

What policy approaches are needed to ensure that people with psychiatric disabilities have access to appropriate housing? Recommendations from a South Australian case study into mental health reform

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Abstract

This paper is based on research which considered policy processes leading to housing outcomes for people with psychiatric disabilities. It examined both intersectoral collaboration between the mental health and housing sectors, and community processes leading to housing outcomes. The previous South Australian mental health reform period (2000-2005) was used as a case study. Qualitative research methods were employed and triangulated across four stages which included; a thematic analysis of national and state policies in health, housing and disability sectors; interviews, focus groups and participant observation with state level NGOs; interviews and focus group with consumer groups; and interviews with professionals from the health, housing and disability sectors. There were 91 participants, including 39 in interviews and focus groups and 52 in participant observation stages. The study pinpointed a number of barriers to ensuring appropriate housing outcomes for people with psychiatric disability, including the neo-liberal policy context, a lack of co-ordination across policy sectors and services, ongoing public sector reform and resistance to deinstitutionalisation. The focus of this presentation is upon policy responses to promote positive housing outcomes. These include strategies for intersectoral collaboration for policy agenda setting and implementation, addressing community stigma, tackling professional resistance to mental health reform, developing advocacy alliances, providing housing models which address social isolation, and challenging medical discourses on disability.

Contextual Background

The South Australian policy context

South Australia has followed a policy of deinstitutionalisation since the 1980s. Deinstitutionalisation was introduced to national policy by the National Mental Health Strategy (NMHS) in 1992. This national strategy established a 'service mix' goal which aimed to develop accommodation to support deinstitutionalisation:

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)

However, the follow up to a major national report on the human rights of people with mental illness - 'Burdekin report' (HREOC, 1993) - identified a gap between stated NMHS policy aims and their implementation, and the need for a range of community care settings, including housing (MHCA, 2005).

In South Australia, responses to both the NMHS goals of 'mainstreaming' services and 'service mix' developed slowly. The absence of political commitment to 'service mix' was reflected in the lack of funding dedicated to non-government organisations (NGOs) and community residential facilities (CDHA, 2002). In 2001-02, the State spent the lowest proportion of funding on NGOs and had amongst the least number of beds in community residential facilities on a population basis (CDHA, 2003). The mental health policy context in SA during the case study period was highly politicised and characterised by crisis and piecemeal rather than planned responses. The State introduced a series of processes designed to reform the mental health service since the introduction of the NMHS (in 1992, 1996, 1998).

The reform processes (2000-2005) considered in this study ran concurrently with a major review of health (Generational Health Review, 2003) and review of the organisation of health services. The period was characterised by considerable organisational instability and change. At the beginning of the mental health reform, a "mega" Department of Human Services (DHS) existed which included health, disability, housing and welfare services. This Department was in existence until a change of government in 2002 led to the DHS being split into two Departments in 2004 – Health and Families and Communities. The 2000-2005 reform was initially led by the Director of Mental Health who was tragically murdered (by a former colleague) halfway through the reform period (in 2003) (Sweet, 2006). This event had an effect on the progress and focus of reform.

This paper is based upon qualitative research into policy agenda setting and implementation processes across the period of mental health reform (2000-2005) in South Australia. The focus of the research was the extent of intersectoral collaboration across the mental health and housing sectors and its effect on housing outcomes for people with mental illness, policy agenda setting on housing within the mental health sector, and the extent to which NGOs and user groups had an influence on policy processes and particularly housing outcomes. This

paper considers the research findings in relation to the question: *What policy approaches are needed to ensure that people with psychiatric disabilities have access to appropriate housing?*

Research Methods

The qualitative methods used in this study were triangulated across four stages namely; 1) a review of policy and programmes in the mental health, disability and housing sectors 2) interviews, focus groups and participant observation with state level NGOs, 3) interviews and focus group with consumer and carer representatives from state-level groups and 4) interviews with professionals from the health, housing and disability sectors. There were 91 participants from across sectors, including 39 people in interviews and focus groups (see Table 1) and 52 people within participant observation (from three key state-level NGO organisations). NVIVO was used to organise the data according to themes. 'Analytic induction' or 'analytic generalisation' was used to link the themes to the original questions in order to make inferences for theory and policy development.

Table 1 Summary of Participants in Interviews and Focus Groups by Sector and Agency

	Health Sector	Housing Sector	Other sector ¹ interviewees	Total number of Participants
STAGE 2				19 Participants in Stage Two interviews/focus groups
Non-Government Organisations	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
Professionals working with state level consumers and carers or tenants, not in NGOs	One Interview ²	One Interview		2 Participants
Consumer and Carer Representatives	Three Interviews, and one Focus Group (4 people).	[NB <i>Not able to access tenant groups</i>]		7 Participants
STAGE 3				20 Participants in Stage Three interviews
State policy/programme/agency professionals	Six Interviews ³	Seven Interviews	Four Interviewees in two Interviews	17 Participants
Regional programme/service delivery professionals	Two Interviews	One Interview		3 Participants
Totals	19 Health Sector Participants	13 Housing Sector Participants	7 'Other sector' Participants	39 Participants in interviewees and focus groups

¹ Includes interviewees from the disability/corrections/justice sectors.

² 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.

³ One public servant (mental health sector) withdrew.

Key Findings: policy problems and factors shaping policy responses

The main ‘housing problem’ for people with psychiatric disability identified was access to housing and disability support resources. The experience of social isolation, turnover in public housing, and housing instability also were identified as crucial issues. Associated with these problems were limited disability support resources linked to housing, a lack of vocational recreational options, neighbourhood stigma and a poor knowledge of mental illness within the community.

The study concluded that there were five key factors shaping policy responses on housing for people with psychiatric disability. These included 1) the political-economic framework, 2) community or lay discourses influenced by stigma influencing the media and the policy environment, 3) the extent of cross-sectoral collaboration, 4) different professional cultures and discourses in each sector, and 5) the nature of government organisation, funding and planning. These factors are explored below.

The political-economic framework

This research provided support for Dean’s (1999) theorising about the influence of neo-liberalism upon new forms of governmentality. Neo-liberalism and its inherent ideology of small government could be associated with a political reluctance to commit to public resources, declining resources for public housing, increased privatisation across the mental health and housing sectors, NGOs playing a greater role in service provision, and government lending support to private solutions. This overall political-economic framework exerted pressure on existing public resources and led to the widespread need for additional public housing and support resources for people with psychiatric disability. Respondents were concerned about the limited housing resources and community based options, the location of people with mental illness in substandard housing, the slow reform of the mental health sector, and limited resources to enable collaboration. A typical comment was:

Firstly, I answered in terms of accommodation support which obviously comes up all the time – 100%...Accommodation is definitely at the forefront of conversation with a lot of members, whether they be carers who are often saying we have adult children with mental illness living with us who, by way of example, the Mental Health Services have said they can no longer provide services for because their needs are too great; not too little, but too great.

NGO mental health sector professional

Inadequate housing and support resources often led to people with a mental illness being housed inappropriately, e.g. living with ageing carers who were keen for their family member to find alternative options, or living closely with other people with severe mental illness in private Supported Residential Facilities (SRFs) where the large proportion of their Disability Support Pension went to private providers.

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.

Health sector public servant

Across the 2000-2005 period there were a number of examples where networks within each sector had formed and successfully lobbied or advocated for housing or support resources. For example, a number of community housing NGOs successfully lobbied for 'affordable housing strategies' which would involve more community housing. Such strategies were reflected in the state housing plan (DFC 2005). Another network within the health sector, dominated by professional organisations, successfully lobbied for temporary social rehabilitation resources. Additionally, private Supported Residential Facilities (SRFs) also successfully lobbied for publicly funded support tied to SRFs, a \$57million commitment in 2004 (Mental Health Unit 2005)). All of these successful strategies were ultimately compatible with neo-liberal strategies of government, so could be perceived as being 'politically acceptable'.

Community Stigma

Lay discourse on disability (Fulcher 1989), associated with community stigma toward mental illness, and reflected in government and the media, were seen to influence the policy environment. Community stigma was associated with a lack of political and bureaucratic commitment to resources for mental health generally, and opposition to the implementation of community based mental health resources. One example of this (occurring just after the reform period in 2006) was public lobbying against a proposed community rehabilitation centre for people with a mental illness, which included a local politician and former psychiatric nurse. Another example of community stigma was the public debates on 'disruptive tenants' (strongly linked to people with a mental illness) which were surrounding the Inquiry into the South Australian Housing Trust (Parliament of South Australia 2003). Both public servants and mental health consumers were

cognisant of the effect of community stigma upon the mental health policy environment, resources and reform. Conversely, at least one media outlet in SA appeared to strongly lobby for SRF resources (where housing was often considered to be expensive and sub-standard).

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.

Housing/disability sector public servant

I think the biggest influences on the government and its policy is X [radio presenter]; its 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.

Mental Health consumer representative

Intersectoral collaboration

There was little evidence of strategic policy level collaboration across sectors, to the extent that sectors could be considered different 'policy subsystems' (Sabatier & Jenkins Smith 1999) with little integration. This lack of integration caused some problems for mental health reform and an integrated government structure attempting to draw together separate sectors and interests:

There is no planning we are aware of. We've raised this issue many times in appropriate forums e.g. SACOSS [South Australian Council of Social Service] meetings with DHS [Department of Human Services] 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.

NGO Housing sector professional

[the] 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 [board]. But

X's [the head of the Social Inclusion Board has] found the way that the public service is structured, which goes right up to Ministers, makes this interaction really difficult.

Housing sector public servant

A lack of strategic collaboration at a strategic policy level inhibited cross-sectoral supported housing agendas. Additionally, poor integration at a programme or service delivery level created housing problems for people with mental illness. For example, a person lost their public housing following a hospital admission, with the community housing sector left to 'pick up the pieces' (Participant Observation notes).

There were a range of factors across levels of government influencing intersectoral collaboration, including bi-lateral agreements, government structures, discourses on health and disability, and the engagement of leaders within and across sectors. Please see table 2 for a visual map of the various factors identified. Key factors impacting upon collaboration are further discussed below.

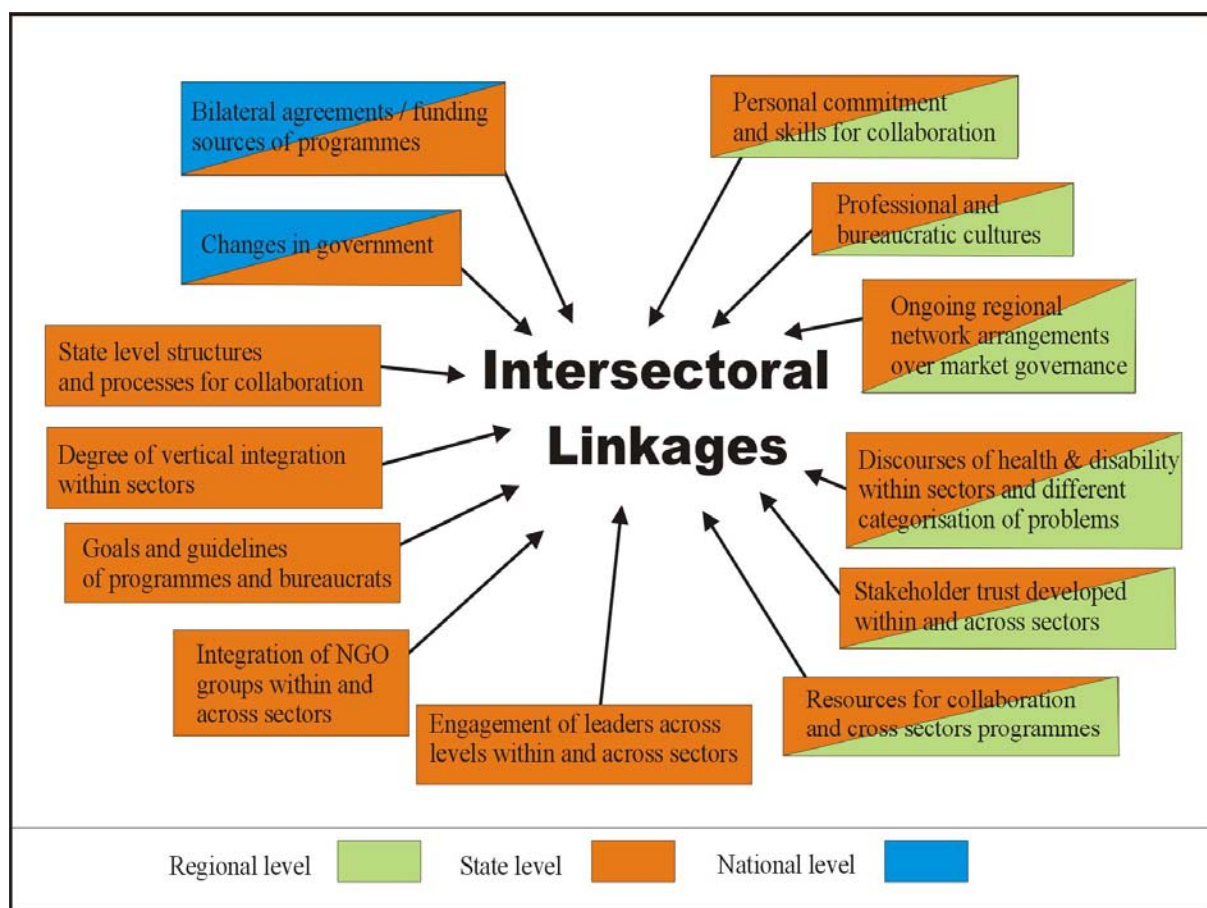
Agreements between sectors and the goals of funded programmes

Separate bilateral agreements between federal and state governments (e.g. the Commonwealth State Territory Disability Agreement -CSTDA, Commonwealth State Housing Agreement -CSHA, Australian Health Care Agreement -AHCA) were not coordinated to ensure appropriate housing and support for people with psychiatric disability. These agreements were tied to funded sectors and programme objectives, sometimes leading to competing goals, guidelines and accountability mechanisms in funded programmes. For example:

a key measure that the Housing Trust reports or the state reports to the commonwealth as a key performance indicator under the CSHA, Commonwealth State Housing Agreement, is vacancy rates, vacancy turnaround and you know, we're wanting to be seen that we're managing vacancies efficiently. Now on the other hand, people who might be a Housing Trust resident who have a psych disability, they might have an episode that requires them to be away from their house, i.e.: they might be admitted to a long stay bed, whether it's in a hospital or Glenside or... Now from a mental health point of view, you would want to be able to secure that person's tenancy for the period that they're away from the place, because you know eventually, but hopefully, eventually say they have to be admitted to somewhere long stay place, they exit that place and they may well lose their accommodation because the Housing Trust's got to focus on needing to fill vacancies.

The various programme goals and accountability mechanisms were seen to affect or limit the ‘responsibilities’ of levels of government and public servants. In 2006, the Prime Minister declared that housing for people with a mental illness was a ‘state’ responsibility (Karvelas and Cresswell 2006), despite dwindling public housing resourced under the CSHA. Housing and disability sectors were also seen as being reluctant to cater for (or not responsible for) people with psychiatric disability. This perception was supported by the fact that the CSTDA, whilst introduced in 1992-93, did not resource people with a psychiatric disability in South Australia until 2006.

Table 2: Factors influencing intersectoral linkages



Within sector problems and solutions

A common problem identified by public servants across sectors was the failure to recognise the overlaps between a range of policy problems, e.g. hospital emergency department demand,

housing instability, social isolation, the over-representation of people with a mental illness in the corrections system. A lack of ‘common view’ of problems and the interplay between them led to a lack of responsibility being taken for problems. This point can help to understand obstacles to agenda setting for housing people in the mental health sector (and housing issues for people with a mental illness in the housing sector), as policy agenda setting is partly dependent upon a common view of problems in the first instance (Kingdon 2003).

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.

Health sector public servant

Within sector advocacy networks lobbied for ‘within sector’ solutions to problems which sometimes overlooked ‘cross sectoral’ problems and solutions. For example, supported housing (24 hour) was successfully lobbied for in the mental health sector – a ‘separate’ mental health sector housing solution. However, this solution did not directly address the problem of stigma and people with a mental illness being considered ‘disruptive tenants’ in public housing, the reported high turnover of people with a mental illness in public housing, or the limited ongoing disability support resources connected to public housing. Conversely, a Social Inclusion Unit report later indicated that the majority of people tied to mental health services (MAC Team, for ongoing clients) were in fact located in public housing.

Discourses on health, housing and disability

Different discourses on health, housing and disability tied to funded sectors helped to explain different perceptions of policy problems and the extent of collaboration efforts. In particular, a dominant medical view of health and disability (Fulcher 1989, Baum 2002, Lewis 2005) was critiqued by many respondents across sectors. This medical discourse was a contributing factor in housing and non-clinical support resources largely being overlooked within the mental health sector. This discourse was tied to expectations of client turnover in clinical services

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 [with severe mental illness] would move on and what I quickly realised is that was an incorrect assumption of that group of 7 or 8 people, many of them had been there for the 14 years.

NGO mental health sector professional

Professional cultures within sectors

Professional culture within the mental health sector was seen to contribute to the historical resistance to deinstitutionalisation and community care, uneasy intersectoral collaboration efforts in supported housing projects, and (lack of) openness to partnership approaches between the Mental Health Unit and NGOs. For example, some mental health professionals' reluctance to work with or refer to non-clinical workers was reported by housing workers. Similar problems in supported housing projects had been finally overcome where leaders had been engaged within levels of state government. Privacy and confidentiality law and practices (in the mental health sector) also posed some problems for collaboration and sharing information about clients across sectors. In another example, housing sector NGOs reported more openness to collaboration processes with the relevant government bureaucracy than did mental health and general health sector NGOs.

Early professional resistance to mental health reform was tied to stakeholder distrust in reform processes, a lack of collaboration with the workforce and professional bodies and more hierarchical/authoritarian styles of leadership during the early stages of reform processes. The close of one psychiatric institution in the 1990s was seen to actually strengthen the resources in another. All of these cultural issues were seen to contribute to the extent of intersectoral collaboration and progress of mental health services reform.

Reform processes: positive and negative factors

Whilst the reform of mental health services, in alignment with the National Mental Health Strategy is desirable, state-level reforms sometimes negatively impacted upon collaboration processes and cross-sectoral processes. The overall reform within each sector (housing/disability and health), tied to changes in government, caused problems for intersectoral projects. Reform led to staff turnover, breakdown in established relationships, and unmatched regional boundaries for service delivery across sectors. The different sectors were reforming at different times and in different ways. One mental health NGO was

lobbying for a mental health community senate partly to mitigate some of the problems encountered by the disruption to the policy community.

Policy approaches to promote better housing outcomes for people with mental illness

The findings pointed towards a range of strategies which could promote better intersectoral collaboration for policy agenda setting and implementation processes for housing people with a psychiatric disability. At the level of policy agenda setting, cross sectoral advocacy for housing and support resources involving NGOs and user groups could help to counter ‘within sector’ professional interests. Cross sectoral advocacy could also help to mitigate the negative effect of ‘top down accountability’ upon lobbying activity, the result of NGOs contracts with government.

The social-political acceptability of any policy proposals, important for successful policy agenda setting (Fischer 2003), would need to be considered in light of community stigma and the ‘hierarchy of disability’ (Borsay, in Fulcher 1989). Getting the media onside, educating the public about mental illness and appropriate housing options, and working with local neighbourhoods is necessary. Cross-sectoral policy networks could also involve community participants – people with a psychiatric disability and carers - to help break down stereotypical and stigmatising views about people with mental illness, as some research has indicated that contact with the subject of discrimination is successful in addressing stigma (Read et al 2006).

The case study also suggested the importance of integrated government structures and processes and measures for pulling sectors together. Collaborative processes could be supported by common accountability targets and mechanisms, for example, measuring *housing stability* of people with a mental illness across the mental health and housing sectors. A precedent for common accountability measures has been set by the South Australian Strategic Plan. Within the case study, some participants spoke about the value of the South Australian Strategic Plan (SASP) in terms of creating ownership over policy problems:

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 [State Strategic Plan] targets.

Housing sector public servant

Challenging medical discourses on health and disability via collaborative policy forums and making the connection between problems (i.e. the contribution of appropriate housing to hospital avoidance) may also assist in engendering ownership of and responsibility for the housing problems faced by people with a mental illness. Engaging all stakeholders, including the mental health workforce and clinical leaders within levels of government, is crucial for the implementation of mental health reform and community based models.

Finally, the case study pointed towards appropriate housing models for people with psychiatric disability. Whilst taking into account user preferences for housing models was considered highly desirable, the current reality is a shortage of available housing options. A well resourced, *cross sectoral* housing and support programme which separates the management of tenancy and support functions, and where housing, disability support and clinical care are linked through service delivery, was considered best practice. The experience of social isolation for many people with psychiatric disability led to an expressed need for ‘citizenship’ housing models which address social and geographical isolation (linking to family and friendship networks and community resources) and employment and recreational options.

Summary

During the mental health reform period 2000-2005, there was a strong connection between policy networks within sectors, discourses on health, housing and disability and conceptions of problems and solutions. This situation sometimes led to certain problems missing policy agendas (e.g. the lack of ongoing disability support resources for people with disability linked to housing), and the connection between problems being overlooked. Better housing models which meet the social, economic and health requirements of people with a mental illness are required. Stable, cross sectoral networks will be important for policy agenda setting on housing for people with psychiatric disability. Community stigma, reflected in the media and influencing policy responses, will be an important factor to consider in policy agenda setting, as it helps to shape the social-political acceptability of policy proposals put forth. Engaging leaders across sectors and within levels of government, and developing integrated processes and structures will be important for policy implementation involving cross sectoral solutions. Policy solutions would be supported by the existence of cross-sectoral accountability mechanisms and indicators, such as indicators on housing instability experienced by people with psychiatric disability.

More information:

The PhD upon which this study was based is available

at: <http://catalogue.flinders.edu.au/local/adt/public/adt-SFU20080926.215213/>

An extended paper which considers the case study findings in-depth and in terms of policy theory has been submitted to *Social Science and Medicine*.

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