

A Place to Call My Own: Identifying Best Practice in Housing and Mental Health

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Abstract — Over the past few years, there has been a growing debate in Australian society about the way housing processes can contribute to social exclusion. Despite this debate some commentators argue that Australian housing policy lacks recognition that the issue of deinstitutionalisation is also a *rehousing process*, which has the potential for achieving social inclusion for people moving into the community. Although housing plays an integral role in deinstitutionalisation, its importance is often submerged and even lost in academic and policy debates about community care in Australia (Bostock and Gleeson (2004). Yet *suitable housing* is a key aspect in the community sustainability of deinstitutionalised individuals with psychiatric disability, whereby they can, potentially, be provided with some choice and control over where and with whom they live. Indeed, gaining control over these aspects of life is considered a critical step towards achieving social inclusion. Our research project aims to identify the housing aspirations and preferences of people with psychiatric disability moving from institutional to community care. This paper reports on the first stage of the research, which synthesizes and identifies baseline evidence from the international literature about suitable models of housing and the housing preferences of people with psychiatric disability.

Key words: deinstitutionalisation, psychiatric disability, housing.

Introduction

Deinstitutionalisation of people with mental health illness is an important social policy reform both in Australia and internationally. Recently, the scaling down of psychiatric hospitals in Australia has moved at a rapid pace with the processes of deinstitutionalisation shifting people with psychiatric disabilities from institutions to care in community settings. While Australian Governments support deinstitutionalisation, progress varies according to the different jurisdictions. In Victoria, the State Government has closed all major psychiatric hospitals with most residents transferred to supported accommodation in the community. In contrast, in South Australia the processes are not yet as well advanced. As deinstitutionalisation has proceeded, the advantages and disadvantages of the different models of institutional versus community care have been widely debated.

Simultaneously, in broader debates, policy makers have adopted the concept of social exclusion to describe groups of people, such as those with psychiatric disability that are at risk of being unable to participate in the mainstream activities of society (Arthurson & Jacobs 2003). Nevertheless, despite the centrality of housing in people's lives, investigations of the way housing processes can contribute to, or reduce, social exclusion have advanced more slowly (Marsh 2004). Specifically, in the Australian context Bostock and Gleeson (2004) argue that housing policy lacks recognition that the issue of deinstitutionalisation is a rehousing process, which has the potential for achieving social inclusion for people moving into the community. For instance, the processes of deinstitutionalisation may provide individuals, for the first time, with some choice and control over where and with whom they live. To date, there has been little contextual research on housing options and mental health in Australia that explores the preferences and experiences of housing and care provision in the community for people with mental health issues. Much about the impact of rehousing for those with mental health issues remains poorly understood in the Australian context.

This paper reports on the first stage of a research project to investigate the housing experiences and preferences of people with psychiatric disability. Whilst acknowledging the importance of context, some of the international literature has begun to investigate these issues. This is an essential first step to take to improve our understanding of which accommodation models are the most empowering and appropriate for people with mental health illness. Before considering this question, the paper discusses the conceptual links between social exclusion, housing and mental health, which provides a context for the sections that follow.

Social Exclusion and Housing

The concept of social exclusion originated from France, nearly three decades ago, where its application is generally credited to Rene' Lenoir when he was Secetaire d'Etat a l'Action Sociale (Lenoir 1974). French socialist politicians initially used social exclusion to refer to individuals not covered by the social security system, such as single parents, the physically disabled, substance abusers and people with mental health problems. The concept then emerged in Britain as a central notion in the Blair Labour Government's election platform. The value of the concept of social exclusion is that it incorporates a broad range of causes of social inequalities, such as inappropriate housing and lack of access to citizenship rights to enable disadvantaged people to reach their full potential (Arthurson & Jacobs 2003). Donnison (1998) argues that social exclusion is a positive concept because it denotes that people are excluded from the mainstream society by structural forces outside their control. By extolling the structural factors that affect individual lives social exclusion is also clearly an advance on some of the pathological arguments that have been used to explain disadvantage (see Murray 1990). Social exclusion thereby captures the best of both worlds, as it is dynamic concept combining identification of causes and incorporating people's perceptions and viewpoints and actions. This concept is relevant to understanding critical issues about the care and provision of people with mental health problems who may travel circular pathways between mental institutions, inadequate housing and support in the community to homelessness and prison (White and Whiteford 2006).

Studies that explore the relationship between the housing system and social exclusion generally take three divergent analyses, focusing on first the extent to which housing contributes to social exclusion; second, the consequences of exclusion from appropriate housing; and third, on housing as a consequence of exclusion.

The Contribution of Housing to Social Exclusion

In the first set of studies, housing itself is acknowledged as a key contributor to social inequality. Therefore, from this viewpoint, any analysis seeking to understand the relationship between inequality and social exclusion must acknowledge the role of housing in shaping outcomes. Inadequate housing affects mental and physical health, education and access to employment. Housing also generates exclusion in term of location, physical condition, security of tenure, overcrowding, sustainability, affordability and availability of other services.

Considerable work has sought to show that the housing system itself can accentuate material disadvantage and social exclusion. Lee and Murie (1997), for instance, pose questions about how the housing system forms part of the process through which social exclusion is experienced. From their perspective, social exclusion provides an opportunity to reflect on key debates about the role of housing in integration, social polarisation and citizenship (Murie 1996). This is relevant to people experiencing the processes of deinstitutionalisation in that if the housing is unsuitable it will contribute to the ongoing processes of social exclusion. O'Brien et al (2002), for instance, in the Australian context, argue that inappropriate housing may aggravate the individual's illness as in the case of phobias. Other important aspects of housing include affordability of rent, energy costs and security of tenure. O'Brien et al contend that these sorts of issues put the housing at risk and must be identified and addressed.

Pawson and Kintrea (2002) explore the way that social housing allocations policies can contribute to the processes of social exclusion. The policies segregate the most disadvantaged in poor areas, deny access to some groups and perpetuate the concentration of impoverishment within the social housing sector. Likewise, Somerville (1998: 772) argues that social exclusion through housing occurs where housing processes deny certain groups control over their lives and reduces access to wider citizenship rights.

The Consequences of Exclusion from Appropriate Housing;

The second series of discussions is about the social consequences of exclusion from housing. Based on their assessment of two UK social housing estates, Cameron and Field (2000) point to the importance of separating out arguments based on exclusion through housing from those based on exclusion from housing. The latter focus is on the detrimental effects of lack of access for people, such as those with mental health issues to adequate housing and material resources. Anderson and Sim (2000: 21) argue that initial debates about residulisation of social housing and social exclusion in the UK ignored the experience of those who could not gain access to this tenure. Yet,

decent secure, affordable, quality housing provides a basis for social integration and is also linked to successful labour market engagement.

Likewise, White and Whiteford (2006) argue that access to stable housing impacts on a person's mental health recovery and on their staying out of prison. The findings of the NSW Framework for Housing and Accommodation for People with Mental Health Problems and Disorders (2002) also highlight the importance of housing in terms of stating that "stable, secure and safe housing is the most important component of rehabilitation for people with a mental illness". Numerous studies link successful reintegration into the community for people with mental health issues following deinstitutionalisation with stable living arrangements, integrated with support (Trauer, Farhall, Newton & Cheung, 2001; Hobbs, Newton, Tennant, Rosen & Tribe, 2002, Andrews, Teesson, Stewart & Hoult, 1990; Newton, Rosen, Tennant & Hobbs, 2001).

Housing as a Consequence of Exclusion.

In the third lot of debates, poor housing is depicted as a consequence of social exclusion. In other words, it is the lack of material resources such as income, which is the causal factor of inequality and not housing itself per se. For instance, unemployment affects access to housing so the disadvantaged, such as people with mental health illness end up in unsatisfactory private housing or are allocated inadequate social housing. In turn, there is a process of exclusion from other services that results in households concentrated in particular parts of the housing market. However, the dynamic between inequality and housing is not a one-way street - a point that Malpass and Murie make in their seminal text '*Housing Policy and Practice*' (1994). They cast aspersion on those texts that seek to see housing as simply the receptacle for inequality. Rather housing is not passive but active in that it can reinforce or reduce social inequality in other areas, for example health, education and employment.

This exploration of housing as a key aspect of social exclusion provides a framework within which to consider important questions about suitable models of housing and the preferences of people with mental health issues.

The Issues of Current Terminology and Models of Housing Support

A key issue that emerged in exploring the literature was the different usage of terms across jurisdictions, which makes meaningful comparisons of research findings difficult. For instance, some commentators consider *supported housing* to differ from *independent housing* (e.g. Fakhoury et al 2002: 308), whereas for others supported housing includes independent housing (e.g. Parkinson et al, 1999) or staffed residential settings. These and other terms including *supportive* and *supported* are often used interchangeably (see Rog 2002). In acknowledging this problem Parkinson et al (1999) have defined three main approaches to housing for people with mental illness as *custodial*, *supportive* and *supported*. It is useful to look at these definitions before reporting the other findings of the literature.

Custodial housing is described as the medical model delivered within 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 deinstitutionalisation. Characteristics of this housing approach include restrictive rules, staff control, high dependency of residents, little choice over housing, living companions or daily activity, long term residency and large numbers of residents (average 17), many with long histories of mental health problems. The resident's role is clearly that of a patient.

In contrast, *supportive housing* involves a residential continuum type approach. This model evolved from 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 standardised and lower level of support and/or treatment for residents. Support decreases as people move through the continuum, which 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 or in supportive apartments (Parkinson et al 1999: 149).

The supported housing model emerged in the 1990s as a "person-centred focus of support" with an emphasis on self-help and support and de-emphasis on professional services (Parkinson et al 1999: 149). It is based on the principles of individual choice and control, resource accessibility, and individualized and flexible support. People with mental health issues 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.

Despite the usefulness of this typology, in the Australian context, the term *congregate housing* is also commonly used, and generally refers to a range of Supported Residential Facilities (SRF) including boarding houses, and even group homes. *Integrated housing* is another term that refers to low-income apartment housing where a variety of services and resources are provided on-site, but are optional for the tenant. It does not specifically target people with psychiatric disability, but a range of people requiring affordable housing that might otherwise be at risk of homelessness.

The Housing Preferences of People with Mental Health Illness

Despite the identified problems with terminology in relation to identifying the preferences of people with mental health issues about particular models of housing and care, three common themes emerge. These themes concern independent compared to conglomerate care and the interrelated issues of living alone or with others; the importance of particular housing related dimensions; and having control over choice of housing or where to live.

Independent Compared to Custodial or Supportive models

The literature consistently records a preference by people with psychiatric disability for independent living. In a review of twenty six studies, Tanzman (1993) found preferences in the following order: living in own apartment/house; living alone or with spouse/partner or friend rather than another person with mental illness. Nelson et al (2003) likewise established that 79.3% of people with mental health issues preferred to live in their own apartment or house; 46% preferred to live alone; 21% with friends; 23% with other consumers; and 17% with a family member or spouse. Forchuck et al (2006: 46) notes complaints in group living situations about poor quality housing, lack of privacy and safety, too restrictive rules and cramped quarters are common in many of the available housing options within the community. Some US and Canadian research suggests that people with mental health illness housed in independent but supported housing are more satisfied overall than those in other models (Tsemberis et al., 2003; Nelson et al 2003: 12).

However, this is not straightforward as there are some problems expressed when it comes to actually living in independent situations in the community. These concerns include feelings of not 'fitting in', issues of stigma and social isolation. One study, for instance, that compared the experiences of people living in independent apartments, with those living in staffed residential settings found that around 40 per cent of participants reported difficulties with fitting into the community. This experience was more commonly expressed amongst those in independent housing (Yanos et al 2004). Unpacking the evidence further of the benefits or otherwise of particular models is difficult, in part due to the problems of terminology as identified earlier, which makes comparisons of findings of different models incompatible.

In another study, conducted by Walker and Seasons (2002), residents expressed discomfit when housed amongst low income groups. The nub of the problem was that they did not necessarily identify with these groups, and expressed a preference for more diversified housing, with a range of income groups within local neighbourhoods. However, in the same study some participants expressed the desire to live with other people suffering from similar mental health problems. Given these findings the authors conclude that the availability of a diverse range of housing options is important, as no single type will suit everyone.

There are few Australian studies that explore these topics although the available literature seems to concur with the international findings. One study, of seventy individuals in Sydney, found that living in one's own home was the favoured preference, followed by living in public housing, private rental (alone), the family home and private rental (shared) (Owen et al 1996). These preferences were not related to demographic characteristics, level of functioning or severity of symptoms. Warren and Bell (2000) also reported the preferred option as the desire to have a place of ones own, but with the necessary supports available, and a predilection for living with friends or family, rather than other people with mental health issues. In contrast to the Walker and Seasons (2002) study, the shared experience of illness was not considered a helpful basis on which to arrange living arrangements. Congregate housing, including boarding houses was rejected on the basis that it represents a personal failure to live a normal life (Warren and Bell 2000).

An aspect that is not explored in the academic literature but which appears in Australian grey literature (program evaluations) is the possible benefits of clustered independent living. Morris et al (2005) and Parry & Daniel (2004) report some evidence of the development of informal supports and sense of community in small blocks of units housing people with severe mental illness. This is another approach that may suit some people and provide a balance between privacy and sociability.

The Important Dimensions of Housing

Numerous studies of people with mental health issues identify the key dimensions of housing, which assist people to make the transition to the community as *affordability, choice, independence, and access to services* (see Tsemberis et al, 2003:584; O'Brien et al 2002). Not unsurprisingly, other aspects which make the housing desirable include adequate space, cleanliness, peace and quiet, access to public transportation and having a yard or garden (Owen et al 1996; Nelson et al 2003; Forchuck et al 2006: 47).

Choice and Control over Housing

The findings of some US and Canadian research suggests that for people with psychiatric illness having some choice about the type of housing that they move into, and control within that housing situation, not only leads to greater satisfaction with the housing but a higher quality of life (Tsemberis et al 2003, Srebnik et al, 1995; Nelson et al, 2003:15; Greenwood et al 2005). An Australian study by O'Brien et al (2002) also found a relationship between housing choice and satisfaction: housing that was accepted in a crisis situation was considered unsatisfactory and did not meet participants long term needs. Aspects such as collective decision-making in group situations and freedom to make choices, over the gender of living companions, for instance, were also identified as important factors (Owen et al 1996; Nelson et al 2003; Forchuck et al 2006: 47). Residents of supportive housing were the most satisfied with choice, but least satisfied with safety, compared with residents of community residences that were least satisfied with privacy and most satisfied with safety according to Tsemberis et al (2003). In summarising these sorts of findings Greenwood et al (2005) suggest that:

“consumer choice-driven models of service delivery may not only have a direct effect on reductions in homelessness and increases in perceptions of choice, but may also have a distal effect on important psychological outcomes such as reductions in psychiatric symptoms” (Greenwood et al, 2005:234).

In summary, questions remain about whether the housing aspirations and preferences of people with psychiatric disability are being met. In reality, individuals' housing choices are often constrained by poverty and housing availability (Cooper et al, 2005:iv). Indeed, the view is frequently expressed that they have no choice over where they live. In examining this issue, Rog (2004) argues that the affordability of housing is a more important factor than the housing program or model in establishing independent, stable living. As Thomas and McCormack (1999:83) report, despite very clearly expressed preferences for independent living, many people are housed in group accommodation, such as hostels and boarding houses. Often these are the only viable options because of multiple constraints on their choices, including financial circumstances, lack of support for activities of daily life and lack of social support.

Conceptualising the Links between Housing, Mental Health Illness and Social Exclusion

Table 1 draws together the research findings discussed in this paper in order to conceptualise the connections between housing, mental health illness and social exclusion. As shown housing plays a key role in whether or not people with psychiatric illness can make successful transitions from insituational to community care.

TABLE 1
The links between housing, mental health illness and social exclusion

Key Elements of Housing	Relationship to social exclusion for people with mental health illness	Outcomes
<p><i>Cost/Affordability</i> Capacity to meet housing costs out of available income & have sufficient income for other basic needs</p>	<p>Rent setting policies/practice - if rental payments in relation to income too high:</p> <ul style="list-style-type: none"> • Reduced income for other needs eg. health, food, supports services. • Participation in consumption & recreational activities compromised • Inability to pay rent -arrears 	<ul style="list-style-type: none"> • Eviction/homelessness • Hospital/institution/prison • Trapped on benefits • Negative impact on mental and physical health
<p><i>Accessibility/Availability</i> Whether or not appropriate housing is available</p>	<ul style="list-style-type: none"> • Lack of access to affordable housing • Needs based allocation policies for social housing potentially inclusive but leads to stigma, poverty concentrations 	<ul style="list-style-type: none"> • Homelessness • Poverty • Residualisation • Feelings of not fitting into community • “Revolving door” of hospitalisation due to lack of housing • Discharge from hospital directly to homelessness • Remaining in congregate housing where no other viable option is available • Negative impact on mental health
<p><i>Stability of housing</i> Extent to which guaranteed continued occupation of housing</p>	<ul style="list-style-type: none"> • Where no security of tenure may have to move sporadically - housing at risk • Insecure accommodation affects ability to maintain supports, employment 	<ul style="list-style-type: none"> • Educational outcomes compromised • Income levels likely to be affected adversely • Social isolation (loss of natural supports)
<p><i>Appropriateness</i> Whether housing meets needs of occupants in terms of:</p> <ul style="list-style-type: none"> • Appearance • Locality • Quality • Suitability:-household size/age of occupants, congregate/independent • Safety • Choice over housing, who to live with 	<ul style="list-style-type: none"> • Housing aggravates person’s illness – eg. phobia • Concentrated with low income groups • Lack of services eg. shops • Reliable support not available for medication & other informal support • Poor social/physical environments due to poorly maintained housing • Overcrowding 	<ul style="list-style-type: none"> • Disruptive behaviour • Housing at risk • Access to employment & education & other services compromised • Poor health, educational, employment prospects • Breakdown in relationship with neighbours, conflict with neighbours” • stigma

Adapted from Arthurson and Jacobs (2003)

Conclusion

The findings suggest that as long as some basic criteria are met, a variety of models of housing and support can successfully sustain people with psychiatric disability within the community and avoid social exclusion. These criteria include, stable, affordable and long term housing, key supports, risk management strategies and providing some choice for people about where they can live. Success in

supporting people with mental health illness to live in the community appears limited more by the supply of appropriate housing and support services than by the challenges presented by the psychiatric disability (O'Brien et al 2002:76).

However, despite the findings suggesting efficacy for some sort of supported housing model, as we discussed not all forms of supported housing arrangements suit everyone with mental illness. Overall the preference appears to be wherever possible for living independently. Nevertheless, in the Australian context there are large gaps in the literature, meaning that the experiences of people with mental health issues and their carers of different approaches to housing and care provision in the community are not fully understood. Areas requiring more investigation include how housing is identified, maintained and matched to peoples' needs, what type of housing is used, what type of neighbourhoods are most accepting of people with psychiatric disability, how support is provided, how decisions are made, and how the housing programs are managed.

To assist in achieving these goals, greater precision is also needed in terms of key definitions, concepts, and contexts used in describing housing options. Australian studies focused on the nature and scope of supports for people with mental health illness are required, to provide a deeper appreciation of suitable models and the housing aspirations and housing preferences of people with psychiatric disability moved from institutional to community care.

References

- Anderson, I. & Sim, D. (2000) 'Social exclusion and housing: an introduction' in I. Anderson, and D. Sim (eds) (2000) *Social Exclusion: Context and Challenges*, Coventry, Chartered Institute of Housing, pp 1-21
- Andrews, G., Teesson, M., Stewart, G., & Houtt, J. (1990). Follow-up of community placement of the chronic mentally ill in New South Wales. *Hospital and Community Psychiatry*, 41(2), 184-188.
- Arthurson, K. & Jacobs, K (2003) "Social Exclusion and Housing" Final Report for the Australian Housing and Urban Research Institute (AHURI), <http://www.ahuri.edu.au>.
- Bostock, L. & Gleeson, B (2004) "Contested Housing Landscapes? Social Inclusion, Deinstitutionalisation and Housing Policy in Australia, *Australian Journal of Social Issues* special edition on Social Exclusion and Social Inclusion, 39(1), pp.41-62.
- Browne, G. & Courtney, M. (2005) "Exploring the experience of people with schizophrenia who live in boarding houses or private homes: A grounded theory study" *Contemporary Nurse* 18(3), pp233-246
- Cameron, P., & Flanagan, J. (2004). 'Thin Ice: Living with serious mental illness and poverty in Tasmania'. Anglicare Australia.
- Cameron, S. and Field, A. (2000) 'Community, Ethnicity and Neighbourhood', *Housing Studies*, 15(6), pp827-844.
- Cooper, L., Verity, F., Masters, M. (2005) *Housing People with Complex Needs* Australian Housing and Urban Research Institute, Southern Research Centre
- Donnison, D. (1998) *Policies for a Just Society*, London, MacMillan Press.
- Fakhoury, W., Murray, A., Shepherd, G., Priebe, S. (2002) "Research in supported housing" *Social Psychiatry & Psychiatric Epidemiology*, 37, 301-315
- Forchuck, Cheryl, Nelson, Geoffrey & Hall, Brent (2006) 'It's Important to be Proud of the Place You Live In: Housing problems and Preferences of Psychiatric survivors', *Perspectives in Psychiatric Care*, 42 (1), pp.42-52
- Forrester-Jones, R., Carpenter, J., Cambridge, P., Tate, A., Hallam, A., Knapp, M., & Beecham, J. (2002). The quality of life of people 12 years after resettlement from long stay hospitals: users' views on their living environment, daily activities and future aspirations. *Disability and Society*, 17 (7), 741-758.

- Grigg, M., Judd, F., Ryan, L., Komiti, A. (2004) "Identifying marginal housing for people with a mental illness living in rural and regional areas" *Australasian Psychiatry*,12(1), pp36-41
- Hobbs, C., Newton, L., Tennant, C., Rosen, A., Tribe, K. (2002) "Deinstitutionalization for long term mental illness: a 6 year evaluation" *Australian and New Zealand Journal of Psychiatry* Vol 36 pp 60-66
- Lapsley HM., Tribe, K., Tennant, C., Rosen, A., Hobbs, C., Newton, L. (2000) "Deinstitutionalisation for a long-term mental illness: cost differences in hospital and community care" *Australian and New Zealand Journal of Psychiatry*,34, pp491-495
- Lee, P. and Murie, A. (1997) *Poverty, housing tenure and social exclusion*, Bristol: The Policy Press.
- Lenoir, R. (1974/1989) *Les Exclus: Un Francais sur Dix* 2nd ed. Paris: Editions du Seuil
- Malpass, P. and Murie, A. (1994) *Housing Policy and Practice*, London: Macmillan 4th Edition.
- Marsh, A. (2001) 'Housing and the Social Exclusion Agenda', Managing Housing and Social Change: Building Social Cohesion, Accommodating Diversity Conference, Hong Kong.
- Murie, A. (1996) *Social Exclusion and its Application to Housing Issues*, Plenary Paper at Housing Studies Association Conference on Housing and Social exclusion, Birmingham, September.
- Murray, C. (1990) *The Emerging British Underclass*, London: Institute for Economic Affairs.
- Nelson, G., Hall, G., Forchuk, C. (2003) "Current and Preferred Housing of psychiatric consumers/survivors" *Canadian Journal of Community Mental Health*, 22(:1), pp 5-19
- Newton, L., Rosen, A., Tennant, C., Hobbs, C. (2001) "Moving Out and Moving On: Some Ethnographic Observations of Deinstitutionalisation in an Australian Community" *Psychiatric Rehabilitation Journal*, 25(2), pp152-162.
- NSW Department of Health (2002) Framework for Housing and Accommodation for People with Mental Health Problems and Disorders.
- O'Brien, A., Inglis, S., Herbert, T., and Reynolds, A. (2002) *Linkages between housing and support – what is important from the perspective of people living with a mental illness*. Final Report, Australian Housing and Urban Research Institute.
- Owen, C., Rutherford, V., Jones, M., Wright, C., Tennant, C., Smallman, A. (1996) "Housing Accommodation Preferences of People with Psychiatric Disabilities" *Psychiatric Services* 47 (6), pp 628-632.
- Pawson, H. & Kintrea, K. (2002) 'Social Housing Allocation Policies and Social Exclusion in Britain', *Journal of International Social Policy*, 31(4), pp. 643-667.
- Rog, D. (2004) 'The Evidence of Supported Housing' *Psychiatric Rehabilitation Journal*, 27(4), pp.334-344
- Srebnik, D., Livingston, J., Gordon, L., & King, D. (1995). 'Housing choice and community success for individuals with serious and persistent mental illness'. *Community Mental Health Journal*, 3, pp 139-152.
- Tanzman, B. (1993) An overview of surveys of mental health consumers' preferences for housing and support services, *Hospital and Community Psychiatry*, 44, pp. 450-455.
- Thomas, K.L and McCormack, C. (1999) "Adequate Housing for People with a Serious Mental Illness, Policy Obstacles and Practice Solutions" *Australasian Psychiatry*, 7(2), pp81-84.
- Trauer, T., Farhall, J., Newton, R., & Cheung, P. (2001). 'From long-stay psychiatric hospital to community care unit: evaluation at 1 year'. *Social Psychiatry Psychiatric Epidemiology*, 36, pp 416-419.

Tsemberis, S., Rogers, E., Rodis, E., Dushuttle, P., Skryha, V. (2003) 'Housing Satisfaction for Persons with Psychiatric Disabilities' *Journal of Community Psychology*, 31 (6), pp. 581-590.

Walker R., Seasons, M. (2002) "Supported housing for people with serious mental illness resident perspectives on housing." *Canadian Journal of Community Mental Health*, 21(1), pp.137-151.

Warren, R. and Bell, P. (2000) "An exploratory investigation into the housing preferences of consumers of mental health services" *Australian and New Zealand Journal of Mental Health Nursing* 9, pp195-202.

White, Paul & Whiteford, Harvey,(2006) 'Prisons: mental health institutions of the 21st century?' *The Medical Journal of Australia*, 185 (6); 302-303

Yanos, P., Barrow, S., Tsemberis, S., (2004) "Community Integration in the Early Phase of Housing Among Homeless Persons Diagnosed with Severe Mental Illness Successes and Challenges" *Community Mental Health Journal*, 40 (2), pp. 133-150.