the success of a range of community living models (not simply 24 hour supervised options) in terms of health and housing outcomes, in the presence of people with a psychiatric disability and carers (and public housing tenants) could assist with challenging stigma.

### **9.5.3 Tackling community stigma**

As suggested in the earlier discussion on governments' role in preventing stigma and discrimination, general community stigma (as compared of that within politics/government) may be an overrated factor when it comes to questions as to why the 'service mix' goal of the National Mental Health Strategy has seen little progression in South Australia. However, generalised community stigma was identified as a feature of, but not significantly addressed within local policy responses between 2000 and 2005 (especially in the housing sector). At the national level, *Beyond Blue* supports an anti-stigma programme which is marketed both locally and at a national level (e.g. through daily state newspapers and on the sides of buses). It also supports research, for example into the experiences and needs of carers and families living with depression and anxiety (Highet et al. 2004; Highet et al. 2004). Additionally, the 'SANE Stigma Watch' programme attempts to tackle stigma through community education about mental illness and targeting media with negative representations of mental illness. Similarly, the SIU's mental health plan recently proposed to tackle stigma through a public health campaign and whilst 'the media'

and ‘community leaders’ have a recognised role in anti-stigma reduction, specific strategies have not yet been identified (Social Inclusion Board 2007). The proposed local community awareness campaign could benefit from strategies which specifically target the media and local community leaders.

The attitudes of community leaders towards mental illness and the openness of high profile figures in speaking publicly about depression may help to contribute to breaking down barriers on the stigma associated with mental illness. High profile public figures have increasingly been associated with mental health advocacy. For example, Ex-Premier of Victoria (Liberal) Jeff Kennett established *Beyond Blue*, of which John McGrath is Deputy Chair. John McGrath and Keith Wilson are former chairs of the Mental Health Council of Australia (established under the Liberal Government) and former (Liberal-Coalition) politicians who have sons with mental illness. *Beyond Blue* is supported by a number of high profile community members, all of whom have had experiences with forms of depression (either personally or in the case of one person, growing up with a parent with depression). There are no identifiable current or former high profile community members in South Australia actively involved with advocacy regarding mental illness/psychiatric disability.

As the state’s latest mental health policy recognises, the media has an important role in sensitively portraying mental health problems. In 2000 Australia saw the first suicide of a serving federal member of parliament (Labour MP Greg Wilton), and the media was heavily criticised by *Beyond Blue* President for its treatment of his mental health problems following this event (ABC 2000). As media watch initiatives have proved effective in tackling stigma (Warner & Mandiberg 2003), local identification of stigmatising attitudes in the media (i.e. through SANE Stigma Watch or other local campaigns) could affect perceptions about the social-political acceptability of stigmatising attitudes expressed in the media or through public debates. Again, involving prominent community members in anti-stigma campaigns is likely to increase the chances of meetings with local media (Thompson et al. 2002). However, broad anti-stigma campaigns seem to have had little effect on the development of new resources for housing people with the most chronic mental health problems (an issue of leadership and political commitment).

The study suggested a need for leadership (including NGO and political leadership)

in tackling community based stigma, particularly through and by developing relationships with the media. The importance of support for housing initiatives across levels of government was indicated by politicians in other levels of government (local and federal, of both political persuasions) lobbying against the local initiatives of state government to provide housing for people with psychiatric disability (e.g. community rehabilitation, local housing projects).

A previous article by Thompson (2006) argues that an anti-stigma culture would see ‘special interest groups’ which focus on the specific personal attributes (i.e. of people with disabilities) abandoned as they could promote stigma, and that groups should focus upon the general problems people may face (i.e. access to housing) (Thompson 2006). A focus for policy networks advocating for resources could be housing problems and desirable outcomes (e.g. housing in/stability and a lack of housing linked to support) for people with a psychiatric disability. A ‘budget promoter’ potentially placing the issue higher on the policy agenda (Kingdon 2003) could be evidence regarding the relatively high financial costs of housing instability and homelessness to governments, compared with the provision of supported housing (Culhane et al. 2002; Horin 2006).

#### **9.5.4 Supported housing models and support linked to existing housing programmes**

A number of examples of homelessness were provided in this study, associated with a lack of connection between services and/or lack of consideration of the housing needs of people with a psychiatric disability. The importance of having a home to health status has previously been highlighted by the number of health conditions associated with the experience of homelessness, including mental health problems (Shaw 2004). The effectiveness of individual-clinical interventions (incorporating medical-cognitive-behavioural approaches) may be limited within the context of homelessness and housing instability. Thus adequate housing would increase the effectiveness of clinical health interventions.

This research emphasised the need for intersectoral and planned policy approaches to housing for people with psychiatric disability at a national level, rather than the current situation where ‘support’ or housing projects are dependent upon the whim of local political decision-making. The need for the private housing sector (e.g.

Supported Residential Facilities) to be generally better incorporated into policy approaches, and the clarification of privacy and confidentiality practices between agencies (including private agencies) was also apparent. The increasing involvement of private sector in the provision of mental health (e.g. private hospitals) also points to the need to improve the incorporation of the private sector within planning and accountability networks.

A number of factors for ideal housing models for people with psychiatric disability were identified (Appendix 18). Respondents emphasised the need for provision of a range of public housing options, including independent and cluster models, however 1) recognised limits to people with psychiatric disability in accessing private forms of housing and 2) the importance of ongoing housing linked to support.

Alternatively, the current focus in South Australia is upon 'housing careers' and homelessness strategies (housing sector) and temporary supported accommodation or rehabilitation centres (health sector). Ongoing support linked to ongoing housing, and linking support to existing public housing (where the majority of people with psychiatric disability reside) is crucial to prevent housing instability, and is likely to relieve the need for such temporary housing models.

Any expanded cross departmental housing and support programme taking into account the housing situation of people with psychiatric disabilities would ideally be cross sectoral in its development, pool commonwealth state resources, collect information about the housing/support situation of people with psychiatric disability and develop common goals and targets on housing stability and homelessness (including primary, secondary and tertiary homelessness). NMHS reporting which is currently focused on service inputs and government expenditure, would ideally be replaced by housing programmes which were supported by cross-sector accountability and reporting mechanisms (involving service user groups both at a policy and service delivery level). The case study suggested that when cross departmental initiatives and programmes are introduced, successes will be promoted and challenges minimised where a common view of problems related to housing and support models, service delivery and joint bidding arrangements for funds has been negotiated and planned. At a policy development and implementation level, neighbourhood strategies would ideally play an important part in housing strategies,

particularly where community stigma can potentially affect the policy environment and political commitment to housing for people with a psychiatric disability.

The under-representation of particular sectors and groups in SIU policy networks (e.g. disability and housing sector in mental health strategies), and the national reporting requirements (focused on 24 hour residential support staffed by medical professionals: DHA 2005) could help to explain the continued focus on 'within sector' responses. In the current response to the SIU report (Government of South Australia 2007), supported accommodation is largely seen in terms of 24 hour supported accommodation supervised by medical professionals (a stage in a 'stepped care' plan). More recently, a supported accommodation project (following the SIU mental health initiative) was established within the health sector. This was separate to the existing supported accommodation programme/projects managed by the DFC (since the split of the DHS) which had led to successful outcomes for a small number of people with psychiatric disability (Health Outcomes International 2002). On face value, this new supported accommodation initiative is a trend away from the original 'mainstreaming' and 'intersectoral linkages' goals of the National Mental Health Strategy (AHM 1992a), and does not create an imperative for cross-sector collaboration at a state-level.

The response is also not in alignment with National Standards for Mental Health Services which state that residents should decide on the level of supervision within housing and have a range of support services available according to their needs (AHMAC 1997), or housing research highlighting the importance of consumer choice in accommodation (Thomas & McCormack 1999; Arthurson et al. 2007). The current 'within sector' policy solution is also unlikely to resolve issues pertaining to 'disruptive tenants', 'housing instability' and dwindling public housing resources. These partly require national level responses where the CSHA is better resourced and includes programmes linking housing and support services, 'safety net' housing (to account for people in hospital or temporary rehabilitation settings), and confidentiality agreements to appropriately share information between housing, mental health and disability agencies.

### **9.5.5 Carers role within policy, programmes and treatment**

One factor which may promote the legitimacy of carers in deliberations regarding

treatment, programmes and policy for people with a psychiatric disability may be to highlight the actual role that they are playing; as care coordinators in the absence of intersectoral linkages between services, in the purchase and provision of housing, and their role as advocates ‘on behalf of’ people with psychiatric disabilities in the absence of ‘consumer voices’. Carers may be providing a greater ‘representative’ role in this area of disability due to the absence of an ‘enunciative position’ of some people with mental illness (affected by their illness and stigma). This study suggested that too often carers’ interests are posed against the interests of people with psychiatric disabilities, by professionals. Indeed in my previous research I pointed to the potential conflict between the interests of people with disabilities and carers and asserted the need for a participatory approach to defining needs (Battams 1994). However, in this study the interests of carers and people with psychiatric disabilities were seen as being more complementary. Carers claimed that they were involved in participation/representation roles only when the person being provided support could not do so (i.e. when consumers had a very serious mental illness), in the hope that better support from formal services would ensue. Carers were frustrated by NGOs and services (privacy and confidentiality practices) developing or suggesting conflicting interests. Carers need more support for advocacy with and ‘on behalf of’ when it comes to housing and disability support services. Breaking down myths regarding the ‘competing interests’ of people with psychiatric disability and carers (by questioning who is promoting this notion and why) may be an important first step in promoting the legitimacy of carers in policy and programmes. Addressing discourses on 1) privacy and confidentiality (rights discourses) and 2) ideologies and expectations about the ‘carer role’ in community care may also be an important part of this process.

## **9.6 Scope for future research**

This research is one of few studies which has examined collaboration between the mental health and housing sectors, community partnerships in these sectors, and policy agendas on housing for people with psychiatric disability. The case study illuminated barriers and enablers to policy change in political, policy and service delivery arena and pointed towards a number of solutions for policy agenda setting,

implementation and accountability to ensure better housing outcomes for people with a psychiatric disability. It found the importance of a range of factors to agenda setting, including the integration of policy networks, discourses on disability and participation and the social/political acceptability of proposals.

A number of areas for future research were identified through this research. These being:

- The role of service users in cross-sector policy and the views of people with psychiatric disability on current housing policy reforms.
- The negotiation of competing discourses of disability and associated housing models/solutions through cross-sectoral forums where experts and service users interact.
- The role which politicians and bureaucrats play in contributing to or alleviating stigma associated with mental health.
- The impact of the media (and different modes of media) upon community stigma, mental health policy, and social trust.
- The relationship between political leadership, the use of and responsiveness to the media, and 'community mood' associated with housing people with a psychiatric disability.
- Professionals' attitudes towards community living and different supported accommodation models.
- The attitudes of public housing tenants and representatives towards living in close proximity to people with a mental illness.
- The role of service users within NGO processes and how consumer perspectives transfer to policy environments through NGOs

## 9.7 Epilogue

As this conclusion was being written in early 2008, there were media reports and political comment on the tragic deaths of four people with mental illness in separate incidents. Sadly, in the final day of 2007, the deaths of two homeless people with mental illness occurred in Adelaide in two separate incidents. It was revealed that both of these people (and the alleged murderer of one) were living in backpackers' hostels. One was a 22 year old woman with a mental illness, allegedly murdered in the Adelaide parklands by another mentally ill young woman, whilst another was a 54 year old homeless man (Henderson 2008; Owen & Vaughan 2008). These incidents led to claims that there were around 30 people with mental illness living in backpackers' hostels in the city (The Advertiser 2008). However, in one media report this was presented as a 'backpacker' problem with backpacker hostels requiring support for when 'backpackers' may become ill (AAP 2008). The Housing Minister claimed that there was 'no policy to direct mental health patients to backpacker hostels' (Owen & Vaughan 2008) however these incidents highlighted the absence of adequate programmes for housing people with a psychiatric disability. These events have led to the state opposition calling for yet another state inquiry into mental health, this time into backpackers hostels being used for mental health patients (The Advertiser 2008). There was no media comment by state mental health NGOs reported in the state's major newspaper when these incidents were mentioned.

In a third tragic incident which occurred in Queensland, as neighbours were celebrating New Years Eve a child was allegedly raped and murdered by her father who was being treated under an involuntary treatment order for mental illness (and released from hospital just 9 days earlier) (Editorial 2008). The Health Department had not informed the Department of Child Safety of this situation, where the father had four children in his care. This incident prompted an Inquiry by the state's Commissioner for Children, again called for by the opposition. After this latter incident, *The Australian* newspaper commented on the need for governments to interact, the adequate follow-up care of people with mental illness in the community and the provision of adequate housing (Editorial 2008). One peak NGO in NSW responded to this editorial by highlighting the previous federal government's failure to address housing people with a mental illness through COAG (Kong 2008).

In yet another separate incident in Adelaide where the state coroner's report was released in February 2008, an adolescent person with mental illness living with other much older people died of a drug overdose in a state Supported Residential Facility and was not found for three days (District Court of SA 2008). These recent incidents indicate that the housing and support for people with mental illness is a far reaching issue going beyond the health, disability and housing sectors. They highlight the relevance of the findings from this thesis as the lack of adequate housing options linked to support, and the lack of communication between services continues to affect the daily lives of people with mental illness and their families.

# 10 Appendices

## Appendix 1 Descriptions of Interviewee IDs

**Table 14: Brief Description of Interviewee IDs by Sector**

Interview Number	Health Sector	Housing Sector	Other Sector
1.	Professional who had worked closely with state level mental health consumer groups.		
2.		Public servant working on state level programmes	
3.		Public servant working with state level community participation groups.	
4.			Senior public servant in the disability sector who had worked in the housing sector
5.		Public servant working on state level programmes who had worked across sectors across government departments and for NGOs	
6.		Senior policy public servant.	
7.		Senior public servant who had worked for NGOs	
8.			Advocacy Focus group consisting of 2 housing and 2 health NGO professionals
9.		Public servant working with housing agency primarily dealing with Aboriginal people.	
10.			Group interview with people working for a government agency on behalf of people with psych disability.
11.	Senior public servant.		
12.	Former NGO professional working at a state level.		
13.	Consumer representative who had worked across a number of state level groups.		
14.			NGO professionals working with people with mental health problems on housing issues who had offended.

15.	Senior manager working at a regional agency/service delivery level.		
16.		Senior policy public servant.	
17.	Senior professional working at a regional agency/service delivery level who had formerly had a state level role.		
18.	Senior public servant – general health sector.		
19.	Senior public servant who had worked in service delivery.		
20.	Former consumer representative who had worked at a state level, who was currently a community representative in the housing sector at a regional level.		
21.		Senior manager working at a regional agency/service delivery level.	
22.		Public servant who had a recent key NGO role.	
23.		Senior policy public servant.	
24.		NGO professional, service delivery/advocacy role.	
25.	Senior public servant in the health sector who had formerly worked in the mental health bureaucracy.		
26.	Senior regional manager who had formerly worked in the mental health bureaucracy.		
27.	Consumer representative working at a state and regional level.		
28.			Former disability sector NGO professional.
29.	Senior public servant.		
30.	Consumer Carer Focus Group (3 Carers, 1 Consumer) –members had worked on state level groups advising the mental health bureaucracy.		

## **Appendix 2 Participant observation themes**

- The extent to which housing or housing provision for users of mental health services is the subject of focus of the meetings. Evidence for the progression of these issues.
- Extent to which NGO advocacy issues raised by consumers and carers (vs. issues raised by professionals) are progressed within NGOs or community participation mechanisms.
- Extent to which NGOs and community participation mechanisms have access to information and decision making processes or avenues to progress issues beyond the meetings.
- Extent to which intersectoral action in NGO advocacy activity is being undertaken.
- Extent to which the carer role or carer views are incorporated in NGO advocacy for housing provision for mental health consumers. Nature of advocacy for carer support needs.
- Extent to which there is conflict or tension exhibited in NGO advocacy arguments or discourses in community participation mechanisms.
  - Extent to which arguments include medical discourse and extent to which 'psychiatric disability support services', 'recovery' or 'rehabilitation' approaches include housing or housing support.
  - Extent to which citizenship arguments for housing are used and include mention of housing options for people with a chronic mental illness.

## **Appendix 3 Questions for focus groups with NGOs**

### **Policy & plans**

How effective are the current policy/plans in mental health and housing for developing appropriate housing for users of mental health services? Do you know about the state housing plan's intentions for 'high needs housing'?

What would the ideal housing situation for users of mental health services look like?

### **Advocacy Experiences**

I'm interested in the extent to which you think that your groups have been able to contribute to the development of policy or programmes at a state-wide level...e.g. the state housing plan or state mental health reform?

- What are the kinds of things which you think you have been able to influence?
- What barriers/enablers were there to influence?
- What sorts of strategies have been used for influence?

In what ways do you consider the Mental Health Unit/state housing authority could facilitate advocacy groups to make a more effective input to policies and plans?

### **Lobbying on Housing for Mental Health**

To what extent have you lobbied on housing issues for users of mental health consumers to date? What processes were used to decide this as a priority issue for lobbying?

In what ways do you consider your advocacy groups could have been more effective in how you have lobbied on housing issues for this group?

### **Intersectoral Activity**

What kind of cross sector networks exist between mental health and housing advocacy groups? What have been the challenges for cross-sector advocacy?

Do you feel able to comment on the effectiveness of strategies for linkages between the mental health and housing aspects of the bureaucracy to develop the mental health reform or state housing plan? Are there ways in which you think their effectiveness could be improved?

## **Appendix 4 Questions for leaders of community groups**

(NGO leaders and public servants overseeing community groups connected to the bureaucracy, or facilitators of groups)

### **Overall views of participation**

What have been the opportunities for community participation into policy and plans?

What have been the opportunities for input into the development of the (mental health reform and/or state housing plan) or the implementation of the plan/s?

What have been the opportunities for input into housing issues by mental health consumers in the group you were connected to?

What processes were used to determine priority issues for discussion at the group you facilitated?

What were some of the challenges for consumer and carer participation and influence by the group? What sorts of policy issues was the group most able to influence?

Do you believe that the views of families and carers were well incorporated into processes for participation?

In what ways do you consider the government could encourage consumers and carers to make a more effective input into policy and plans?

### **Housing issues**

Was the issue of housing or accommodation support for users of mental health users a key component of community participation activity? Why/why not? How often do housing issues for mental health consumers arise?

Do you consider that there have been (or are there) barriers to providing input into appropriate housing and support solutions for this group?

Do you believe that carers needs differ from consumers of mental health services when it comes to housing and accommodation support needs?

Who do you believe should deliver housing and accommodation support services to users of mental health services? How would this ideally occur? How easy is it to suggest alternative suggestions for housing options to funders?

How effectively are links being made between the housing sector and the mental health sector through the Mental Health Reform? (at policy/programme level)

Were there many opportunities to discuss cross-sectoral issues such as housing with other sectors?

### **Future Initiatives**

Are you able to comment upon current processes for input into housing plans by mental health consumers and carers?

How would more effective input into policy and plans occur by consumers and carers in relation to the mental health/housing related policy & programmes?

## **Appendix 5 Questions for focus groups with consumers & carers**

### **Participation experiences**

What has been your overall experience of participation over the period of the Mental Health Reform (2000-2005)?

How have community participation groups in mental health been able to influence the mental health reform process? What are the kinds of things which you think you have been able to influence? What barriers/enablers were there to influence?

What input have you had into the mental health reform since the disbanding of SACAG/MH Consumer Carer Steering Group/Interim committee?

In what ways do you consider the mental health system could encourage consumers to make a more effective input to policies and plans?

### **Mental Health and housing**

To what extent do you consider that consumers of mental health services have had problems with housing stability? Or, access to appropriate housing? What have been some of the barriers to improving access to appropriate housing for this group?

Do you feel able to comment on the effectiveness of strategies for linkages between mental health and housing programmes or services?

Are there ways in which you think their effectiveness could be improved?

How are the views of consumers or families incorporated into solutions for housing and accommodation support for mental health consumers?

In what ways do you consider the advocacy or community participation groups could have been more effective in how they have lobbied on housing issues?

## **Appendix 6 Questions for interviews with professionals**

(Background about agency/unit/person's role)

### **General Perceptions on the Mental Health Reform Period & Mental Health/Housing**

#### **Perceptions on the problem of Housing Stability**

To what extent do you consider people living with mental disorders have had problems with housing stability?

#### **Ideal Housing Situation**

What would the ideal housing situation for users of mental health services look like? Who should provide accommodation and support services for this group? How would this ideally occur?

#### **Barriers/challenges to housing MH consumers**

What have been some of the barriers to improving access to appropriate housing for this group during the mental health reform period? What are some of the main challenges in providing housing and accommodation support to people with a chronic mental illness?

#### **Intersectoral Links in Policy and Programmes**

##### **Effectiveness of linkages at various levels**

How effectively are links being made between the housing sector and the mental health sector in the development of housing solutions for people with a chronic mental illness (discuss Mental Health Reform period)?

- At a policy level?
- At a programme level?
- At a practice level?

Are there ways in which you think their effectiveness could be improved?

What have been the challenges for cross-sectoral initiatives?

### **Cultural issues**

Have you noticed any cultural differences in working across the two sectors? What impact do these differences have on the ability to co-operate?

Are there any specific challenges in influencing the development of non-clinical mental health services (or "psychiatric disability support services")?

### **Influences upon MH & Housing Strategies**

What do you think have been the greatest influences on the development of activity between the housing and mental health sectors? (e.g. policy, inquiries)

### **Policy and plans**

#### **General Observations regarding policy/programmes**

How would you characterize the mental health and housing sector responses to deinstitutionalisation and providing housing and accommodation support for users of mental health services?

#### **Commonwealth/State linkages**

How effective are the national policy frameworks for mental health and housing in addressing the needs of housing users of mental health services?

#### **State Housing Plan**

How would the state housing plan's intentions for 'high needs housing' be best implemented?

#### **State Mental Health Reform**

How well do the mental health reform documents incorporate housing strategies for a range of mental health consumers?

### **Consumer Participation**

How are the views of consumers/tenants or families incorporated into solutions for housing and accommodation support for mental health consumers? How well do you think these views are incorporated in the development of housing provision at a state and regional level? How could this input be improved?

How often do you meet with advocacy groups and/or consumer/tenants or families to develop housing and/or support options? Is this often enough? If not, what are the constraints to more meetings? What are some of the challenges for consumer participation in this area?

### **Other**

Are there any other issues you think are important in the development of housing for users of mental health services that we have not discussed?

## **Appendix 7 Aims, mission and Terms of Reference of NGOs groups observed**

### **Shelter SA**

Shelter SA's 2005 workplan stated aims

- Shelter SA will initiate and lead the housing debate in South Australia
- Shelter SA is the credible reliable and authoritative voice on housing issues for disadvantaged, vulnerable and low income groups
- Shelter SA acts strategically

(Shelter SA 2005)

Shelter SA's stated objectives (from membership flier)

- To promote and maintain the right of every person to access affordable, safe and secure long term housing that they identify as appropriate to their needs
- To promote and maintain the right of every person to housing of a quality which enhanced people's health, well-being, dignity and life opportunities.
- To promote the benefits of public and community housing in the community and all spheres of government.
- To publish, research, collect or other-wise disseminate information on matters relating to the provision of housing, particularly for people on low to moderate incomes.
- To create opportunities to support, establish, resource and co-ordinate non-government organisations and agencies with similar interests and objectives to the Association.
- To promote opportunities for members of the community to access housing provision free from discrimination as [a] result of factors such as age, gender, ethnicity, health status or disability
- To promote and support consumer and community participation in

decision making in relation [to] their housing and to promote access to avenues of appeal across all housing tenures

Shelter SA (undated)

### **Mental Health Coalition of South Australia**

The Mental Health Coalition of South Australia Business Plan 2004-05 - 2006-07 states that the mission of the organization is

To represent and promote the interests of non-government organisations supporting people with a psychiatric disability in South Australia, on behalf of all those affected by mental illness.

(MHCSA 2005, p. 5)

A major focus of the business plan is

To promote the quantity and quality of psychiatric disability support services and to promote the development of the non-government mental health sector.

(MHCSA 2005, p. 4)

The objectives of the organisations are as follows:

- Countering prejudice against people with mental illness by facilitating strategies to raise community awareness and reducing stigma;
- Advocating for people affected by mental illness by participating in State and Commonwealth government policy development, planning and service development including legislative reform;
- Advocating for the appropriate types and supply of psychiatric disability support services to assist recovery;
- Enhancing the effectiveness and quality of psychiatric disability support services delivered by the non-government mental health sector
- Generally do all such acts, matters and things to enter into and to make such agreements as are incidental or conducive to the attainment of any of the objects of the Coalition.

(MHCSA 2005, pp. 5-6)

The organization is divided between foundation members and other members.

Foundation members are NGOs which represent or provide services to people with a mental illness. Other members are generally generic organisations.

## **Community Housing Council of South Australia Inc Disability Focus Group Terms of Reference**

### 1.0 Definition of Disability

Interpretation of "disability" in relation to a person means a disability -

- (a) that is attributable to intellectual, psychiatric, cognitive, neurological, sensory or physical impairment, or a combination of any of those impairments; and
- (b) that is, or is likely to be, permanent; and
- (c) that results in the person having
  - a. a reduced capacity for social interaction, communication, learning, mobility, decision making or self care; and includes such a disability notwithstanding that it is of an episodic nature.

(extracted from the Disability Act [sic] 1993)

### 2.0 Objects of the Disability Focus Group

As a Disability Focus Group of the CHCSA, recognising the decision and policy making role of Office for Community Housing and the CHCSA, the Disability Focus Group will have the following overall objectives:

- (a) to assist the just, accessible, equitable and effective delivery of Office for Community Housing and CHCSA services to people with disabilities.
- (b) To ensure that the consumer's voice is heard in government decision-making.
- (c) To represent issues of concern to consumers.
- (d) To ensure physical access to housing for disadvantaged persons further to

assist maintenance of successful tenancies.

- (e) To promote the concept of universal design and accessible housing.

To achieve these objectives the disability focus Group will have the following roles:

- i. to provide information and advice to the CHCSA and the government on matters affecting the interests of consumers with a disability
- ii. to provide expertise, develop and influence policy, planning and operations in areas which are CHCSA's responsibility and which impact on consumers with a disability
- iii. to assist the development of policy that impacts on consumers with disabilities.

### 3.0 Committee Membership

The membership of this Disability Focus Group will be as follows;

- (a) membership with [will] be open to individuals and CHOs with the same interest in objectives of the Disability Focus Group
- (b) this Disability Focus Group has the power to co-opt any relevant persons with expertise who can make a valuable contribution to the Disability Focus Group
- (c) this Disability focus Group will ensure that no one disability group dominates the Group and that the members role is to advocate on behalf of the sector.

### 4.0 Functions of the Disability Focus Group

Functions of the Disability focus Group include:

- (a) researching and making recommendations through the CHCSA on matters relating to people with a disability and their housing
- (b) producing reports for publication when required
- (c) considering draft legislation, proposals, policies, practises and procedures that

may impact on people with disabilities and their tenancies

(d) identifying priorities for action for CHCSA

(e) networking.

#### 5.0 Procedures

(a) The positions of Chairperson to be elected annually by the Disability Focus Group.

The Disability Focus Group will meet regularly as deemed by the members

## **Appendix 8 Terms of Reference for consumer and carer groups**

### **South Australian Consumer Advisory Group Terms of Reference 1995**

(from Field Diary)

- Role is to assist the Minister & Chief Executive Officer in formulation of mental health policies and plans and promote the involvement of consumers and carers at all levels.
- Provide support to the SA rep on National Consumer Advisory Group.
- Provide input to other government departments through the State Minister for Health.
- Various terms of Reference for the Consumer Carer Steering Committee

### **Focus Group consumer and carer framework August 2001**

It was declared that the aim of the focus group would be:

To develop a consumer and carer steering committee in order to establish partnerships, representation and participation in mental health services and reform in South Australia.

Aim of steering group:

To ensure consumer and carer participation in the development and reform of mental health services in SA through the establishment of equitable representation and partnership arrangements.

Group decided basis for which people could nominate for the steering group.

## **Focus Group Consumer and Carer Framework September 2001**

Aim of steering committee - considered outside of the scope of the focus group.

Nominations for the SA Consumer Carer/Advocate Steering Committee for Development and Reform of Mental Health Services

Steering committee is set up for:

- Policy formation, planning and associated legislation in terms of its effect on people with mental illness and their carers and advocates.
- Providing a reference group to the government from the consumer and carer/advocate perspective.
- Monitor implementation of policy and act as a check on the suitability of plans
- Act as a conduit to other government departments who may affect the rights and welfare of people with a mental illness and their carers/advocate.

### **Terms of Reference Consumer/Carer Steering Committee**

NOTE Changed from above purpose during nomination period

To advise the MHU of DHS about appropriate structures and processes for consumer and carer/advocate representation and participation in the SA Mental Health Service.

Terms of reference were not developed with consumers.

### **Interim Group**

(from Field Diary)

Interim group - SACAG and steering group merged July 2003 to form an interim state consumer and carer advisory committee - the group was to provide advice to DHS on mental health policy, planning and service delivery.

## **Appendix 9 General letter of introduction**

(tailored for NGO participant observation and focus groups)

GPO Box 2100

Adelaide 5001 Australia

PH: (+61 8)8204 5983

Email: fran.baum@flinders.edu.au

2nd May 2005

### LETTER OF INTRODUCTION

Dear

This letter is to introduce the research of Samantha Battams who is a PHD student in the Department of Public Health.

Samantha is researching the intersectoral links between the housing and mental health sectors. She would be most grateful if you would spare the time to assist in this project, by agreeing to observation of the X meeting which touches upon certain aspects of this topic. She anticipates attending 3 meetings . Additionally, she would like to undertake a content analysis of minutes of this meeting from the period 1st July 2004 - 30th June 2005<sup>45</sup>, and a one and a half hour focus group with selected members from the group (the questions for the focus group would be forwarded to members prior to the focus group being conducted). Attached is an explanation of this study and research design. Also attached is a consent form for the observation of professional activity.

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, report or other publications. You are, of course, entirely free to discontinue your

---

<sup>45</sup> Minutes were considered for a period of 6 months only as discussed in Research Methods.

participation at any time or to decline to answer particular questions at the focus group.

Since Samantha intends to make a tape recording of the focus group, she will seek your consent, on the attached form to record the focus group prior to its commencement, to use the recording or a transcription in preparing the thesis, report or other publications, on condition that your name or identity is not revealed, and to make the recording available to other researchers on the same conditions (or that the recording will not be made available to any other person). It may be necessary to make the recording available to secretarial assistants for transcription, in which case you may be assured that such persons will be advised of the requirement that your name or identity not be revealed and that the confidentiality of the material is respected and maintained.

Any enquiries you may have concerning this project should be directed to me at the address given above or by telephone on 08 8204 5983, fax 08 8204 5689 or e-mail [fran.baum@flinders.edu.au](mailto:fran.baum@flinders.edu.au). This research project has been generally approved by the Flinders University Social and Behavioural Research Ethics Committee, and questions for the focus groups will also be submitted to this committee for approval prior to their commencement. The Secretary of this Committee can be contacted on 8201 5962, fax 8201-2035, e-mail [sandy.huxtable@flinders.edu.au](mailto:sandy.huxtable@flinders.edu.au).

Thank you, in anticipation, for your attention and assistance.

Yours sincerely,

Prof Fran Baum

Head of Department

## **Appendix 10 Letters to focus group attendees**

GPO Box 2100

Adelaide 5001 Australia

Phone: (+61 8) 8204 6389

Fax: (+61 8)8204 5693

Email: sam.battams@flinders.edu.au

22nd August 2005

Dear X

Following our recent phone conversation, I am writing to invite you to a focus group of representatives from advocacy Non-Government Organisations in the housing and mental health sectors, as part of my PHD research. As discussed, the research is on the topic of linkages between the mental health and housing sectors, and the influence of advocacy activity upon policy in this area. Please find attached a 'letter of introduction' to this research from my principal supervisor and a sheet on 'information for participants'.

It would be greatly appreciated if you could assist with this research by agreeing to attend the focus group. Questions for the focus group are also attached. The focus group will be held as follows:

Thursday, 17th November, 9.30am-11am,

Mental Health Resource Centre (Board Room)

1 Richmond Road, Keswick, South Australia

If you are able to attend this meeting, please rsvp to the email above, or telephone 8204 6389.

Yours Sincerely

Sam Battams

## **Letter for Focus Groups with Consumers and Carers**

Dear X

Following my telephone call, I am writing to invite you to a focus group with consumers and carers for my PHD research project which pertains to community participation over the mental health reform period. More information about this research is enclosed on the 'Information for Participants' sheet.

This focus group is being held on Wednesday, September 14th at 4pm, in G6 Seminar Room (top level), "The Flats", Flinders Drive, Bedford Park. I attach a map of the location of "The Flats" (point 80 on the map).

I also enclose a consent form for your participation, and the questions for the focus group.

Thank you for agreeing to participate. I look forward to meeting you.

Yours Sincerely

Samantha Battams

## **Appendix 11 Information sheet for participants**

### **Aims of the Research**

To determine the extent of inter-sectoral activity between the housing and mental health sectors in developing housing provision for users of mental health services. To assess the effectiveness of community participation mechanisms in influencing housing provision for users of mental health services and their carers.

### **Research Questions**

1. To what extent have inter-sectoral links between mental health services and the housing sector been developed through the implementation plan of the South Australian Mental Health Reform 2000-2005?
2. To what extent have these links been effective in improving housing options for people with mental illness?
3. How have community participation mechanisms (which include state level advocacy and consumer and carer groups) been able to influence the mental health reform process and the development of housing initiatives for consumers of mental health services?

### **Rationale for the research project**

Mental health is now one of the leading health priorities, both in Australia and overseas, with the World Health Report (WHO 2001) calling for an integrated public health approach to reduce the burden of mental health disorders. WHO (2001) solutions for the way forward include:

- giving care in the community
- involving communities, families and consumers
- establishing national policies, programmes and legislation
- linking with other sectors, and
- supporting more research.

The Burdekin Report (1993) highlighted a need to improve the quality and extent of community services for people living with a mental illness in Australia. There is a strong policy framework in the 1992 National Mental Health Policy (Australian Health Ministers 1995), however the shift from hospital care has not been matched by funding for community care. The overall growth in 24hr staffed community residential units in Australia is only a quarter of the reduction in long stay beds in psychiatric hospitals, and funding for residential services represents only 6.7% of total mental health services expenditure (Commonwealth Department of Health and Ageing 2002). This draws attention to the importance of inter-sectoral partnerships between mental health services and other sectors.

Inter-sectoral partnerships are part of the rhetoric of the national strategy, justified by studies showing that links between mental health support and housing services, for example, are crucial in the lives of people with a mental illness. Australian Housing Urban Research Institute research has highlighted, from a consumer perspective, the importance of linkages between housing and support services for people with a mental illness, especially for maintaining housing stability (AHURI 2002), and providing a holistic approach to homelessness (AHURI 2003). Consumers and carers (individuals and groups) are also advocating for specialist mental health services to develop inter-sectoral links, particularly with the housing and employment sectors (MHCA 2003).

Despite the fact that the 2nd National Mental Health Plan (Australian Health Ministers 1998) declared 'partnerships in service reform and delivery' as one of its key themes, its evaluators found that "inter-sectoral collaboration has been evident in some pilot areas, but not developed in a systematic or coordinated way" (Steering Committee Evaluating NMHP 2003). There was also more scope for mental health services to establish partnerships with consumers, carers and families. Carer support was particularly lacking at all levels of mental health service delivery - local, regional and state/territory government (Steering Committee Evaluating NMHP 2003). SA is also well below national averages for consumer and particularly carer participation mechanisms in mental health service delivery (Commonwealth Department of Health and Ageing 2002).

Subsequently, the 3rd National Mental Health Plan resolves to develop "Increased levels of full and meaningful consumer, family and carer participation in policy and in service planning, delivery and evaluation at all levels with evidence of improvement in quality." (Australian Health Ministers 2003, p 24). However, little is known about inter-sectoral links and the effectiveness of community participation mechanisms, and this research project aims to provide a detailed picture that will guide future development of more appropriate services for people with a mental illness.

Inter-sectoral community based initiatives are limited in South Australia as it spends proportionally the least on community services and the most on stand alone public hospitals of any Australian state. Expenditure through mental health services on NGOs and community residential services is around one half and one twentieth of national averages respectively (Commonwealth Department of Health and Ageing 2002). The state's supported housing initiatives under the mental health reform implementation plan were deemed pilot demonstration projects (DHS 2000). Now there are twelve projects (now considered a programme) and in the last year of the mental health reform, following the State Housing Plan (2005), a state government unit was established to oversee these and other 'high needs housing' initiatives. However, housing policies or initiatives have the potential to conflict for people with a mental illness (e.g. South Australian Housing Trust Successful Tenancies demonstration projects and Disruptive Tenants Policy and Procedures 2004).

### **Research Methods**

Stage one will involve a comprehensive review of major mental health and housing policies, plans and programmes for the period 2000-2005 (e.g. SA Mental Health Review, Generational Health Review and State Housing Plan) both in terms of their inter-sectoral focus and strategies for community participation. Government responses to relevant state-level inquiries (e.g. parliamentary inquiries into Supported Accommodation and Disruptive Tenancies) and reports undertaken during this period will also be assessed.

Stage two relates to all research questions, but is focused on research question 3 and will seek to determine what state level advocacy groups are advocating for or what

community groups are commenting upon, and progress/challenges in these endeavours. It will also inform an understanding of issues/barriers to the development of inter-sectoral linkages and housing provision, as perceived by members of community participation mechanisms. Data collection will be triangulated through the various components to the stage two research:

- Observation and participant observation of advocacy groups (attendance at three meetings of Shelter SA, Mental Health Coalition of SA and the Community Housing Council's disability forum (total 9 meetings).
- A content analysis of documents such as minutes (over a period of six months) and key submissions from the above groups,
- A content analysis of the minutes of the consumer/carer groups that existed over the period of the mental health reform 2000-2005 (South Australian Consumer Advisory Group, the Mental Health Consumer Carer Steering Group and the Interim Committee)
- Interviews with key professionals working on community participation in mental health and housing and the Health Consumer Alliance (4 interviews),
- One focus group with advocacy groups in mental health and housing, and,
- One focus group with former members of the consumer/carer groups that existed over the period of the mental health reform

Stage three relates to research question 1 and will involve 20 interviews undertaken with key members of the housing and mental health sectors of the state bureaucracy. Semi-structured in-depth interviews will be undertaken in order to gauge experiences of collaboration, perspectives of the importance of and barriers to inter-sectoral relationships between the mental health and housing sectors, discourses on mental health and housing, and examples of successful collaboration efforts in the form of housing options for mental health consumers.

## **Appendix 12 Consent form for participation in research by interview**

I .....

being over the age of 18 years hereby consent to participate as requested in the  
..... for the research project on .....

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to my information and participation being recorded on tape.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. 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, and individual information will remain confidential.
  - I may ask that the recording/observation be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.

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 Samantha Battams

Researcher's signature.....Date.....

NB. Two signed copies should be obtained. The copy retained by the researcher may then be used for authorisation of Item 6.

6. I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.

Participant's signature.....Date.....

### **Appendix 13 Consent form for observation of professional activity**

I hereby give my consent to Samantha Battams, a PHD research student in the Faculty of Medicine, Department of Public Health at Flinders University, and whose signature appears below, to record my work activities as part of a study of professional activities and role.

I give permission for the use of minutes of meetings over the prescribed period, and of other information which I have agreed may be obtained or requested, in the writing up of the study, subject to the following conditions:

My participation in this study is voluntary, and I understand that I may withdraw from the study at any time.

#### **SIGNATURES**

Participant.....Date.....

Researcher.....Date.....

**Appendix 14 Consent form for participation in research by focus group**

I .....

being over the age of 18 years hereby consent to participate as requested in the ..... for the research project on .....

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to my information and participation being recorded on tape.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. 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, and individual information will remain confidential. Members of focus groups will be requested to maintain the anonymity of other members and confidentiality of the discussion.
  - I may ask that the recording/observation be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.

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. The copy retained by the researcher may then be used for authorisation of Item 6.

6. I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.

Participant's signature.....Date.....

## **Appendix 15 Letter from Department for Families and Communities, Social Inclusion Strategy and Research**

Ms Sam Battams

Department of Public Health

Flinders University

GPO Box 2100

Adelaide SA 5001

Dear Ms Battams

RE: Research proposal 'Partnership Development in the Provision of Housing Support for Mental Health Consumer'

The DFC Research Development Committee considered your research proposal at its meeting on the 26 of September 2005. The Committee gave approval for the research to proceed.

The topic of your research relates to the key strategic directions of the Department and is therefore of considerable interest. A request was made by the High Needs Housing Unit to be kept informed about outcomes of your research (Karen McAuley from the High Needs Housing Unit can be contacted on 8415 4193 or karen.mcauley@dfc.sa.gov.au). In addition, information about upcoming

seminars/presentations/reports can be forwarded to the Executive Officer, RDC (contact details below) who may assist with dissemination.

If you have any questions, please contact Krystyna Slowinski on 8226 7056 or [krystyna.slowinski@dfc.sa.gov.au](mailto:krystyna.slowinski@dfc.sa.gov.au).

The Committee wishes you success with your project.

Yours sincerely

Nancy Rogers

Chair, Research Development Committee

Date:

## **Appendix 16 South Australian figures on service mix throughout the National Mental Health Strategy**

Nationally, there are 12 priority areas articulated for mental health reform (National Mental Health Strategy Evaluation Steering Committee 1997, p. 35), with the "Service Mix" priority area including the goal of:

To reduce the size or to close existing psychiatric hospitals and at the same time provide sufficient alternative acute hospital, accommodation and community based services

(AHM 1992a, p. 9)

In the years prior to the NMHS in South Australia, there was a gradual decline in the number of inpatients in the stand-alone psychiatric institutions (Glenside and Hillcrest) and psychiatric hostels, and an increase in numbers in private psychiatric institutions (Henderson 1992). The year 1955 was the peak of the state's stand alone institution in terms of number of inpatients (2638 inpatients) (Henderson 1992). The 'inpatient' figure at this time included people with an intellectual disability and older people with a psychiatric disability or mental disorder, so it is very difficult to compare this figure with current figures.

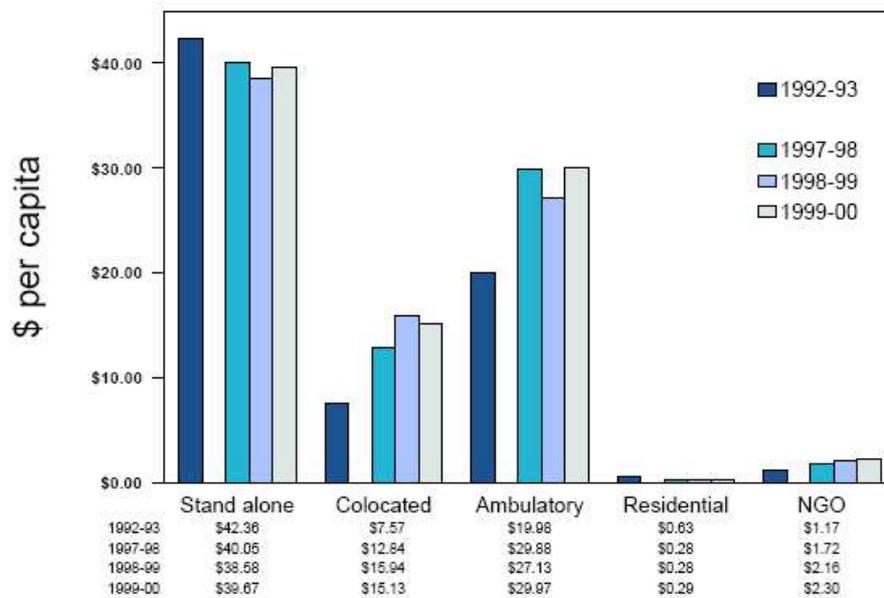
Immediately prior to the NMHS, between 1989-1992, South Australia (SA) had the highest number of psychiatric facilities, the highest ratio of psychiatric beds and the highest number of hospital separations for psychiatric treatments in Australia (Elzinga et al. 1994). There were 72 inpatient beds for psychiatric care per 100,000 including psychiatric hospital, general public hospital and private hospitals (Elzinga et al. 1994). In 1993, at the commencement of the NMHS, there were 665 beds in separate psychiatric hospitals in South Australia (231 beds in Hillcrest and 434 in Glenside) (Henderson 1992), leading to a figure of 45 public inpatient beds in stand-alone psychiatric institutions per 100,000 of population (Hillcrest was closed in 1993) (Commonwealth of Australia 1993).

### **Since the commencement of the National Mental Health Policy 1992**

Figures from 1999-00 indicated that SA had maintained a funding focus on the main psychiatric institution (Glenside), maintaining high numbers of non-acute beds in the

stand alone psychiatric institution when compared to other states (CDHA 2002) (see diagram 7). The state also increased expenditure on co-located beds and ambulatory care (CDHA 2002). However, 'while the number of institutional beds decreased by 32%, spending on the state's two psychiatric hospitals reduced by only 4%' (CDHA 2002, p. 85). Ten years after the introduction of the NMHS (in 2002-03), beds in stand-alone institutions still represented 73% of all psychiatric beds (CDHA 2005).

**Diagram 7: Changes in per capita spending mix 1992-03 1999-00 South Australia (DHA 2002)**



Source: National Mental Health Report 2002 (CDHA 2002, p. 86)

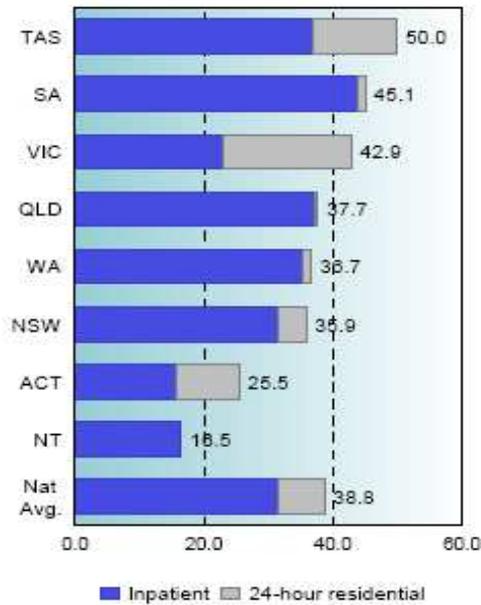
The goal of the National Mental Health Strategy was to eliminate stand-alone psychiatric institutions, reduce the number of psychiatric beds and co-locate acute beds in mainstream public hospitals. However, South Australia has the lowest number of beds co-located within mainstream services (DHA 2004). There has been a reduction in the proportion of non-acute beds and rise in the proportion of acute beds across the NMHS (CDHA 2005). Overall, the total number of non-acute and acute beds in South Australia has in fact dropped from the commencement of the NMHS, with baseline figures from the first National Mental Health Report (NMHR) (Commonwealth of Australia 1993) showing 51.6 beds per 100,000 (NMHR 1993) , 40.7 beds per 100,000 in 2002 for general psychiatry (DHA 2004) and 38.8 beds per 100,000 in 2003 in general adult mental health services (CDHA 2005). Across 1993-2002 there was a reduction in non-acute beds, from 29.2 per 100,000 non-acute beds

in 1993 (Commonwealth of Australia 1993) to 20.1 per 100,000 non-acute beds in psychiatric units in 2002 (CDHA 2003) and 13.6 beds per 100,000 in 2002 (CDHA 2005). However, SA has increased its proportion (per 100,000) of acute beds from 22.4 in 1993 (Commonwealth of Australia 1993) to 23.6 per 100,000 in 2002 (CDHA 2003) and 25.3 in 2003 (CDHA 2005).

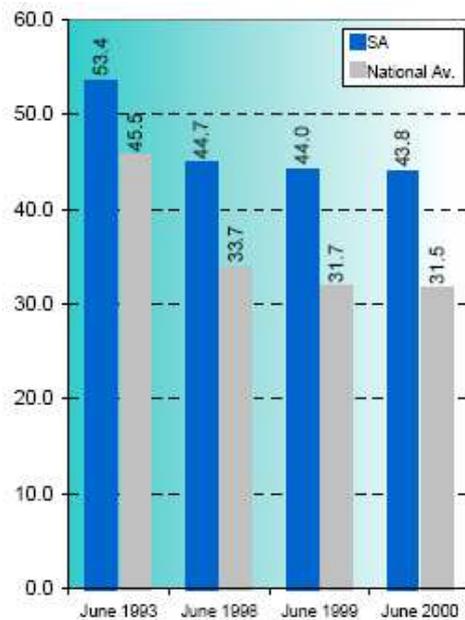
Due to South Australia's high number of non-acute beds in stand alone psychiatric institutions, this figure of 40.7 beds per 100,000 meant that South Australia maintained the second highest proportion of psychiatric beds in 2001-02 (including both acute and non-acute beds) of all Australian states in 2002 (CDHA 2003) (see diagram 8). However in June 2003, when 24 hour staffed residential facilities were included in reporting, SA was well behind in this category (CDHA 2005).

At a national level, the growth in community residential facilities (e.g. staffed 24 hour beds) funded through the mental health system in 2001-02 and 2002-03 was only around a quarter of the reduction of long stay beds in psychiatric hospitals (CDHA 2003; CDHA 2005). South Australia and Queensland had the lowest percentage of acute beds as a proportion of non-acute beds and spend the lowest proportion of funding on community based services in 2002-03 (CDHA 2003). In SA, there was a decrease in 24hr staffed community beds per 100,000 in the first seven years of the National Mental Health Strategy (CDHA 2003). South Australia reduced its level of community residential facilities from 3.5 per 100,000 in 1993 to 2.1 per 100,000 in 2002 (CDHA 2003), a figure which remained unchanged in 2003 (CDHA 2005).

**Diagram 8: Total inpatient and 24 hour staffed residential beds per 100,000 at June 2000 by state and territory (DHA 2002)**



**Diagram 9: Total inpatient beds per 100,000, South Australia (DHA 2002)**

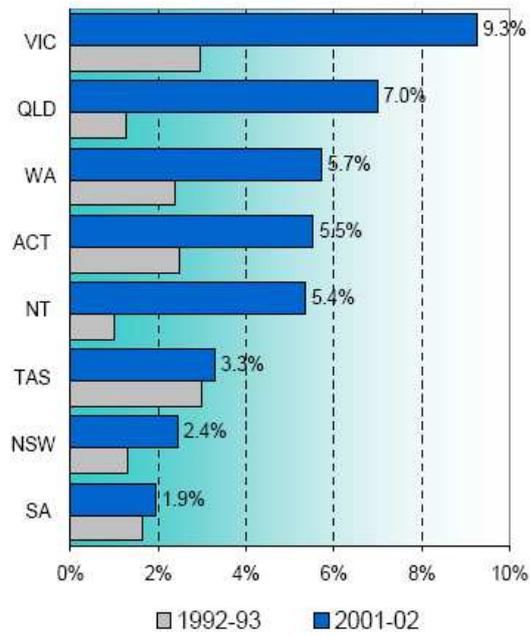


Source for Diagrams 8 and 9: Mental Health Report 2002 (CDHA 2002, p. 35) and National Mental Health Report 2004 (CDHA 2003, p. 87)

There was a small increase in funding to NGOs which provide services such as accommodation support, however South Australia still spends proportionally the least on NGOs of any Australia state (see figure 9) (CDHA 2003). In 2002-03, NGO funding was 2.1% of total service expenditure (compared to 6.2% nationally) and

residential services were 0.4% of expenditure (compared to 7.3% nationally) (CDHA 2005).

**Diagram 10: Funding to non government organisations as a percentage of total spending on mental health services (DHA 2003)**



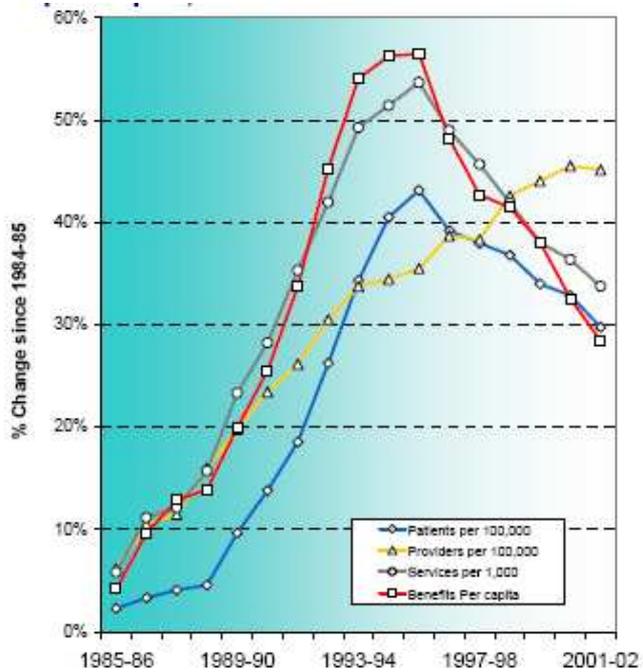
Source: National Mental Health Report 2004 (CDHA 2003, p. 5)

## **Appendix 17 National and state trends on privatisation in mental health services**

Overall government expenditure on mental health services indicates the increasing privatisation of mental health services. In 1999-00, 34.5% of commonwealth funding to mental health services went to the Pharmaceutical Benefits Scheme (PBS) (39.6%), Medicare Benefits Scheme (MBS) psychiatric consultations (21.9%), GP services (16.9%), private health rebates (3.7%) and 7.1% for the National Mental Health Strategy (CDHA 2002). Of the 37.1% of mental health funding spent by the commonwealth in 2001-02, most of this went to the PBS (43.4%) and MBS psychiatric consultations (17.2%), GP consultations (14.6%), private health rebates (3.3%) and 8.2% to the NMHS (CDHA 2003). In 2002-03, 45% of commonwealth funding went to the PBS, 16.4% to MBS psychiatric consultations, 14% to GP consultations, 10.7% to DVA (not previously included in reporting) and 7.8% to the NMHS and 3.9% to private hospital rebates (CDHA 2005). In 2002-03, total mental health funding from commonwealth and state funding included 29% of funding going to state-territory hospitals, 22.9% to ambulatory services, 17.2% to PBS medicines, 6.5% to private hospital care and 5.5% to GP services (CDHA 2005).

There has been a significant increase in the private hospital sector over the National Mental Health Strategy which parallels the reductions in the public sector system (CDHA 2003) (see diagram 2 in chapter 5). There has been a significant increase in funding for, and number of beds located in, the private hospital sector; in 1992/93, psychiatric beds only accounted for 14% of all beds (Commonwealth of Australia 1993), but this rose to 21% in 1999/00 and 23% in 2001/02 (CDHA 2002; CDHA 2003). In 2001/02, there were 1,737 beds in private psychiatric hospitals in Australia, a 38% increase since the commencements of the National Mental Health Strategy (CDHA 2003).

**Diagram 11: MBS Consultant Psychiatrists, percentage changes in patients seen, number of providers, services and benefits per capita 1993-94 to 2001-02 (DHA 2003)**



Source: National Mental Health Report 2004 (CDHA 2003, p. 37)

According to Mental Health Services in Australia 2002-03, 29.4% of ambulatory separations for specialized psychiatric care (through GPs, private psychiatrists, hospital outpatient services, 'ambulatory equivalent' same day hospital separations, and community based services) occurred in the private sector in 2002-03 (AIHW 2005d). Although there has been a steady increase in the number of private psychiatric providers over the period 1985-86 to 2001-02, there has also been a 15% decline in patients per 100,000 since 1992/93 using MBS consultant psychiatry services, and a more significant decline in services since 1993/94 (CDHA 2003) (see diagram 11).

As a national average, private hospital separations for psychiatric care are around three times more common than public hospital separations (AIHW 2005d). Across Australia, 29.4% of separations for specialized psychiatric care occurred in the

private sector in 2002-03 (AIHW 2005d).

In South Australia, figures for both the public and private sector ambulatory equivalent hospital care hospital separations are around the same (AIHW 2005d). Twenty one percent (21%) of hospital psychiatric separations in SA occurred in private hospitals, 24.7% in the stand-alone public psychiatric hospital, and 54% in public hospitals (AIHW 2005d). Around 19% of all psychiatric separations in public psychiatric hospitals in Australia are occurring in SA, and can be attributed to the continued reliance of the state's stand alone institution (AIHW 2005d). In 2002/03, 9.2% of all hospital separations for psychiatric care occurred in South Australia (AIHW 2005d); however, the SA total population in 2003 was only 7.7% of Australia's total (ABS 2006).

## Appendix 18 Problems identified, gaps in information and preferred housing solutions for people with a psychiatric disability

**Table 15: General problems raised regarding housing for people with psychiatric disability Across Sectors and related solutions and concepts of ideal housing**

<b>Problem Identified</b>	<b>Solutions identified/'Ideal Housing'</b>
<b>Poor access to ongoing community based disability support</b> to maintain people in housing in SA, and the 'crisis responses' of mental health services (Interviews 2, 3, 5, 6, 7, 9, 11, 12, 15, 21, 22, 24, 26, 28, 30, Consumer Carer Focus Group, Advocacy Focus Group, Participant Observation notes)	Ongoing disability support, including flexible support, or episodic support when required (Interviews, 2, 3, 5, 6, 11, 12, 15, 17, 22, 23, 24, 26, 30, Advocacy Focus Group, Consumer Carer Focus Group)
<b>Housing Access and Supply, including decline in public housing stock and waiting list for public housing</b> (Interviews 4, 5, 14, 15, 17, 19, 22, 24, 28, 29, 30 Consumer Carer Focus Group, Advocacy Focus Group, Notes from Minutes of Consumer Groups, Participant Observation Notes)	The provision of a range of housing options was considered necessary (Interviews 5, 6, 16, 23, 26, 28, Advocacy Focus Group). 'Manageable homes' were considered important (Interviews 2, 6, 9, 21, Consumer Carer Focus Group).
<b>Community &amp; Neighbourhood Stigma</b> & need to work with neighbourhoods (Interviews 2, 3, 4, 5, 6, 7, 11, 13, 15, 21, 22, 24, 26, 28, Consumer Carer Focus Group)	<i>[Addressing community stigma, working with local neighbourhoods and media strategies appeared warranted given the magnitude of community stigma.]</i>
<b>Housing Instability</b> (Interviews 2, 4, 5, 7, 11, 13, 14, 19, 21, 23, 24, 26, Advocacy Focus Group)	<i>[this issue was linked to support issue and service linkages]</i> The importance of proactive communication by services and professionals for people with psychiatric disability living in the community was recognised (Interviews 6, 15, 22, 24).
<b>People in substandard housing: SRFs and boarding houses</b> (Interviews 2, 5, 13, 19, 22, 23, 25, 26, 28, 29)	<i>[Initiatives to monitor the SRF/boarding house sector were introduced through the State Housing Plan.]</i>
<b>Rooflessness/Homelessness</b> (Interview 2, 11, 13, 14, 17, Advocacy Focus Group, Participant Observation Notes)	<i>[linked to housing and support access and service linkages]</i> Homeless Strategy initiatives were introduced through the DPC Social Inclusion Unit (chapter 5). However, recognition across sectors of the secondary and tertiary homelessness population with a psychiatric disability and the turnover in these populations was considered necessary (e.g. SAAP, SRF) (Interview 5).

<p><b>Social Isolation/Lack of Community Engagement</b> or Activities for People with Psychiatric Disability (Interviews 4, 11, 19, 21, 30, Consumer Carer Focus Group, Advocacy Focus Group)</p>	<p>Developing ‘full citizenship’ as a goal considered important (Interviews 5, 15, Advocacy Focus Group) – addressing social isolation (4, 11, 21) and ensuring that people have vocational and recreational options (Advocacy Focus Group). Developing a sense of community and housing close to community resources and in an appropriate location not geographically isolated (Interviews 6, 11, 13, 16, 20, 23, 25).</p>
<p><b>Lack of support to maintain people in private rental</b> (Housing Sector professionals only: Interviews 6, 7, 16, 24, Advocacy Focus Group)</p>	<p>[The state government was committed to developing a proposed tenant support service for private tenants however this had not been implemented (Advocacy Focus Group)]</p>
<p><b>Disruptive Tenants</b> (Interviews 3, 11, 15, Consumer Carer Focus Group)</p>	<p>The need to focus on the development of social and independent living skills of tenants was recognised by many (Interviews 9, 21, 22, 23, 24, 30) [The issue of disruptive tenants is partly related to community stigma, lack of support and ghettoization of public housing. Government strategies to deal with disruptive tenants are discussed in chapter 8.]</p>
<p><b>Trans-institutionalisation into prison</b> (Interviews 4, 9, 14, Advocacy Focus Group)</p>	<p>[A parliamentary inquiry into mental health and corrections was underway in South Australia (Parliament of South Australia 2006)]</p>
<p><b>Skilled staff with an understanding of mental illness</b> in housing lacking or unavailable (including culturally sensitive workers across sectors) (Primarily Housing Sector respondents: Interviews 2, 6, 9, 24, 28 Advocacy Focus Group)</p>	<p>The importance of developing trust between professionals and people with a psychiatric disability was highlighted (Interviews 3, 9, 28). Mixed views were expressed about the desirability of community housing vs. public housing tenures due to different perceptions on the skills and attitudes of workers associated with each sector (Interviews 15, 16, 24, 28, Advocacy Focus Group, Participant Observation Notes).</p>
<p><b>Poor Service Linkages Across Sectors</b> directly related to housing problems (including lack of proactive, safety net housing in the event of hospitalisation). Need for staff with skills in working in partnership. (Interviews 6, 14, 23, Advocacy Focus Group, Participant Observation notes)</p>	<p>Service linkages (including with the corrections sector) and recognition of common clients in policy (Interviews 11, 24). Safety net housing in the event of hospitalisation (Interview 6). Separation of tenancy management and support considered necessary (Interviews 6, 16, 24).</p>
<p><b>Cost of private rental and SRFs</b> specifically for people with a psychiatric disability (Consumers Only Interviews 13, 20, Consumer Carer Focus Group)</p>	<p>[Affordable housing strategies were not specifically targeted towards people with psychiatric disability]</p>
<p><b>Burden to Carers of Purchasing Homes for People with Psychiatric Disabilities</b> (Carers Only Consumer Carer Focus Group)</p>	<p>[Recognition of carer’s role in housing policy and the problem of secondary homelessness (people living with families) not mentioned]</p>

**Table 16: Indicators of problems related to housing for people with a psychiatric disability referred to by respondents within specific sectors**

<b>Indicators referred to by housing sector professionals</b>	<b>Indicators referred to by health sector professionals</b>
Percentages of People with a Psychiatric Disability in SRFs (Interviews 2, 22, 23)	Emergency Demand and Length of Hospital Stay increases associated with a lack of housing options (Interviews 17, 19)
Turnover in the SAAP sector and numbers of people with a psychiatric disability in SAAP services (Interviews 2, 23, Participant Observation notes)	Percentage of Homeless people with a mental illness attending hospitals (Interview 11)
Turnover in public housing for category 1 'high needs' clients* (Interviews 7)	Shortage in supported accommodation support places and social rehabilitation packages in regions on per capita basis (Interview 15)
Housing affordability –home ownership and private rental (Interview 16, Advocacy Focus Group)	Under funding mental health on a per capita basis in South Australia and funding focus on acute sector (Advocacy Focus Group, Interview 30)

**Table 17: Gaps previously identified on information or feedback mechanisms in government programmes (2000-2005)**

Homelessness	Haggerty (2005) referred to the need to enumerate homelessness in South Australia, particularly through agencies engaging in information sharing (Haggerty 2005). Nationally, information on the use of the SAAP programme by people with disabilities is difficult to collect and specific figures in relation to the use of the programme by people with a psychiatric disability are not available (AIHW 2005b).
Supported Accommodation	The Parliamentary Inquiry into Supported Accommodation (Social Development Parliament of South Australia Social Development Committee 2003, p. 3) noted that the mental health sector was not collecting information about unmet need in relation to supported accommodation for people with psychiatric disabilities.
Disruptive Tenants in Public Housing with a Psychiatric Disability	The Parliamentary Inquiry into the South Australian Housing Trust whilst implicating ‘disruptive tenants’ and mental illness together (Statutory Authorities Review Parliament of South Australia Social Development Committee 2003 p. 58; AIHW 2005b), noted that statistics on the nature of the problem were not being kept. A follow-up indicated that the vast majority of disruptive tenants were not considered to have a psychiatric disability (Parliament of South Australia 2003). The Chair of the Public Housing Customer Forum highlighted poor exchanges between departments as being an important issue (Parliament of South Australia 2003).
Housing situation of users of mental health services	At the time this PhD research commenced mid 2003 there was no complete information on the housing situation of users of mental health services (Field Diary). This information was collated in 2007 (Social Inclusion Board 2007).
Disability Support Services provided to people with a psychiatric disability	In South Australia, information on disability services provided to people with psychiatric disability was not being collected as services had not been provided through the Commonwealth State Territory Disability Agreement (CSTDA) (AIHW 2005e). HACC programme reports do not indicate the number of people with psychiatric disability being serviced by the programme in South Australia (Field Diary).

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