

BREAKING DOWN THE SILOS TO MAKE A DIFFERENCE: IDENTIFYING HOW GOVERNANCE ARRANGEMENTS CAN BE MADE MORE RESPONSIVE

Emily Schindeler *et al.*

Introduction - Setting the Context

The motivation for the writing and delivery of this Paper emerged from the chasm between the current rhetoric and the current reality of community service planning and delivery. It is essential therefore to look at the nature of this rhetoric and the fundamental barriers it presents to implementation.

The rhetoric says that we should be delivering a service network that:

- operates in partnership
- is client focused and holistic
- offers flexibility in service models and practice
- delivers demonstrable outcomes
- provides the best use of resources and is financially viable,
- is accountable to, and operates from, the priorities of the funding agency
- demonstrates a high level of professionalism, meeting quality standards for service delivery and management.

These are, of course, admirable goals, which in practice could generate significant improvements in the outcomes for the community and for those having a variety of support and service needs. In fact, being 'against' such noble ends would seem to be almost unthinkable.

Therefore, it would be reasonable to expect that, despite the proverbial problem associated with Government silos, systems would be in place to facilitate and even actively encourage the implementation of service solutions based on the principles set out in the rhetoric. It would not appear to require complex scientific solutions to achieve such outcomes. However, in reporting our experience in working across the different domains of Government departments and programs and across the Government and community sectors, the essential infrastructure of policy, practice and process was at every step working against rather than facilitating our initiative.

It is not our thesis that cross sector, cross program and cross Government service solutions have not been achieved. There is a plethora of evidence that this has occurred in each State involving a number of core program and service areas. Despite these precedents, there is still a problem. For us, barriers existed at almost every step, often with a greater focus on why 'we couldn't rather than 'how we could'. At the same time there seemed to be no doubt as to the merit of the project.

From this experience our beliefs were made concrete, that the discussion we have today needs to be had, and had again until we get it right. The topic then is how can we draw from successes to demonstrate the need, direction and priorities for change which will transform the rhetoric to practice. We will set out our experience, our questions and our thoughts and actively seek your help in finding solutions.

Our Objective

*“Client needs as opposed to program needs - basis of the whole rationale”
“We deal with problems, not people’s lives”*

To understand the importance of our partnership, it is essential to understand our clients, our individual program roles and the framework within which we work. The first sections of this paper look at each of these elements and how they have impacted on our capacity to achieve an integrated client response.

Mental Health Service Clients

Our clients experience mental health problems for which they receive clinical support from the Queensland Health Division of Mental Health Services (Mental Health Services).

- ◆ Because mental health problems are often episodic, our clients may require different levels of assistance at different times, with the needs of the individual able to range from intensive to periodic intervention.
- ◆ All our clients have the capacity to live in the community, whether at home with family, in private or public housing, boarding houses or are without stable accommodation at all.
- ◆ Some of our clients require a periodic stay in the hospital which might jeopardise a normal private housing tenancy.
- ◆ Some of our clients require access to an appropriate housing option in order to exit from a hospital stay.
- ◆ Finally for some of our clients, hospitalisation is the only option for respite for themselves or for their families, although high levels of intervention may not be needed.

Many of our clients need access to either short or long term transitional housing, , but there are many high need families and individuals for whom appropriate and affordable housing and support is also out of reach. However, it is important to appreciate the needs of our clients within the broader context of the strong relationship between mental health problems and homelessness.

There is no shortage of reports highlighting the disadvantage faced by people experiencing mental health problems in accessing their clinical, support and housing needs. In fact, mental health has been found to be one of the two major risk factors associated with homelessness. Reports suggest that the incidence of serious mental health disorders is twice as high amongst the homeless; and individuals with such disabilities are amongst those at the highest risk of becoming homeless. However, housing in itself is not adequate. Evidence demonstrates that individuals with severe and long term mental health disorders living unsupported in mainstream housing in the community often find the ordinary stress of managing on their own more than they can handle. After a while they tend to forget their medications, to neglect nutrition and to let their lives unravel and become unorganised. Eventually they find their way back to hospital or the streets. (cited in Mental Health Housing Project, from Hudson,1997)

The Burdekin Report found that, “one of the biggest obstacles in the lives of people with a mental illness is the absence of adequate, affordable and secure accommodation”. Since the publication of that Report, there is continuing evidence that accessing appropriate and affordable housing and support is increasingly difficult for people experiencing mental health or psychiatric disorders, resulting in greater risk of avoidable hospitalisation and reduced opportunity for individual well being. Reports by such agencies as the Wesley Mission, Mission Australia, St Vincent de Paul as well as reports prepared for the Commonwealth and Queensland Government, continue to highlight the need to achieve better community based responses to housing and support for mental health consumers.

So where does this project fit into the broader picture of risk? From the mental health and well being perspective, transitional and short term housing can be a key factor in assisting individuals to:

- develop personal and environmental coping strategies
- acquire essential skills and self confidence in a community environment
- achieve greater social integration and the ability to sustain independent living, reducing the stigmatising affect of ‘special housing’
- avoid the cycle of homelessness.

It is essential then to highlight two fundamental factors contributing to the poor access to appropriate housing and risk of homelessness for people disadvantaged by mental health problems. The first factor is the separation of mental health services as a discrete medical service focused on health treatment. The lack of resourcing for a more holistic approach for the package of needs means that Mental Health Services need to rely on the capacity of other services to respond. At the same time, social housing providers have limited capacity to provide the needed housing response.

A second factor contributing to the risk of people with mental health problems is the perception and treatment of respite housing as a health model. Access to respite can be critical to the maintenance of individual independence, through support of the client and family. However, the existing approach to respite often marginalises mental health service clients and can place them, inappropriately, in a medical rather than community model. At the same time, community housing is well positioned to fill this gap. Established infrastructure, management systems and community orientation make community housing a natural player in a broad range of housing options – including management of accommodation for social and support respite purposes. Yet, compartmentalisation processes of housing, health and mental health have virtually ignored this need.

The outcome then that we are seeking to achieve is to increase the ability of the individual, with diagnosed mental health problems to establish and maintain independent living arrangements, whether with family, friends or independently, through facilitating access to the appropriate mix of housing and support within the community.

Community Housing Clients

Our clients are people who experience a range of disadvantages in accessing affordable, appropriate and secure housing. Many are at risk of homelessness. A number of our clients have experienced the cycle of public housing, eviction, supported accommodation, community housing and public housing. Although we are not a supported housing service, a substantial proportion of our clients require assistance to maintain their tenancies. Our clients present with a wide range of physical, intellectual and mental health disabilities as well as socio-economic disadvantage. While we are able to provide referrals to a wide

range of services within the community, we have no real capacity to provide the type of follow up which is often required. Finally our clients often require a significant period of housing stability simply to be able to address the other problems in their lives. The period of stability we are able to offer has, however, been largely dictated by our program guidelines rather than individual need.

Clients with mental health problems requiring specialist support have historically provided a real tenancy management challenge for community housing. Many people self present for housing assistance after a cycle of failed tenancies and with no linkages with Mental Health Services, despite having a need for specialist assistance. Other people have had such support and cease to be within the system. Where mental health issues result in behavioural problems, the community housing provider generally has little support in working to resolve them other than by a referral which may or may not be pursued. The extent to which local mental health teams are able, resourced or interested in responding to such referrals can also be quite erratic, depending on the leadership, culture and priorities of the individual service. The result has been then a reticence by many providers to accept applicants who are likely to present such problems if there are inadequate community resources to provide the specialist support. Clients with dual diagnoses, such as mental health and substance abuse, have significantly diminished chance of accessing mainstream community housing. While gating processes are certainly not consistent with program guidelines or policies, the reality of practice may make it a necessity for poorly resourced services.

It was important then for us to look at a partnership with the local Mental Health team for a number of reasons. Firstly, we are well placed to provide an appropriate housing response to a well defined local need. Secondly, through such partnerships we have an enhanced capacity to respond to clients who otherwise may have had difficulty in maintaining a tenancy. Finally, by building up such relationships, we will be able to develop not only our own skills in managing special tenancy support needs, but hopefully to develop a better team approach in responding to tenants who have not initially come through the partnership, but for whom specialist support will be critical. In short, we can build a foundation for a growing number of strategies for responding to the needs of more challenging tenants.

The outcome that we are seeking is to increase our ability to respond to a target group that experiences barriers to accessing and sustaining affordable and appropriate housing solution. Furthermore, we wish to lay the foundation for future initiatives with the Mental Health Service to enhance our ability to effectively respond to the needs of tenants who have similar clinical needs but have not been picked up by the system.

Our aim as a partner has been to build effective organisational capacity through collaboration.

Meeting Client Needs

The objective of this initiative was to establish a partnership in which clients of the Logan- Beaudesert Community Mental Health Service were able to access accommodation which support their needs and was flexible in length and nature of tenure. Importantly the project has focused on putting in place an economic, outcome oriented and integrated response which will assist the Logan- Beaudesert Community Mental Health Service clients to achieve and maintain appropriate and effective living arrangements within the community,

A partnership between the Logan- Beaudesert Community Mental Health Service and Interlink emerged then from a shared vision. This vision is an image of a more complete response to individual need not

achievable by services acting independently. It is a response which is holistic and based upon common commitment not shaped by program limitations. This approach was seen as being able to provide more sustainable, quality outcomes and best value for service resources and objectives.

How Governance Arrangements Impacted on our Project

To get this project up and running did not require sophisticated planning or management processes. The initial agreement, between Interlink and the Logan - Beaudesert Community Mental Health Service was easily nussed out. With a commitment by the Mental Health Service to the provision of funding for housing management and the ability of Interlink to offer access to existing housing stock, it looked like it should be smooth sailing. At the same time, a community based disability service expressed interest, subject to funding, in providing intensive day to day support for clients requiring it. However, the initial establishment phase was soon to hit turbid waters with many rocky outcrops. It is important to draw out the complexity of developing a joint initiative which crossed three program boundaries, an equivalent number of Government Departments and funding limitations. It was in fact this complexity which brought the project to a grinding halt for a period of several months, from which it is now slowly beginning to emerge .

Governance issues which have raised a major problem for this project were found in:

- the lack of congruence between Government goals and policies
- the lack of consistency between policy and operational objectives
- the lack of mechanisms for systemic responses to these incongruencies
- initial lack of interest by key Government programs to resolve these incongruencies
- the complexity of the networks needed to be negotiated to build inter-organisational collaborative capacity.

Government Goals and Policies

The first barrier is the lack of congruency between explicit goals and policies within and across government departments and program areas. In terms of housing two core documents which need to be considered are the *Community Housing Plan 1999-2004* and *Improving People's Lives through Housing*. These documents clearly set out a commitment to:

- ◆ responding to local housing need in a flexible way and in partnership with other agencies, community and tenants
- ◆ encouraging community housing sector viability through growth
- ◆ provision of successful housing outcomes.

In terms of Queensland Health and Mental Health, the *Queensland 10 Year Mental Health Strategy* identifies a commitment to:

- ◆ establishing mainstreamed integrated services to promote continuity of care across service components
- ◆ improving intersectoral links, particularly with housing and disability support agencies
- ◆ providing locally available care through the more equitable distribution of mental health resources.

The *Strategic Plan for Psychiatric Disability Services and Support Plan* for Queensland similarly identifies a commitment to:

- ◆ the development of holistic responses
- ◆ increasing access and equity to services and support
- ◆ working in partnership with clients, Government and non government services
- ◆ working flexibly to provide and foster innovative responses to need.

Given this goal and policy framework, it would seem on the surface that there is a significant level of congruence to support the proposed project. In practice however, we experienced a very different reality.

Goal conflicts occurred within the single program of social housing. Conflicts occur between goals for public housing, community housing and resource management. Although there is a strong focus on responding to clients with greatest needs, providing individually appropriate housing outcomes and working in partnership across agencies, program boundaries prescribe what is ‘in and out’ of scope irrespective of the extent to which such exclusions conflict with the broader social housing goals. By inflexibly aligning resources to defined program parameters, there is little or no allowance for the negotiation of boundaries, even when it is clear that broader social housing strategies are being advanced. For example, because short term transitional housing (in our project’s context) was seen by Queensland Housing as outside the traditional program framework and as a health rather than a ‘social housing’ issue, and because clients could possibly transition to family rather than public housing (a key reporting indicator for our CRS program) the initial response was not supportive, even where the project was clearly linked to:

- (a) delivering a social housing response to identified local need and target group
- (b) increased viability of the community housing provider by enhancing the ability of the agency to work with a range of partners (eg increasing funding through management fee arrangements)
- (c) achieving appropriate and sustainable housing outcomes from a client group known to experience the highest level of risks of homelessness

Lack of congruence between goals and policies create significant barriers to building inter-organisational capacity building. For example, while the DSQ Strategic Plan sets goals for promoting greater service integration, responsiveness and accessibility, the establishment of individual funding packages to the exclusion of funding organisations to provide disability support for eligible clients, creates an insurmountable barrier to building partnership and holistic responses.

Lack of congruence between public policies, programs and service delivery operations creates significant gaps through lack of responsibility for resourcing a holistic response. For example, the establishment of independent living options with support is clearly consistent with the goals for reducing risk of homelessness, for integration of people with mental health problems within the community and ensuring accessibility for people with disabilities. However, there is no defined responsibility for the practical resourcing needed to make this happen – either in terms of infrastructure (such as housing or furnishing of such housing) or service (such as provision of support to that independence.) In fact, there are no apparent resource incentives within the system to even encourage such partnerships.

Despite shared goals, the compartmentalisation of strategies and programs within specific departmental goals contributes to a lack of congruence across complementary responsibilities. While it is well recognised that responses to the individual need to be holistic at the ground level, the lack of a holistic goal or policy integration by public agencies continues to dissect responsibilities into individual, anti-symbiotic compartments. This was clearly apparent in our project. While the Logan Beaudesert Mental Health Service was prepared to contribute human and financial resources to the project, the lack of linkage with Disability or Housing nearly compromised the project's implementation. In short, the configuration of responsibilities for service provision has no practical or structural linkages outside of any given department again creating a need for continual renegotiation outside the context of any common policies or principles for resourcing inter-organisational capacity building. Further, there is no apparent system for bringing the public agency partners together despite the explicit shared goals at a strategic level. This has created a substantial barrier to the development of integrated responses in which responsibilities for determining and reporting on resource allocations go across these structures.

Inconsistent interpretation of goals and policies at the strategic and operational ends of government leads to inconsistent decision making. Governance arrangements have also been shaped by a shifting of responsibilities from central office to regional or local structures. In some cases, planning and establishment of priorities has been allocated to the local or regional level, whereas in other areas such responsibilities have been retained at a statewide level. Even where there has been a downward push of rights and responsibilities to the local, area or regional level, this has been largely constrained by statewide definition of programs, parameters or priorities. In this sense then, governance arrangements have acted as a significant constraint to the development of holistic and locally appropriate service configurations. At the other end of the spectrum, we know from recent experience in North Queensland, that any precedent of breaking boundaries can facilitate replication elsewhere. It is through our success in Logan that a similar project is getting some support from Area Housing Management in the north.

Conflict exists between public goals for prevention and early intervention and for prioritising those most in need. The policy of priority for those in greatest need not only acts as a gate to keep people out, but also creates a high degree of inflexibility. Service provision can be limited to, and defined by, the suite of people in most need. In an environment of limited resources, service providers may often define target clients as those who are likely to achieve the best outcomes, stretching the interpretation of strict target populations. In this scenario, early intervention priorities may take precedent. However where is ambiguity about how to allocate resources to conflicting priorities. Studies show that in this circumstance, the operational end may suffer from confusion and low morale.

Conflict exists between Government policies for fostering innovation and resource management strategies. Resource management strategies have had a number of impacts on how willing the operational end of service is to work in a collaborative model:

- ◆ There is, for many services, a real disincentive to risk the trial of innovate strategies, with a view to staying on the safest path. In a climate of economic rationalism, only those with substantial resources of their own are likely to be able to move outside of the tight leash of program and funding guidelines and restrictions.
- ◆ The processes of competition for funding, which is encouraged by Government, means that services often grow at the expense of others. The outcome is that individual viability becomes the driving force for decision making, Darwinism in the community sector. This then creates a significant barrier to inter-organisational capacity building through collaboration. The reality appears to be, that community organisations find themselves in the position of needing to decide whether they wish to participate as the carnivore or the meal. An apparent conflict between complementary disability support providers over turf and ownership of support in this project brought this home strongly. In fact, this conflict was exacerbated by the need to identify previously funded hours of support available from services given the lack of any new funding from DSQ for such an approach.

Conflict exists between Government policies and goals and the system of accountability. For example:

- ◆ outcomes upon which a service or program is measured are an invalid indicator of real outcomes
- ◆ lack of ability to provide quantifiable outcomes creates a barrier to accessing resources, for example savings on avoiding hospitalisation days or enhancing likelihood of successful tenancies in the long term are difficult to quantify or demonstrate without the benefit of longitudinal studies, which are outside the scope of existing funding accountability frameworks.
- ◆ lack of capacity to report positively on achieving integrated outcomes creates its own disincentive. Without such outcomes being included as a key performance indicator, the importance of inter-organisational capacity building is simply not valued. For example, if the only program-based housing exit which is valued is movement by target groups to public housing, than this creates an artificial definition of housing outcomes which conflicts with wider goal of assisting people at risk or in housing need into secure, affordable appropriate housing solutions.

Each of these factors directly impacted upon the capacity of our services, as a direct Mental Health Service provider and a government funded community housing service, and as a disability service provider, to provide a locally appropriate and integrated service response.

How Far We Travelled and The Road Ahead

Despite this complexity of barriers, we have actually travelled quite far now.

- ◆ The Queensland Public Housing Area Office has made housing available for the short term housing service with the approval of the Community Housing Manager and Minister
- ◆ Some CRS housing has been able to be made available for the transitional housing model as part of an ongoing Crisis and Transitional Housing Demonstration Project
- ◆ A grant has been made available from the Gaming Machine Community Benefit Fund of furnishings for the properties
- ◆ Housing maintenance and management funding has been made available from the Logan Beaudesert Community Mental Health Service
- ◆ Disability support hours have been able to be amassed through contributions by a disability support service and the local Home and Community Care Program
- ◆ Formal service agreements, including protocols for how we will work effectively together and with our clients, have been established and endorsed by our respective organisations
- ◆ We are hoping to have our first clients housed no later than mid November.

The important question which needs to be answered is how did we achieve this. The answer is simplicity accompanied by incredible hours of angst, confusion and frustration. It was first and foremost done by workers. Workers in each of the agencies wanting to make it happen worked through their individual bureaucracies. Workers in each of the agencies lent support to each other to present a coherent team approach. Workers in each agency pushing their own program boundaries that extra bit to increase everyone's capacity to deliver a real outcome.

For the future, we have not been able to identify:

- ◆ any long term resourcing for disability support after existing pre-allocated funds are spent
- ◆ any long term resourcing for housing maintenance and management after existing trial funds are expended
- ◆ any established path for bringing the responsible agencies together to breakdown the compartmental boundaries which have made this project so difficult
- ◆ any substantive way to gain additional support or growth as a result of our inter-organisational partnership by any Department or program of Government.

This then raises the issue as to whether the outcomes achieved, the greater capacity building and client outcomes will only be ephemeral. Using an analogy from the construction industry, we will have laid down a solid foundation and yet have no resources for the bricks and mortar of the future.

What We have Learned

To date, we have not had the opportunity to test how well our approach will work on the ground. We had hoped that by the time of writing this that we would be able to at least report on our initial experience – but this will need to wait until next year. Nonetheless, we have learned a great deal. We have learned that:

- ◆ without real determination, this whole collaboration could have well fallen by the wayside – we needed to be in it for the long haul
- ◆ it turned out to be more difficult than we had anticipated, largely due to broad governance issues, most of which were outside our real sphere of influence
- ◆ building inter-organisational capacity across Government and non government agencies is no easier than partnerships within the same sector
- ◆ there is a need for a real change in how Governance arrangements operate in order to create incentives rather than barriers to capacity building across sectors, across programs, across goals and across Departments.

Creating Incentives rather than Barriers to Making the Rhetoric Practice

The aim of this Paper has been to stimulate discussion about how to best implement change to reduce the boundaries to innovation, to inter-organisational capacity building and to operating holistically at the strategic and operational levels, and across all goals of Government to meet community need. We are hoping to stimulate this discussion then by putting out a few ideas – some of which would appear to be transparently obvious and others controversial – but it would appear even the obvious has not gone on to the agenda in any substantive way. Therefore we will risk stating the obvious and hope that the combined wisdom of a National Housing Conference will help to move this forward.

Boundaries of Social Housing

- ◆ There is a need to breakdown the barriers between social housing programs to generate a greater continuity across the housing options, providers and sectors to allow clients and providers to move more flexibly to appropriate solutions
- ◆ There is a need to breakdown barriers between the goals of social housing and the goals of other community programs to generate whole of Government responsibility for integrated resourcing
- ◆ There is a need to achieve better congruency between social housing goals, policies, practices and resourcing of the operation of community housing
- ◆ There is a need to promote enhanced viability of community housing by creating more incentives for inter-organisational capacity building through collaboration
- ◆ There is a need to re-examine whether social housing can make a significant contribution to special needs clients, such as those experiencing long term mental health problems, through the adoption of more inclusionary approaches to funding and delivery of respite models.

Inter-Organisational Capacity Building Through Collaboration

- ◆ There is a need to establish better mechanisms for recognising, promoting and rewarding inter-organisational collaboration across housing and non housing sectors
- ◆ There is a need to establish an integrated approval process for inter-organisational initiatives which advance the achievement of whole of Government goals when managed or administered across a variety of departments and programs
- ◆ There is a need to establish new methods of accountability which incorporate key performance indicators associated with inter-organisational capacity building.
- ◆ There is a need to develop new management processes which identify and reconcile barriers to solutions for complex problems and resourcing strategies

Finally it is our view that the key to solutions lies in reducing the barriers to collaboration, reducing the level of compartmentalisation of governance and generating a more proactive approach to inter-organisational capacity building. Social housing generally and community housing in particular has demonstrated its capacity to form partnerships and generate collaborative strategies. The challenge lies in how we approach this to reduce the need to reinvent the processes every time and establish systems which facilitate this well established foundation.