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Housing & Mental Health - Best Practices in Australia?**

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The paper discusses evidence from international research and the Australian literature about approaches and models of housing for consumers with psychiatric disability in the context of deinstitutionalisation and closure of psychiatric institutions. Although there are only limited Australian examples documented in the literature, there is substantial European and North American literature that documents good practice and the successes and failures of alternative accommodation initiatives. The primary question for this paper is not whether any one 'best practice' can be identified for Australian conditions but what can be learned from the successes or failures of international approaches and their likely transferability to Australian contexts. It is a central contention that it is difficult to identify any one approach that can be held up as a single 'best practice' due to the diversity of preferences and needs of consumers and to the broad range of opinions of all those involved – consumers, their families and their institutional and community based service providers. This inevitable range of views about suitable care makes it essential to evaluate all accommodation models in terms of adequacy, humanity and cost effectiveness – these appearing to be key variables. This is essential for looking at working models for Australia within continuing patterns of deinstitutionalised service provision and current rather ad hoc patterns of accommodating those discharged.

Introduction

The paper sets the scene with some discussion of impacts of the downsizing of institutional care options for mental health patients occurring in Australia in the last few decades and then explores some of the key variables involved in re-housing adult mental health patients. A review of evidence from international and national research on the primary housing approaches is presented with a proviso about uncritical adoption of international models and the danger of attempting to define any one approach as superior to others. The continuing and increasing need to achieve positive housing outcomes is underlined for both consumers with psychiatric illness and residents of recipient communities as is what occurs when inadequate housing is the only option. Gaps in existing research are briefly reviewed before the paper concludes with a call for evidence based research on the housing needs and preferences for those with mental health issues.

Deinstitutionalisation and re-housing

Deinstitutionalisation has involved one of the most complex recent changes in mental health policy in Australia. Previously, most patients with a psychiatric illness in Australia were institutionalised but most states went through a process of deinstitutionalization in the last few decades (Newton, Rosen, Tennant & Hobbs, 2001). Numerous reports have noted the need for a broad range of community services providing support and treatment for patients with continuing needs as well as the provision of decent accommodation options. The 1993 Burdekin Report stated that ‘one of the biggest obstacles in the lives of people with mental illness is the absence of adequate, affordable and secure accommodation’ (HREOC 1993). More than a decade later the ‘provision of appropriate community housing options’ remains one of the ten highest priorities of consumers, carers and families documented in the *Not For Service* report of the Mental Health Council of Australia (MHCA, 2005).

Despite the implementation of the National Mental Health Strategy and Plans as a national framework for mental health reform since the mid 1990s, the establishment of comprehensive, viable and effective community based alternatives to psychiatric institutions is far from complete. The Select Committee on Mental Health of the Australian Senate reported that ‘deinstitutionalisation moved thousands of people out of institutions and into the community, but without a commensurate growth in accommodation’ (Commonwealth of Australia 2006, p.239).

There is evidence that many people with mental illness are not able to access the existing social housing and emergency housing programs available in Australia, such as the Supported Accommodation Assistance Program (SAAP). Consequently, many experience homelessness and insecure and/or inferior housing, which exacerbates their illness and puts them into a high risk category for homelessness, police notice and possible imprisonment (Commonwealth of Australia 2006, p. 244). On the other hand, some remain in situations of heavy support and care that may limit opportunities for recovery. As Clark (2006, p.31) notes, despite the ‘deinstitutionalisation movement and current mental health policy’ many mental health clients ‘continue to live in accommodation and receive support services at one end of a housing continuum, namely the more institutional end’, even though many would appear to benefit from residential situations with some greater independence.

Nevertheless, successful deinstitutionalisation has benefits for clients, for the community and if managed well, public finances. Even if what they move to has not always been of high standard, research on deinstitutionalisation in Germany, the UK

and the US links the *move out* of psychiatric hospitals to marked improvements in patient satisfaction and quality of life (Forrester-Jones, Carpenter, Cambridge, Tate, Hallam, Knapp, & Beecham, 2002; Priebe, Hoffman, Isermann & Kaiser, 2002; Leff, Trieman & Knapp, 2000; Leff, Trieman & Gooch, 1996; Srebnik, Livingston, Gordon & King, 1995; and Lapsley, Tribe, Tennant, Rosen, Hobbs & Newton, 2000). Hobbs, Newton, Tennant, Rosen & Tribe (2002) suggest that *financially*, further deinstitutionalization is warranted in that a hospital setting usually costs twice that of other forms of care in community settings.

Deinstitutionalisation has not removed the obligation on government bodies to provide suitable homes for those relocated to the community as a result of state and/or federal deinstitutionalisation policies. Bostock & Gleeson (2004) argue however, that the re-housing aspects of deinstitutionalisation policies have been neglected in discussions about community care. Also, there has been little contextual research on housing options in mental health in Australia that also includes evaluation of outcomes, program implementation issues, consumer experiences and the preferences of all others involved. Until there is more coherent research, much about housing for those with mental health issues remains poorly understood in the Australian context.

Housing Approaches from International and National Perspectives

As substantial analytical and critical European and North American literature documents a range of practices in housing for those with mental illness, some review of the successes and failures of these initiatives are included in this discussion as they may illuminate possible best practice options for Australia. Usage differs across jurisdictions, making international comparisons difficult, so it is essential to define some key terms. For example, some authors consider supported housing to be different from independent housing (e.g. Fakhoury, Murray, Shepherd & Priebe, 2002, p. 308), whereas for others, supported housing *includes* independent housing (e.g. Parkinson, Nelson & Horgan, 1999). It seems important to establish some clearer definitions of housing approaches in attempting any estimate of best practices in this field.

One of the major differences between existing housing approaches appears to be in the degree and nature of support involved. This is probably one of the most contested variables in examining housing options for mental health patients: too much support may foster dependence and inhibit recovery, too little may contribute to relapse and rehospitalisation, or bouts of homelessness or imprisonment. Cooper, Verity & Masters (2005) analyse the housing and support needs of people with complex needs in the south of Adelaide. This includes people experiencing mental illness, challenging behaviour and physical health problems. They define support, after Williams & Popay (1999), as a 'landscape of enabling resources'. Cooper et al (2005) also take a similar approach to that of O'Brien, Inglis, Herbert, & Reynolds (2002) in arguing that achieving stable housing for people with complex needs is not reducible to a simple equation, but is instead the result of a range of interrelated variables:

'These variables are a combination of private factors (e.g. individual health status, goals, aspirations, resources, social networks and engagement) interacting with public factors (e.g. access to resources such as finances, human services, appropriate housing, partnerships, service coordination, interagency linkages and public policies). The existence or lack of these factors can result in a situation whereby someone has complex needs, and can either enable or constrain that person's housing stability' (Cooper et al, 2005, p. 9).

Greater precision than this in describing housing approaches is necessary to define some best practices. Canadians Parkinson et al (1999) define three main approaches to

housing for psychiatric consumers/survivors as being *custodial*, *supportive* and *supported* and it seems useful here to look at these.

Custodial Housing

Parkinson et al (1999) describe *custodial housing* as ‘the medical model in the community’. It is characterised by board and care homes, single room occupancy, foster homes and nursing homes and in some countries has been the predominant approach to housing in the initial phases of deinstitutionalization. Characteristics of this housing approach often include restrictive rules, staff control, high dependency of residents, little choice for consumers (over housing, living companions or daily activity), long term residency and large numbers of residents usually around 20). The consumer’s role is that of patient. Parkinson et al (1999) report on a large 10-year follow-up of 360 residents of sheltered care in the US. It was found that that custodial housing offers few benefits to consumers/survivors. The researchers report that days in hospital decreased, but that participants’ health was poorer, they had more symptoms, reduced levels of independent social functioning and family contact and no significant changes in external social interactions (Parkinson et al 1999, p. 156).

O’Malley and Croucher (2005) claim there are tensions around the purpose of high support facilities and custodial approaches in general: are they rehabilitation units providing transitional accommodation while people prepare for more independent living, or are they long stay, permanent homes for the most disabled patients? This question has enormous implications for all approaches adopted in any setting. Clark (2006) describes the problem of residents in SRF’s becoming stuck in this kind of accommodation, thus limiting their potential for developing greater self efficacy.

Supportive Housing

Supportive housing is described as the ‘residential continuum approach’ – providing graded levels of support over time. This developed as part of a community treatment and rehabilitation approach. Within this arrangement, the number of housemates reduces as functioning increases and the norm is a group home with a relatively standardized and lower level of support and/or treatment for residents. Professional support services are maintained as long as patients require them but decrease as consumers move through a continuum of need. This is designed to foster eventual independence. Peer support and community participation is also encouraged. There is some evidence that residents of supportive housing in a group community setting have more support than those living independently (Parkinson et al 1999, p.149). They report evidence from a large number of studies that living in group homes can have positive outcomes such as ‘increases in housing and financial stability, instrumental roles, independent functioning, self-esteem, social skills, competence in daily living skills, vocational functioning, social networks, capacity to meet basic needs, cognitive and social functioning, quality of life, reduced number of days spent in hospitals, reduced hospitalization rates, and fewer symptoms’ (Parkinson et al 1999, p. 156). Reduced homelessness and increased likelihood of moving to permanent housing have also been reported. Not all forms of fully staffed housing arrangements suit everyone however. Forchuk, Nelson & Hall (2006, p.46) in their US study, note complaints from residents about lack of privacy, too many rules and regulations and cramped quarters in many of the supportive housing options available.

An Australian example of supportive housing was the subject of a detailed study by Newton and colleagues (Hobbs et al, 2002)). This longitudinal study of the deinstitutionalization process and outcomes for a population of psychiatric patients in

Sydney reports success with group homes with on-site support. Staff support was gradually reduced over two years as residents' capacity for independent living increased. Initially two staff per 8 hour shift were provided, with additional staff provided as required. By the end of the study period this had reduced to daily visits and 24 hour telephone contact rather than 24 hour staff presence and some of the residents had moved to independent housing. The clinical outcomes were positive with significant improvements in quality of life and significant reductions in psychiatric symptoms and no negative changes in social behaviour or medication levels (Hobbs, Tennant, Rosen, Newton, Lapsley, Tribe, Brown, 2000). The authors also recommend that purpose built, clustered units would be better than the large group homes of ten or so residents that were provided in this case (Hobbs et al, 2002).

The economic analysis shows that the costs of care and living in the community were 43% of the costs in hospital. Staff costs amount to about 75% of the total in both settings. Their analysis reveals that even a model that includes 24 hour on-site staff support for two years provides cost savings compared to hospital care (Lapsley, Tribe, Tennant, Rosen, Hobbs, Newton 2000, pp. 493-495). However, they cite other research that shows costs rise in later phases as more highly disabled cohorts require more specialized assistance to live in the community, infrastructure needs may increase with higher numbers of individuals deinstitutionalized, and the price of the specialist skills will go up with demand (Lapsley et al 2000, p. 495). The authors claim that this study was the only published outcomes research on Australian deinstitutionalization.

Supported Housing

Supported housing can be described as the new paradigm of community mental health. This emerged in the 1990s as a 'person-centred focus of support, emphasizing self-help and natural supports and de-emphasising professional services' (Parkinson et al 1999 p.149). The idea is that consumers 'are assisted to *choose, get and keep* non-segregated, stable, quality housing and supports that they want in the community' (Parkinson et al 1999 p. 150). Consumers live on their own or in pairs and where the housing is the form of apartments, there is often a low ratio of supported housing to other forms in the apartment block. Wong, Filoromo & Tennille (2007) define the principles of supported housing as consumer choice, normalised housing with resource accessibility, consumer control and individualised and flexible support.

Parkinson et al (1999) reviewed the outcomes research on supported housing that was emerging in the US during the 1990s. They found that supported housing residents experience increases in residential stability, independent living, resident satisfaction (especially if they received a housing subsidy), and reduced homelessness (related to increased stability), hospitalization rates and symptoms. The use of effective case management did not contribute additional residential stability. Parkinson et al (1999) identify social isolation and poor employment results (when compared to supportive housing) as the two weaknesses of supported housing.

Despite the need for more evidence regarding 'what features of housing and supports make the most difference and for whom' (Rog, 2004, p. 342), the cost effectiveness of supported housing and consumer preference for it causes many researchers to recommend this approach. From their review of the evidence from a range of housing approaches for people with psychiatric disability Parkinson et al conclude that 'the best controlled studies tell us that providing homes through the supported housing approach is the best strategy' (Parkinson et al, 1999, p. 158) and they urge policy makers and service providers to replace custodial housing with supported housing. They do,

however, recognize that supportive housing has a role to play, and that residential alternatives to hospitalization for acute care are required. They argue that group living can have short term benefits but must be available as a choice rather than the only option. They also recommend the de-linking of housing and support in group living situations, as is done for supported housing. Finally the authors call for more research on the processes and outcomes of supported housing and supportive apartments.

Rog (2004) claims conflicting evidence exists about the superiority of supported housing over other supportive housing approaches. She cites one study with a strong design showed that affordability of the housing is a more important factor than housing program or model in establishing independent, stable living. Rog (2004) notes the importance of eight major housing dimensions of supported housing as developed by the US organization the Centre for Mental Health Services (CMHS), summarised as in the following:

1. Housing is in the individual's name (owned or leased) not the agency's name, is not linked to the particular program and is 'permanent' in so far as any housing in the community is so;
2. Housing and service agencies are legally and functionally separate;
3. Housing is integrated into the community;
4. Housing is affordable (under 40% of gross income);
5. Services including medication are voluntary;
6. Individuals have choice of housing and services;
7. Services are community based not live-in;
8. Crisis services are available 24 hours a day, 7 days a week (Rog, 2004, p.340).

An Australian example of supported housing within a public housing framework was studied by Jones, Chesters & Fletcher (2003). The 'SNAP' supported housing program in regional Victoria was reported to successfully meet many of the housing and support needs of its residents. Within the supported housing approach, there seems to be an emerging model of an Australian partnership approach between Government providers of housing stock and mental health services, and non-government providers of tenancy support and non-clinical services (Jones et al, 2003; Parry & Daniel, 2004; Morris, Muir, Dadich, Abelló & Bleasdale, 2005).

A note on Australian terminology

In the Australian context, 'congregate housing' is a term often used to describe Supported Residential Facilities (SRF), boarding houses, and sometimes group homes. Depending on the features of the housing service, these would fall into either custodial or supportive housing in the Parkinson et al (1999) typology. 'Integrated housing' is another term referring to low-income apartment housing where a range of services and resources are provided on-site, but are optional for the tenant. It does not specifically target those with mental illness, but is pitched at a range of people requiring affordable housing and who might otherwise be at risk of homelessness.

Synthesis - Housing Approaches and Mental Health

Inferior accommodation options for adult deinstitutionalised mental health patients can pose risks to them and the community, both socially and economically. White and Whiteford (2006) raise essential issues about the care and provision in our society for those with mental health problems who also travel the broad, circular path between mental institutions, inadequate housing and support at the community level and prisons. Among other issues, they see access to stable housing as impacting on a person's recovery and on staying off the street and out of prison. Zapf, Roesch & Hart (1996, p.

439) note the research of Leukfeld indicating that prisons are little more than ‘warehouses’ for those offenders with mental illness and the related link with homelessness within this large cohort. In her review of the evidence on supported housing in the USA, Rog (2002) points out that the clearest evidence of the benefit of any mental housing program is achieved when it is compared to no program, i.e. homelessness and its accompanying risks for all. Langdon, Yáguez, Brown & Hope (2001) describe how instances of self-harm and violent behavior produced in part by stress about housing, feed into social stereotypes about people with mental illness. Disruptive behavior seen as causing problems between public housing residents, in the case of those with mental illness often points to lack of adequate support (Housing SA, 2007), suggesting that appropriate and stable housing requires assisted risk management. Such services provide vital preventative measures in recovering from mental illness. As well, re-hospitalisation or imprisonment produces social, psychological and economic costs for the individual, the community and governments.

Knowing how to establish stable housing options that work for adults with mental health issues is thus an essential research and policy issue, intersecting as it does this previous range of perspectives. Friedrich, Hollingsworth, Hradek, Friedrich & Culp (1999, p.512) note that ‘separation of staff from housing, as recommended in the supported-housing literature, may be an inappropriate arrangement for a large number of clients, particularly those with schizophrenia’ and this underlines the need for some form of integrated support for adult patients with serious and ongoing mental health issues.

Central in this discussion is the search for holistic approaches to accommodation for adults with psychiatric disability. For a beginning, in the Australian context, O’Brien et al (2002) identify four key elements that enable stable, independent housing to be achieved. These are:

- the housing situation does not aggravate the individual’s illness;
- reliable support for medication is available and trusted (may be informal support);
- the person is willing and able to manage daily challenges of independent living;
- any issues that put housing at risk have been identified and pro-actively addressed.

This still leaves much to be defined, however, in particular how to get the balance right between support and independence and between privacy and companionship. In general, in examining perceptions of consumer preference from other Australian studies, O’Brien et al (2002) describe group settings providing limited privacy as the ‘least preferred’ housing and living in a private house or flat as the most preferred option, including independent living in a range of public and private tenures. O’Brien et al (2002) cite studies indicating that for many people leaving psychiatric institutional care, living arrangements offering a balance of independence and assistance or support may mean the difference between recovery or readmission.

Many authors link patients’ recovery and reintegration into the community following deinstitutionalization, to *flexible* support offered in combination with a flexible range of living arrangements (Trauer, Farhall, Newton & Cheung, 2001; Andrews, Teesson, Stewart & Hoult, 1990; Newton, et al, 2001). UK researchers O’Malley & Croucher found a range of evidence to support the development of low intensity support services for some people with mental health problems. There are dangers however, in assuming that low levels of support will be adequate for all types of patients, particularly in terms of the ‘revolving door’ between homelessness, prison and/or readmission that can result from providing inadequate levels of care (O’Malley and Croucher, 2005 p. 837). US research suggests that people in independent but supported housing are more satisfied

overall than those living in more heavily supported communal (supportive) arrangements (Tsemberis, Rogers, Rodis, Dushuttle & Skryha, 2003). In Hong Kong also, mental health patients reported increased quality of life if they were living in less restrictive community settings with integrated support (Chan, Ungvari, Shek & Leung, 2003). In an Australian example, ongoing support in staffed group homes, even when there is only limited independence, has enabled positive outcomes for a group of deinstitutionalised people in Sydney (Newton et al., 2001b). With adequate levels of supports (as described by O'Brien et al 2002), many adults with mental illness are able to live quite successfully in arrangements featuring partial or full independence. The limited supply of appropriate housing prevents full exploration of successful arrangements. Additionally, as mentioned by Newman (2001) and Rog (2004), research evidence of the benefits of particular programs and models is lacking in vigour and may reflect consistency of implementation rather than effectiveness of the model of accommodation as such.

There is dispute about whether those with some forms of mental illness, particularly those with schizophrenia, require more structure than is provided in some forms of supported housing. Also homeless people referred directly from psychiatric hospitals are more likely to have poor housing outcomes, possibly due to functional impairment and substance abuse issues that mean they require additional transitional support focused on 'housing readiness' (Rog, 2004: 341). Other Australian researchers have suggested that the accommodation to which people with schizophrenia are discharged is a key determinant of their rate of re-admission to hospital (Browne and Courtney, 2005). Friedrich et al (1999) concluded from their research on family and client perspectives of different residential settings, that the separation of staff from the housing, a key principle in supported housing, may not be suitable for many clients. Friedrich et al (1999) also found that a third of participants who were currently living without 24 hour staff supervision actually wanted it. Questions remain however about whether or not best practice models can be clearly identified and whether the reasons for the success or failure of models internationally and nationally are definable and transferable.

Are there any definable best practices for housing mental health clients?

Since the 1990s it would appear that the supported housing approach has become more prominent in the literature, if not yet in the actual housing situations of the majority of consumers of mental health services. However, there has been little research in Australia on the successful application of supported housing for those with mental illness. Client outcomes, program implementation and consumer experiences of approaches to housing and care provision are poorly understood in the Australian context. O'Brien et al (2002, p.76) suggest that research shows that highly focused support at the outset was more likely to ensure individuals received housing that met their needs, but that this needs to be backed up with ongoing monitoring and support so that the investment that goes into establishing and maintaining housing stability is not undermined.

Rog concludes that so far there is insufficient evidence that shows better outcomes of any one particular housing approach or model. She argues that this is in part due to poor study design, where those models compared may share many characteristics and be insufficiently distinguished especially as well as issues with the low statistical power of many studies. In addition, the high regard for models of supported housing among consumers and advocates has led to some features of this approach being incorporated

into many other housing programs, although the service environment of this approach means that ‘fidelity to a model is often difficult to sustain’ (Rog, 2004: 340-341).

The housing environment clearly plays a role in the social experiences of people with mental illness. Despite the rhetoric of living ‘in the community’ however, deinstitutionalisation may have replaced the ‘inbuilt’ (though artificial) community of the institution with a life of isolation in individual homes (Jones et al 2003), a topic rarely discussed from the point of view of the people with mental illness (Chesters, Fletcher and Jones, 2005). Tensions are inherent in the supported housing approach. One of the core principles of supported housing - that of ‘normalisation’ - promotes living environments the same as dominant forms in the neighbourhood of residence. This is believed to prevent the stigma of “ghetto housing” and to increase community integration. However, Wong and Solomon (2002) point out that there is no clarity in the literature regarding the role of normalized housing in integration: perhaps it promotes integration because of the need to develop relationships with neighbours who do not have mental illness, but on the other hand it may *reduce* integration because of the absence of opportunities to develop mutual help and social networks with other mental health consumers. In the TAPS study of clinical and social outcomes for 523 people after five years of community living, Leff, Trieman & Knapp (2000) found that few patients had developed social networks with other members of the public. This suggests that there may be a need to consider approaches to, and the relative benefits of *social* integration versus *physical* integration. There are some hints in the Australian literature that ‘normal housing’ does not always meet the needs of people with psychiatric disability. The authors of the only sustained, outcomes evaluation of deinstitutionalisation conducted in Australia found that a purpose-built, clustered housing model has some advantages over the group homes and block of units in supporting transition from living in institutions. They believed that this allows ‘a combination of autonomy, companionship to reduce loneliness, and access to staff on a more regular and needs based basis’ (Hobbs et al, 2002, p.65).

Given that much is unknown in terms of the impact of housing approaches on the mental well being of these residents, consensus on the issue of best practises in mental health housing remains elusive. There is substantial consistency in the literature about important key variables such as the balance between support and independence, the need for flexibility in terms of resident’s changing needs over time, the importance of consumer control and choice in housing, and the crucial aspect of affordability. The international and Australian evidence suggests that a flexible balance between housing choices should be expanded to permit the reduction of more custodial accommodation over time.

Existing Gaps in Current Research into Best Practices

It is apparent then that humane deinstitutionalisation processes in Australia require the provision of a more creative range of support for those who have been relocated into the community as a result of deinstitutionalisation policies and practices. As noted previously, by Bostock & Gleeson (2004) the actual re-housing policies have been largely neglected in attempting any agreement about community housing options. New responses are required to the housing needs of people with mental illness. Most Australian studies do not rely on contemporary data collected from patients at the point of exit. With the exception of one long term study in Australia by Hobbs et al., (2001) most Australian studies have also not studied what happens to mental health patients several years following their deinstitutionalization. Some of the areas requiring greater evidence concern the efficacy of matching of housing to consumer needs and to those of

the neighbourhoods in which they are located. At the moment the evidence base about best housing options for those with mental health issues is patchy and poorly articulated in reference to other care combinations.

A better evidence base is required to assess the likely outcomes for consumers and the effectiveness of service delivery in any form of supported housing provision. Because of the risk implicit in unstable and/or inferior housing, families may often consider their adult mentally ill relatives are better off in some form of supportive accommodation (Trauer et al., 2001) or even back in institutionalised care. As noted by Robinson (2003, p.6) 'The continuing large numbers of homeless people with mental disorders suggests a failure to respond effectively to certain aspects of individuals' experience'.

There are a number of other significant gaps in our understanding of the role of housing in recovery from mental illness. Browne and Courtney (2005) claim that the international and Australian evidence suggests that 'the quality of accommodation contributes significantly to the mental health of people with schizophrenia', but that there is limited understanding of why it makes such a difference (Browne and Courtney, 2005, p. 235). Furthermore Friedrich et al (1999) claimed that the needs of the most ill clients are not captured in consumer surveys and are therefore not reflected in the literature on consumer housing preferences. Fakhoury et al (2002) discuss the need for future research that focuses on identifying specific features that discriminate between different settings and outcomes. Newman identifies key policy questions focused on the relative effects on mental health outcomes of housing and services and of different housing and service bundles. She is very critical of the quality of the research and especially the research design in this field. She states that there is no set of theories guiding this research and that 'each study appears to be starting over'. There is a need for a coherent research agenda built around key hypothesis about linkages between housing and mental illness (Newman, 2001, p.1315-1316).

A more complete assessment of relevant housing options is clearly indicated, including estimates of cost effectiveness and suitability of models for meeting the needs of all those involved. Long term studies internationally strongly suggest some form of supported housing is the best alternative (Forrester-Jones et al., 2003, Hobbs et al., 2000). However, there has yet to be sufficient evidence from longitudinal Australian research conducted on clients' well-being in reference to such models. As a range of community housing is being used in a number of States in Australia, there is a need to determine the most viable options in the longer term. In the final assessment however, it remains the case that any analysis of 'best practices' in mental health housing provision is virtually meaningless if housing cannot be accessed, or is unaffordable. For instance, Cooper et al conclude that the lack of appropriate, affordable housing options remains a major barrier to housing people with complex needs, and also constitutes the 'limiting factor in the realization of best practice' in this field (Cooper et al, 2005, p. iv).

Conclusion

We have had decades of deinstitutionalisation policies and the provision of alternative accommodation models in Australia and around the world, yet there remains limited agreement on best practices in housing for adults with psychiatric disability. Greater precision is needed in terms of definitions, key elements and contexts in housing options. Studies focused on the nature and scope of supports for a broad range of mental health consumers are required, to provide evidence about the most viable and effective approaches for enhancing consumer satisfaction, social functioning, quality of life and community integration. This research needs to interrogate policy directions, housing

options, lessons from national and international approaches and consumer satisfaction and to foster a deeper synergy between such research and state and national policy.

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