

# **The role of informal community resources in supporting independent housing for young people recovering from mental illness**

authored by

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## **ACRONYMS**

ABS	Australian Bureau of Statistics
AHURI	Australian Housing and Urban Research Institute Ltd.
ASIB	Australian Social Inclusion Board
COAG	Council of Australian Governments
DofHA	Australian Department of Health and Ageing
DHS	Department of Human Services (Victoria)
FaHCSIA	Australian Government Department of Families, Housing, Community Services and Indigenous Affairs
HASI	Mental Health Housing and Accommodation Support Initiative
HASP	Housing and Support Programs
MHCA	Mental Health Council of Australia
MHPF	Mental health Providers Forum (UK)
NAHA	National Affordable Housing Agreement
PDRS	Psychiatric Disability Rehabilitation and Support
SAAP	Supported Accommodation Assistance Program
VICSERV	Psychiatric Disability Services of Victoria

## EXECUTIVE SUMMARY

This project has three key aims. The primary aim is to investigate the role of informal community resources in promoting stable housing outcomes and enhancing social inclusion for young people recovering from a mental illness. The second aim is to identify the neighbourhood factors that potentially moderate the risk of homelessness for youth in recovery. The third aim is to explore how housing policy interventions can strengthen the array of informal community resources available to support stable housing for youth in recovery. To achieve these aims, research will be conducted in two sites, Melbourne and Launceston, in two phases. The first phase will involve the recruitment of a sample of youth aged 18–30 and recovering from a mental illness. Up to 20 youth will be recruited in each site, including a mix of homeless youth, youth currently living in supported accommodation and youth living independently. This phase will employ a range of innovative qualitative methods to identify the various informal resources available in young people's communities to facilitate the transition to independent housing while promoting recovery and social inclusion. The second research phase will involve focus groups in Melbourne and Launceston with housing policy-makers, practitioners and service providers. These sessions will explore how the informal resources identified in phase one might be mobilised in the design of novel, place-based, housing and social inclusion initiatives for youth recovering from a mental illness. In relation to each phase, the specific research questions are:

- What kinds of community relationships, resources and supports facilitate the acquisition and retention of stable housing for youth recovering from a mental illness?
- How do youth recovering from a mental illness identify and deploy these informal resources and relationships in support of stable housing?
- How might these resources be mobilised in the design of novel housing and social inclusion initiatives for youth recovering from a mental illness?

This Positioning Paper reviews the available literature pertaining to these research questions, identifying key gaps and controversies in this literature. Our review indicates very strongly that young people recovering from a mental illness have a preference for independent housing. Typically, the transition from supported accommodation to independent living is regarded as a key milestone in the recovery from mental illness. The extant literature emphasises the importance of formal resources in promoting the transition to independent housing for youth in recovery. This includes the role of public housing programs, rental subsidies, psychiatric rehabilitation services, financial management and life skills training. Largely overlooked in the literature has been the role of informal resources, assets and supports. Examples of these informal resources include the social, financial and emotional resources provided in family, peer and social networks; the resources sustained via participation in sporting clubs, church, cultural and community groups; and in the various social capital resources generated in communities. We assess the emerging evidence indicating that these informal resources play a vital role in facilitating young people's recovery from mental illness and promoting more secure housing outcomes by enhancing community belonging and social inclusion. We note however, that the specific ways in which informal community resources facilitate young people's transition to independent housing remains unclear. This gap in knowledge hinders the development of social support and rehabilitation services for youth in recovery who require assistance accessing and maintaining stable housing. We conclude with recommendations for addressing these research gaps.

# 1 INTRODUCTION

Mental illness can be especially debilitating for young people. Primary health problems associated with mental illness in youth populations include accidents, injuries, eating disorders and obesity (Phelan et al. 2001); increased risk of homelessness and/or unstable housing (Chamberlain et al. 2007; Herrman 2001); drug and alcohol dependence (Hamilton et al. 2004); as well as low academic achievement, unemployment and family breakdown (Flatau et al. 2010). Available evidence indicates that around 19 per cent of Australian adolescents aged 13–17, and 27 per cent of young adults aged 18–30, will experience some kind of mental health problem, typically depression and/or anxiety disorders, over the course of their adolescence and early adulthood (McGorry et al. 2007). McGorry et al. (2007, S5) conclude that there is ‘some evidence that this prevalence may have risen in recent decades’; an observation that is supported in recent national surveys of mental health and wellbeing (ABS 2008, p.1).

The links between mental illness, unstable housing and homelessness are especially significant in Australia with recent estimates suggesting that 50–75 per cent of homeless youth have some experience of mental illness (Chamberlain et al. 2007, p.6; MHCA 2009; Pryor 2011, pp.14–17). This relationship between mental illness and unstable housing has prompted a range of dedicated policy responses in recent years. The 2009 Australian *National Mental Health Plan* endorses the integration of mental health and housing services to promote recovery and reduce the risk of homelessness for youth experiencing mental illness. Similarly, the 2009 *Victorian Mental Health Reform Strategy* proposes to improve access to stable and affordable housing and to enhance links between housing and psychosocial rehabilitation in order to facilitate recovery and promote social inclusion for youth experiencing mental illness. These strategies and others around the country reflect the ‘housing first’ approach to mental health care planning and delivery in which secure long-term housing is regarded as the foundation for ongoing recovery from mental illness (Pearson et al. 2007). This principle underpins both government and community sector responses to mental illness in Australia, reflecting the significance of secure housing in promoting the stabilisation of, and long-term recovery from, mental health disorders in youth populations (Rosenberg et al. 2009, p.193).

The importance of housing is further indicated in research suggesting that young people recovering from a mental illness have a strong preference for independent housing<sup>1</sup> (Flatau et al. 2010; Irwin et al. 2008; Pryor 2011; Wasserman & Clair 2011). Typically, the transition from crisis and supportive accommodation to independent living is regarded as a key milestone in the recovery from mental illness (Nelson et al. 2005, pp.98–100; and/or Peace & Kell 2001, pp.103–5). Like most young people, youth recovering from a mental illness regard the acquisition and retention of independent housing as an important part of the transition into adulthood, while housing itself provides a secure material and social basis for the pursuit of significant life-goals such as gaining meaningful employment, finding a life-partner, establishing broad social networks and so on (Bradshaw et al. 2007; Evans et al. 2003; Herrman 2001; MHCA 2009; Pryor 2011). Housing, in this way, remains integral both to the

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<sup>1</sup> The language of independent housing will be used throughout this Positioning Paper to refer to housing arrangements in which residents receive no formal service supports such as rental subsidies or ongoing psychiatric rehabilitation. We will use the language of ‘supportive housing’ to refer to those circumstances in which youth are in receipt of this kind of formal support, either ‘on-site’ in residential rehabilitation or through ‘off-site’ case management and welfare support (see Nelson et al. 2005, pp.98–100; and/or Peace & Kell 2001, pp.103–5 for a fuller discussion of these definitional issues).



promotion and maintenance of 'good' mental health in youth populations, and to the pursuit of young people's social, personal, material and economic goals.

## 1.1 Housing policy and mental illness research

Given the significance of housing in the management of mental health disorders and the longer term prospects of meaningful recovery, it is perhaps unsurprising that the main body of research has focused on the array of *formal public policy responses* likely to improve young people's access to, and retention of, stable housing (see Pearson et al. 2007). The balance of this research has sought to clarify the formal support services that youth in recovery require to secure stable housing (Peace & Kell 2001, pp.108–12; Hinshaw 2005, pp.721–3). This includes the role of crisis and 'supportive' accommodation such as residential rehabilitation programs; assistance accessing independent public housing; subsidies to support private renting; psychiatric rehabilitation support services; financial management and life skills training and so on. In each instance, researchers have considered the impact of formal services, programs, resources and subsidies—like those offered by state and federal housing and welfare departments and agencies, or in the community sector by non-governmental organisations such as charities—in promoting recovery while reducing the risk of homelessness and/or unstable housing for youth living with a mental illness (Bleasdale 2006; Chamberlain et al. 2007; Flatau et al. 2010; MHCA 2009; Pryor 2011). There now exists a substantial research and policy literature documenting the importance of formal programs and supports in facilitating access to secure housing for youth in recovery. This includes a growing body of research and evaluation evidence assessing the efficacy of individual housing programs in Australia (see Bleasdale 2006; FaHCSIA 2010; MHCA 2009; Pryor 2011 for commentaries). In reviewing the relevant domestic and international evidence, and in drawing conclusions from the evaluation of individual housing programs, scholars and advocates typically call for increased funding for formal housing supports, for earlier and more effective interventions, and for the provision of longer term supports for youth recovering from a mental illness (Chamberlain et al. 2007).

Without ignoring the importance of formal responses in the maintenance of secure housing for youth in recovery, an emerging body of international research suggests that the transition to stable housing also requires various *informal supports* (Almedom 2005; Duff 2010a; Hopper 2007; Irwin et al. 2008; McKenzie et al. 2002; Parr 2007). Examples of these informal supports include the social, financial and emotional resources provided in young people's family, peer and social networks (Dalgard & Tambs 1997); the benefits associated with participation in voluntary and community associations like sporting clubs, church and spiritual organisations, cultural bodies and service organisations (Almedom 2005; Carpiano 2006; Hopper 2007); participation in social networking and other online forums (Barratt & Lenton 2010); and the various personal and emotional benefits associated with 'place attachment' and/or 'place identity' (Easthope 2004). In each instance, researchers have documented the significance of these informal resources and relationships in promoting recovery for young people experiencing mental health problems. It is also evident that these informal resources can help augment the effectiveness of formal resources like those provided by dedicated mental health services (Kawachi & Berkman 2001; McDermot et al. 2011, pp.34–40).

Arguably the most familiar of these informal resources—certainly the most widely researched—are those associated with the production and distribution of 'social capital' (Almedom 2005; Irwin et al. 2008). Social capital is commonly regarded as the store of social, relational, informational, material and/or affective resources that obtain within a given social network (Portes 1998). These resources are said to 'flow' through

social networks in the diverse interactions and relationships that transpire between network members. Depending on one's location within a given network, membership in that network facilitates access to the various resources available therein. Network membership is thus understood as the basis for the kinds of trust, reciprocity, recognition and civility that are regarded as hallmarks of the production and distribution of social capital in a given setting (Carpiano 2006). It is also the basis for the various primary health benefits known to be associated with social capital in youth populations (see Baum 2002). This includes a small but growing literature documenting the role of social capital in 'bridging' and 'bonding' young people's social networks, and the ways that this capital can be drawn on to promote good mental health and to facilitate recovery from mental illness (Boardman 2010; Cattan & Tilford 2006; Henderson & Whiteford 2003; Irwin et al. 2008; Parr 2007; VICSERV 2008).

The example of social capital is raised here not to exhaust the notion of informal community resources but rather to provide an early illustration of the importance of such resources in the maintenance of secure housing and the recovery from mental illness for youth. A common conclusion of studies examining the significance of informal community resources in relation to housing and mental illness is the claim that formal services, while crucial, rarely guarantee the ongoing retention of independent housing for youth in recovery (McDermot et al. 2011). Rather, it is argued that formal resources like the provision of public housing stock, case management and/or rental subsidies provide *a necessary foundation* for recovery and social inclusion, although these outcomes also depend on a raft of informal resources and supports typically provided in communities and related social networks (Boyd et al. 2008; Parr 2007). In light of the wealth of insights offered in the emerging literature on informal resources like social capital, and the preponderance of research and evaluation evidence regarding the importance of formal services in securing stable housing for youth in recovery, the present project focuses on the importance of informal community resources and their role in facilitating housing retention among young people recovering from a mental illness.

This Positioning Paper therefore examines various informal community resources and their role in promoting housing retention, recovery and social inclusion for youth in recovery. On the basis of our review of the available evidence, three classes of informal community resources will be identified: *social, material and affective* resources. These resources define community as much as they are the product of it; just as they support the myriad therapeutic processes that shape the everyday experience of recovery and social inclusion for youth living with a mental illness (Boyd et al. 2008; Duff 2011; Parr 2007). Briefly, social resources include relations of trust and reciprocity associated with social capital (Portes 1998), as well as the diverse relational and affective sensitivities that support intimate relationships and wider social networks (Payton et al. 2000, p.184). Material resources include access to goods and services in formal and informal exchange relations, as well as the very materiality of place conceived in terms of the distinctive 'affordances' that individual places makes available (Gibson 1979; Clark & Uzzell 2002). Affective resources describe the kinds of 'place relationships' characteristic of 'belonging' and social inclusion within a particular community, as well the kinds of affective and emotional associations that particular community settings generate (Easthope 2004; Thrift 2004, pp.59–64).

It is claimed in this Positioning Paper that close attention to the generation and distribution of informal resources ought to provide a basis for identifying the various ways that communities support recovery and social inclusion for young people experiencing a mental illness, as well as the more specific links between access to such resources and the acquisition and retention of stable housing. Furthermore, these informal resources are potentially more inclusive and cost effective than formal

housing programs, although it is not yet clear which informal activities are important in assisting youth in recovery to make the transition to independent housing and why. The empirical component of this project will therefore examine the role of informal resources in facilitating the transition to stable housing for youth in recovery, identifying and assessing the ways these resources are identified, cultivated and deployed in the context of young people's broader housing careers (Hopper 2007; Peace & Kell 2001; Reynolds & Inglis 2001).

## **1.2 Research aims, questions and methods**

This Positioning Paper is the first output of an AHURI project (50682) exploring the role of informal community resources in supporting independent housing and social inclusion for young people recovering from mental illness. The project will compare and contrast the sources, distribution and availability of informal community resources in two locales (Melbourne and Launceston), and assess their role in facilitating the acquisition and retention of stable housing for youth in recovery.

The specific research aims are to:

- Identify the informal community resources, relationships and supports that facilitate the acquisition and retention of stable housing for youth in recovery.
- Ascertain the various ways that youth recovering from a mental illness use these informal resources and relationships in support of stable housing.
- Consider the ways that these resources might be mobilised in the design of novel housing and social inclusion initiatives for youth in recovery.

The analysis of informal community resources is especially significant given the intensive demands placed on formal housing services by youth in recovery. In investigating the production and distribution of informal resources, the planned research should support housing policy interventions that strengthen the array of informal 'social assets' (Irwin et al. 2008, pp.1936–7) available in communities to support stable housing for youth recovering from a mental illness. The project will build on emerging international evidence demonstrating links between access to informal resources, recovery from a mental illness, and the acquisition and maintenance of independent housing (Almedom 2005; Dalgard & Tambs 1997; Goldstrom et al. 2006; Herrman 2001; Hopper 2007; Irwin et al. 2008; Parr 2007; Peace & Kell 2001; Stone & Hulse 2007; Wasserman & Clair 2011). The project should also help to clarify the distinctive features of housing arrangements, community contexts and neighbourhood characteristics that generate social inclusion, economic opportunities and wellbeing. In identifying resources and supports that are not typically considered in housing research, the project will make recommendations for the reform of housing and psycho-social support services to incorporate a wider array of community relationships, activities and processes. It is anticipated that our findings will assist policy-makers to gauge how these informal community resources can be mobilised to facilitate the acquisition and retention of independent housing for youth in recovery. This should include ideas for the development of novel service delivery partnerships to involve non-traditional stakeholders in the provision of housing programs for youth in recovery. This analysis has a range of important implications for housing policy, particularly in relation to housing tenure, housing transitions, location and allocation policies, each of which will be explored in the chapters to follow.

### **1.3 Structure of the paper**

Chapter 2 provides a brief overview of recent Australian research and policy debates regarding the links between mental illness and housing for young people, touching on the broader national and state policy contexts for the project. This review will consider the links between recovery, housing and social inclusion for young people living with a mental illness—and the specific informal community resources that mediate these relations—which will remain the primary focus of the research to follow. Chapter 3 considers the issues of recovery and social inclusion, focusing on the recent emergence of more holistic accounts of recovery which provide the conceptual and analytical framework for the discussion of informal community resources set out in Chapter 4. Chapter 5 concludes the Positioning Paper by summarising the empirical stage of the project, and the data collection activities that will be undertaken.

## **2 MENTAL ILLNESS IN YOUTH POPULATIONS IN AUSTRALIA**

Mental illness is a generic term used to denote a range of loosely related problems, conditions and disorders. Clinically indicated disorders associated with mental illness are typically grouped into two main categories; psychotic and non-psychotic disorders (APA 2004). Psychotic disorders include schizophrenia and schizo-affective disorder, bipolar disorder, delusional disorders and acute mood disorders. The main symptoms are 'delusions, hallucinations, disorganised communication, lack of motivation and planning ability and mood swings' (Jablensky et al. 1999). Non-psychotic illnesses include personality disorders; anxiety disorders including various phobias and panic disorders; obsessive-compulsive disorder; post-traumatic stress disorder; substance use disorders; and depression. Both psychotic and non-psychotic mental disorders typically emerge in late adolescence and into early adulthood, even though the initial onset of symptoms often occurs much earlier in the life-course (Patel et al. 2007; Rickwood et al. 2005). While available epidemiological data rarely distinguish between psychotic and non-psychotic disorders when estimating the prevalence of mental illness in Australia, it is well known that psychotic disorders have a much lower prevalence than non-psychotic disorders (ABS 2008, pp.6–7; DoFHA 2010, pp.1–3). Psychotic disorders, like schizophrenia/schizo-affective disorder and bipolar disorder, generally affect around 1–2 per cent of the population in Australia; a figure that is broadly consistent with international accounts. Estimates of the prevalence of non-psychotic disorders are much less reliable (Highet et al. 2001). However, recent reports suggest that between 40–50 per cent of Australian adults will experience some kind of non-psychotic disorder over the course of their lifetime, typically depression, mood and/or anxiety disorders.

Recent estimates of the prevalence of mental illness in adolescent and young adult populations in Australia indicate that around one in four young Australians experience some kind of mental illness in any one year, with anxiety and depressive disorders again the most prevalent (ABS 2008, pp.7–9). Perhaps reflecting the apparent increase in the prevalence of mental health disorders in youth populations in recent decades (see ABS 2008; McGorry et al. 2007, S5), it is further the case that there remains significant unmet demand in youth cohorts for dedicated mental health care in Australia. Recent estimates suggest that half to two-thirds of all young people experiencing mental health problems in Australia receive no treatment at all for their illness (ABS 2008; Rosenberg et al. 2009). Research also confirms that youth who are homeless and/or inadequately housed; are at risk for substance use disorders; are of Aboriginal and/or Torres Strait Islander descent; or speak a first language other than English, may face additional barriers accessing adequate mental health care in Australia (ABS 2008; Chamberlain et al. 2007; FaHCSIA 2010). Meanwhile, the effectiveness (or otherwise) of existing adolescent and young adult mental health services in Australia continues to generate heated debate, amid perennial demands for greater investment in youth mental health care in Australia, particularly outside of the capital cities (McGorry 2007, S53–6; Rickwood et al. 2005).

Studies highlighting unmet demand for youth mental health services in Australia, and ongoing debates regarding the relative efficacy of available services, point to the significant disruption and disability associated with mental illness for young people. Common features of most mental health pathologies in adolescent and young adult populations include the experience of significant disruption to daily life including education and/or employment opportunities; disruptions to extended family life, peer and social networks; and to mood, wellbeing and health (Rickwood et al. 2005). This

nexus of problems and symptoms is commonly referred to as psychiatric disability (Andresen et al. 2011). Psychiatric disabilities are the direct consequence of mental illness, impacting a young person's emotional and social wellbeing, and limiting the ways they manage the normal stresses of everyday life. Psychiatric disability can range from mild, episodic and manageable impairment through to debilitating and chronic disruptions to a young person's capacity to manage even the most basic of everyday tasks (Reynolds & Inglis 2001; Sawyer et al. 2001, pp.807–11). The episodic nature of many mental illnesses also has a significant bearing on the character of psychiatric disability, in that the sudden onset of symptoms typical of many disorders presents significant challenges for young people and their families in planning appropriate treatment interventions (VICSERV 2008).

## **2.1 The impact of mental illness on young people's housing**

Mental illness and associated psychiatric disabilities have an often profound effect on a young person's capacity to secure and maintain stable housing (Kirsh et al. 2009; Pryor 2011; Sawyer et al. 2001; VICSERV 2008). The links between mental illness and homelessness in youth populations are well documented, even though the underlying causal relations are difficult to determine with a range of studies suggesting that it is often the experience of homelessness that precipitates mental illness, rather than a pre-existing mental illness that causes a young person's subsequent homelessness (Chamberlain et al. 2007; Kirsh et al. 2009). Research and clinical observations confirm that most of the symptoms associated with mental illness increase the risk of homelessness for young people, largely by disrupting their capacity to discharge many of the normal responsibilities associated with maintaining stable accommodation (Patel et al. 2007). For example, Parker, Limbers and McKeon (2002, p.11) report that symptoms such as 'memory loss, anxiety, self harm, compulsive behaviours, hallucinations or periods of deep depression' disrupt almost every aspect of daily life, reducing a young person's capacity to live with family and/or relatives, or to maintain a private tenancy. This disruption is further compounded with the experience of complex disorders such as schizophrenia or bipolar disorder, or by the occurrence of dual diagnoses (or co-morbidities) such as co-occurring mental health and substance use disorders (Hamilton et al. 2004). The common experience of stigma and related social and personal discrimination, widely reported by young people living with mental illness, further reduces one's capacity to maintain stable accommodation (Evans et al. 2003). Research indicates that private landlords are reluctant to execute private rental agreements with young adults they either know or suspect are experiencing a mental illness, while anecdotal evidence suggests that landlords are apt to arbitrarily break a lease agreement with tenants suspected of a mental illness (Chamberlain et al. 2007; Kirsh et al. 2009). More generally, adolescents and young adults living with a mental illness are often isolated, have disrupted family, social and peer networks and sometimes suffer poor physical health, all of which further reduces their capacity to find and maintain adequate housing (Jablensky et al. 1999; MHCA 2009; Parker et al. 2002; Patel et al. 2007).

The known link between mental illness and homelessness in youth populations has led to a range of dedicated housing policy responses in Australia at all levels of government and in the community sector. Such programs work to facilitate access to secure housing while ameliorating some of the risk factors known to precipitate homelessness among youth living with a mental illness. A series of comprehensive reviews of such programs have recently been published (Beer & Faulkner 2008; Bleasdale 2006; Evans et al. 2003; FaHCSIA 2010; Flatau et al. 2010; Kirsh et al. 2009; McDermot et al. 2011; MHCA 2009; Pryor 2011; VICSERV 2008), most of which contain specific assessments of the reach and efficacy of housing supports in

youth populations. Hence, the discussion here will rather describe some of the common features of available housing programs, and the specific values and principles that underpin them. Throughout, we will seek to draw out the features of existing housing strategies most relevant to our discussion of the housing needs of adolescents and young adults living with a mental illness. This discussion will also seek to clarify the importance of informal community resources in countering the risk of homelessness, and for promoting stable housing outcomes for youth in recovery.

In recent years, the two most important policy mechanisms for addressing housing and homelessness issues in Australia have been the National Affordable Housing Agreement (NAHA), negotiated through the Council of Australian Governments (COAG), and the Commonwealth Government's 2008 White Paper on combating homeless (*The Road Home*). The NAHA aims 'to ensure all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation', thereby endorsing the foundational role of housing in promoting social inclusion. The agreement also identifies various groups who are either currently experiencing, or are at risk of experiencing, 'deep social disadvantage', including mentally ill and homeless youth, nominating a series of dedicated policy interventions to redress this disadvantage. Meanwhile, the Commonwealth Government's White Paper on homelessness (Commonwealth of Australia 2008, p.viii) sets two broad policy goals to be achieved by 2020: first, to achieve a 50 per cent reduction in homelessness over this period, and to provide supported accommodation to all 'rough sleepers who seek it'. The first of these goals refers to all types of homelessness, including primary, secondary and tertiary homelessness (see McDermott et al. 2011), whereas the focus of the second goal is on reducing primary homelessness, particularly among single homeless people, including youth. Resources have been allocated towards achieving these goals through the National Partnership Agreement on Homelessness which is incorporated within the NAHA. Both the NAHA and the White Paper also emphasise the need for innovative approaches to assist those who are homeless, or at risk of homelessness, to secure appropriate accommodation over the long term.

A common feature of the NAHA—and almost all contemporary housing programs in Australia, including those explicitly targeting youth—is the recognition that the mere provision of adequate housing is insufficient to counter the array of vulnerabilities that place individuals and families at risk of homelessness (Chamberlain, et al. 2007; CofA 2008; VICSERV 2008). Obviously, access to secure housing is critical and much Commonwealth and state expenditure is devoted to the acquisition and maintenance of housing stock, primarily through the provision of public housing and related subsidies. Still, it is well known that unless this physical infrastructure is provided as part of a package of broader rehabilitative interventions, then the housing provided through such programs is unlikely to deliver long-term, stable housing outcomes (McDermot et al. 2011). It follows that the provision of adequate housing should be aligned with appropriate support services to ensure that vulnerable people like adolescents and young adults experiencing mental illness, are successful in accessing and retaining secure housing over the longer term (Bleasdale 2006, pp.34–6).

Reflecting these insights, the most effective housing interventions in Australia—like the long-running Supported Accommodation Assistance Program (SAAP) offered by the Commonwealth and the states; the various Housing and Support Programs (HASP) offered by state and territory governments, or the more recent NSW-funded Mental Health, Housing and Accommodation Support Initiative (HASI)—provide a mix of services and supports in addition to facilitating access to secure housing. A common goal is to provide transitional supported accommodation and related support

services to assist people who are homeless to achieve the maximum possible degree of self-reliance and independence. With more specific reference to the housing needs of young people recovering from a mental illness, typical program goals include assisting youth to access appropriate health and human welfare services to help them resolve the crises or personal challenges associated with their homelessness; to help youth to deepen or re-establish relations with extended family and wider social networks; and to acquire the array of social, physical, material and emotional life skills necessary to live independently without requiring formal assistance (Bleasdale 2006; Flatau et al. 2010; Hinshaw 2005; Rickwood et al. 2005). As these programs and others indicate, effective responses to combating the links between homelessness, unstable housing and mental illness in adolescent and youth populations must entail a mix of services and supports. This should include early intervention and support strategies that prevent homelessness; crisis and emergency support and accommodation; and transitional and post-crisis support. O'Brien and colleagues (2002, p.23) add that effective policies must also satisfy diverse and competing demands including discrete 'housing policy and procedure requirements, mechanisms for effective coordination and linkages of local support services, including networking amongst local agencies'.

Additional research on the housing needs of young people recovering from a mental illness indicates that these needs are generally in keeping with the housing needs expressed by other young Australians (Bleasdale 2006; MHCA 2009; Pryor 2011). These needs include independence and choice; amenity and community appeal; safety and comfort; affordability; privacy; and the proximity of local resources and infrastructure (O'Brien et al. 2002). While clearly it is not possible to guarantee the satisfaction of these preferences in every instance—particularly in light of chronic problems in public housing availability in Australia and the wider problem of housing affordability (Milligan et al. 2004)—the kinds of requirements identified by O'Brien and others highlight the array of issues relevant to discussions of the best ways of promoting secure housing outcomes for young people living with a mental illness. Most researchers in this area recognise that *formal support* is one of the most important factors in the maintenance of housing security for youth living with such illnesses. Critically, however, this formal support should be provided in such a way as to help youth to *re-establish and/or further develop significant informal relations and attachments within their community*. The point here is that housing must be seen as the foundation from which adolescents and young adults can develop richer and more meaningful bonds within their community, whether this involves education, training and employment, the broadening of family, peer and social networks, or the development of more meaningful life pursuits. This suggests the growing importance of 'social inclusion' and the ways such a policy framework is beginning to reshape thinking about housing policy and service provision in response to mental illness in youth populations in Australia (see Boardman 2010; Hulse et al. 2010; VICSERV 2008).

## **2.2 Housing and social inclusion**

Social inclusion has been an increasingly salient theme within housing policy debates both in Australia and internationally in the last 10–15 years. This is true of national and state governments, and in terms of the organisational goals of various community-based housing, human and social welfare agencies (Boardman et al. 2010). In part, this reflects a broader 'whole of government' approach to social inclusion at both the state and national level in Australia, and the view that complex social problems—like mental illness and homelessness in youth populations—require complex policy responses involving diverse departments, agencies and organisations.



In keeping with this view, social inclusion has been variously defined as a fundamental human right; an inalienable obligation of government; a feature of good corporate 'citizenship'; a philanthropic responsibility and a common store of 'healthy' communities (see Jacobs et al. 2004). Developing these themes, Huxley and Thornicroft (2003, pp.198–90) draw the helpful distinction between social inclusion understood in terms of citizenship and democratic participation—as a measure of the extent to which different groups and communities participate in the various formal mechanisms of representative governance—and the shared values, identifications and sense of cohesion associated with active membership of particular social groups and communities. Each aspect, the political and the social, combines in the expression of social inclusion; giving rise to often heated debates about the most effective strategies for enhancing or increasing political and social participation in the interest of improving social inclusion in a given setting (see Bryne 2005, pp.151–54).

No doubt evading some of these tensions, the Australian Government (ASIB 2009, p.2) defines the concept this way:

Social inclusion means building a nation in which all Australians have the opportunity and support they need to participate fully in the nation's economic and community life, develop their own potential and be treated with dignity and respect.

With greater focus on the relationship between social inclusion and health, Psychiatric Disability Services of Victoria (VICSERV 2008), the peak body for psychiatric disability services in Victoria, speaks of social inclusion as:

A sense of belonging to community that makes people feel cared for, loved and valued, which in turn protects wellbeing. On the flipside, (social) exclusion is linked to unhappiness, illness and reduced life expectancy. There is a strong correlation between poor social networks and mortality from almost every cause of death.

Given these kinds of definitions, it is self-evident that the provision of stable housing for adolescents and young adults experiencing mental illness should be regarded as a pre-requisite for meaningful participation in the community, for social inclusion broadly defined. This view is premised on the assumption that housing provides both a foundation and a tangible set of resources useful for facilitating the various processes by which youth cultivate and sustain participation (or inclusion) in their community (Mallett 2004, p.68). Housing should in this respect be understood as a distinctive material, emotional, ontological and social resource essential for the development of meaningful relationships within a neighbourhood, community and/or wider society. To this end, housing is known to promote personal security (Mallett 2004); to support the cultivation of intimate relations within the family and the broadening of social and peer networks outside of it (Baker & Arthurson 2007); and to support the development of the social, emotional, and intellectual skills necessary to pursue specific educational, employment and/or vocational ambitions in the community (Dupuis & Thorns 1998). Without the distinctive material, ontological, social and emotional resources provided in the home, each of these processes becomes more difficult, more tenuous and less secure for any young person experiencing mental illness (Hulse et al. 2010). It follows, moreover, that each of the various domains typically associated with social inclusion—like community participation; gainful employment; the pursuit of education and training opportunities; access to essential services including adequate health care; respect for cultural diversity and so on (Boardman et al. 2010; Levitas 2005; Sen 2001)—depend in one way or another on the specific emotional, ontological and material foundations provided through secure housing.

Without ignoring the importance of secure housing, it is nonetheless apparent that housing does not, in and of itself, guarantee social inclusion, particularly among vulnerable groups like youth living with a mental illness. Indeed, there is now significant research indicating poor social inclusion outcomes, even in instances where high-quality housing stock has been provided for young people recovering from a mental illness (see Chamberlain et al. 2007; Dalton & Rowe 2004; Hinshaw 2005; Nelson et al. 2005; Peace & Kell 2001; VICSERV 2008). This does not of course dismiss the importance of adequate housing in promoting social inclusion and facilitating recovery; only that these outcomes depend on a variety of factors in addition to the provision of housing. It suggests, moreover, that social inclusion requires various *formal and informal* supports that help youth to develop meaningful relationships within their community. This includes formal relations associated with education, training and/or employment; utilisation of local services and amenities such as parks and libraries; and ready access to essential services like health care and transportation. Yet it must also include the development of *informal* relationships and networks, like those associated with the everyday 'life' of a community; of participating in a community of neighbours, strangers and acquaintances in public space (Levitas 2005). The development of these informal ties helps to embellish feelings of community belonging and 'place-attachment' that are known to be critical to the development of social inclusion for youth in recovery (Hidalgo & Hernandez 2001; Hopper 2007; Boyd et al. 2008). Put more simply, informal community ties give tangible form to the subjective experience of *being included* in a society or community.

Social inclusion has for these reasons, typically been defined in existing housing policy debates in ways that include both informal, private and/or civil processes, as well as formal, public or 'state-mediated' ones (Boardman et al. 2010; VICSERV 2008). This is largely because the everyday experience of social inclusion is clearly mediated by the informal processes by which individuals and groups forge social networks in their community, as well as those formal processes associated with the state and the market that mediate employment outcomes, education and training opportunities, access to public resources like health services and so on. As we have noted, most researchers and policy-makers have focused on this second set of processes in examining the links between housing and social inclusion for youth recovering from a mental illness. It is only more recently that attention has turned to the ways social inclusion is mediated in more informal ways, including the implications these processes have for the study of housing and housing retention for youth in recovery (Chamberlain et al. 2007; Nelson et al. 2005; VICSERV 2008).

Looking more broadly then across these diverse housing and social inclusion literatures, informal community resources can be defined to include the varied relations that shape feelings of place attachment and community belonging; the physical and aesthetic amenity of the neighbourhood, including housing quality, community infrastructure and the 'affective' experience of local streetscapes; as well as the diverse informal resources generated and distributed in local, neighbourhood social networks. More directly, place attachment describes the array of social, emotional, material and physical relationships that individuals and groups develop in and with particular places. It describes the depth of emotional, physical, intellectual and/or spiritual intimacy or 'closeness' (Hidalgo & Hernandez 2001, p.274) that individuals experience in particular places. Place attachment captures the degree of comfort, belonging or security that particular places generate. It also confirms the philosopher Edward Casey's (2001, p.688) observation that 'places come to be embedded in us; they become part of our very self, our enduring character, what we enact and carry forward'. The concept of 'place attachment' attempts to capture the quality of this relationship between belonging in place, social inclusion and the sense

of closeness or intimacy that individuals experience in certain places, and the ways that these processes shape personal, social and cultural identities (Manzo 2005).

Neighbourhood amenity, meanwhile, reflects the character of the physical and aesthetic infrastructure discernible within a local neighbourhood or community setting, and the various feeling states, moods, or 'affective atmospheres' (Anderson 2009) generated in such settings. It also reflects the social, cultural, political and economic reputation or image that a particular setting has, which typically denotes that site's 'desirability' (Ziersch & Baum 2004). As we have already noted, social capital describes the specific ways that social networks work to generate (or undermine) social cohesion, social support and organised participation within a particular setting (Baum 2002; Carpiano 2006). While the relationship between social capital and social inclusion is far from settled, with much research suggesting that relatively 'closed' social networks can actively exclude newcomers or strangers (Duff 2010a; Saunders & Tsumori 2002), it is largely accepted that the more open a social network is in terms of the 'bridging' opportunities it offers to incorporate new individual members and/or additional networks, the greater the impact on social inclusion in that network. Bridging capital may, in this way, facilitate the development of more diverse ties that may provide access to resources not previously available, such as information about employment opportunities (Almedom 2005; Hulse et al. 2010; Kawachi & Berkman 2001).

Despite the more generic insights available in the study of place attachment, neighbourhood amenity and social capital, the role of informal community resources in facilitating housing retention and promoting social inclusion among adolescents and young adults recovering from a mental illness remains poorly understood. Certainly when compared with the role of formal resources and supports, analysis of the significance of informal community resources in facilitating housing retention for youth in recovery remains in its infancy. Interestingly, this is not the case in relation to the study of recovery from mental illness, where the analysis of informal community resources is much more developed. Indeed, the notion of recovery has received close attention in a number of fields in recent decades, leading to the emergence of holistic models that go well beyond the simple psychological and physiological functioning of the individual (Henderson & Walter 2009). Recovery is rarely regarded in the contemporary literature as the simple elimination of symptoms associated with mental illness; it is rather seen as a holistic process or journey involving diverse social, emotional, existential, material, psychological and physiological factors and processes (Andresen et al. 2011). Recovery is further understood to require a range of formal supports and services, like those provided by mental health care providers and related agencies, *as well as informal resources* and relationships within the community. Emerging research suggests that these informal community networks, resources and relationships are critical in promoting long-term recovery from mental health problems for adolescents and young adults (Boardman et al. 2010; Patel et al. 2007; Sawyer et al. 2001). Hence, a fuller and more explicit review of this literature should provide a range of insights into the character of informal community resources. This will also provide a basis in later chapters for determining the ways that these informal resources support the maintenance of secure housing for youth recovering from a mental illness.

### **3 MENTAL ILLNESS, RECOVERY AND YOUNG PEOPLE: IMPLICATIONS FOR HOUSING POLICY**

For many decades, the vast majority of mental illnesses like schizophrenia, depression and bi-polar disorder were regarded as incurable, chronic conditions, associated with significant disability and reduced quality of life (Ramon & Williams 2005). Even with the emergence of dedicated pharmacotherapies and their ongoing refinement, the goal of treatment was largely confined to the successful management of symptoms and the longer term 'stabilisation' of the disorder. This was typically true of treatment regimes for adults and for adolescents and youth, even though the character of mental health problems was known to differ significantly across the life-course (see Cattan & Tilford 2006; Rickwood et al. 2005). Underpinning such prognoses was a largely biological and/or organic model of mental illness, which regarded such disorders as a function of pathological brain function. This 'bio-medical' model of mental illness, and its discrete etiology, remains highly influential in contemporary debates regarding mental illness and its treatment in youth populations, even though it has been challenged in recent decades by a range of more holistic accounts and frameworks (see Henderson & Walter 2009; Patel et al. 2007). Including 'psycho-social' models, strengths and resiliency models and various recovery-oriented paradigms, these emerging alternatives dispute earlier claims regarding the chronic nature of mental illness, while criticising so-called bio-medical models for ignoring the social, cultural and personal contexts of mental illness.

The emergence of more holistic understandings of recovery has widely influenced the treatment of mental health problems in youth populations in Australia, as clinicians and service providers have become more aware of the stigmatising effects of mental illness diagnoses among youth, and the vast differences in illness trajectories in these populations (Cattan & Tilford 2006). This has led to calls for greater sensitivity in the assessment and diagnosis of mental health disorders in youth populations, and greater attention to the diversity of lived experiences of mental health problems, particularly the incidence of what is now called 'functional recovery' in these cohorts (Rowling 2006, pp.101–6). Indeed, the development of the idea of functional recovery has been part of a broader move to repudiate the longstanding characterisation of recovery as 'cure', understood as the complete remission of observed symptoms caused by mental illness (Andresen et al. 2011). In sketching the first accounts of a 'biopsychosocial' approach to health care, including the treatment of mental illness, George Engel (1977) stressed that earlier understandings of recovery were overly reductive and exclusive, and failed to capture the diversity of treatment outcomes experienced by people living with a mental illness, including adolescents and young adults (see also Rowling 2006). Engel's biopsychosocial paradigm, which has become hugely influential in Australian mental health care planning and delivery (Andresen et al. 2011; DHHS 1999), acknowledges the interplay between biological (symptoms, genetic influence), psychological (cognitions, emotions, behaviour), environmental (access to support networks) and socio-political factors (stigma, mental health system) in both the etiology and lived experience of mental illness. It also acknowledges that individuals may lead healthy, productive and fulfilling lives despite the ongoing experience of symptoms associated with mental illness.

In the last two decades, the growing importance of the biopsychosocial paradigm has been facilitated by an international consumer advocacy movement led by individuals living with mental illness, their families and their supporters (Beeble & Salem 2009; Bradshaw et al. 2007). This consumer movement has contributed to the emergence of more dynamic and nuanced understandings of recovery as consumers themselves

have provided testimony of their experiences. Subsequent shifts in the conceptualisation of recovery have been further prompted by longitudinal studies demonstrating that recovery from mental illness is possible (Harding 1988; Harding et al. 1987; Harrison et al. 2001; Jobe & Harrow 2005; Lysaker & Buck 2008). In a systematic review of such studies, Calabrese and Corrigan (2005) report that between 36 per cent and 77 per cent of individuals recover from mental illnesses like schizophrenia. This study shares the view endorsed by many researchers in the field that recovery requires more than just passive compliance with medical regimes, and that recovery is more of a process than a static outcome (Anthony et al. 2006; Corrigan & Ralph 2005; Houghton 1982; Leete 1989; Lovejoy 1982; O'Hagan 2004; Ridgway 2001; Unzicker 1989; Wentworth 1994). This conclusion is echoed in much of the recent literature on youth mental health, which stresses that recovery is unique to each young person, and that treatments ought to focus on improving a young person's quality of life rather than focusing solely on mitigating symptoms associated with their illness (Rowling 2006; Solomon & Stanhope 2004). Other researchers have emphasised the traumas experienced by young people as a result of their diagnosis, treatment and/or hospitalisation, arguing that recovery should involve some palliation of these traumas in addition to the physical and psychological problems associated with mental illness (Deegan 2001; Hinshaw 2005; Whitwell 1999). All of this suggests the need to treat the consequences of mental illness in a young person's life and not just the illness alone.

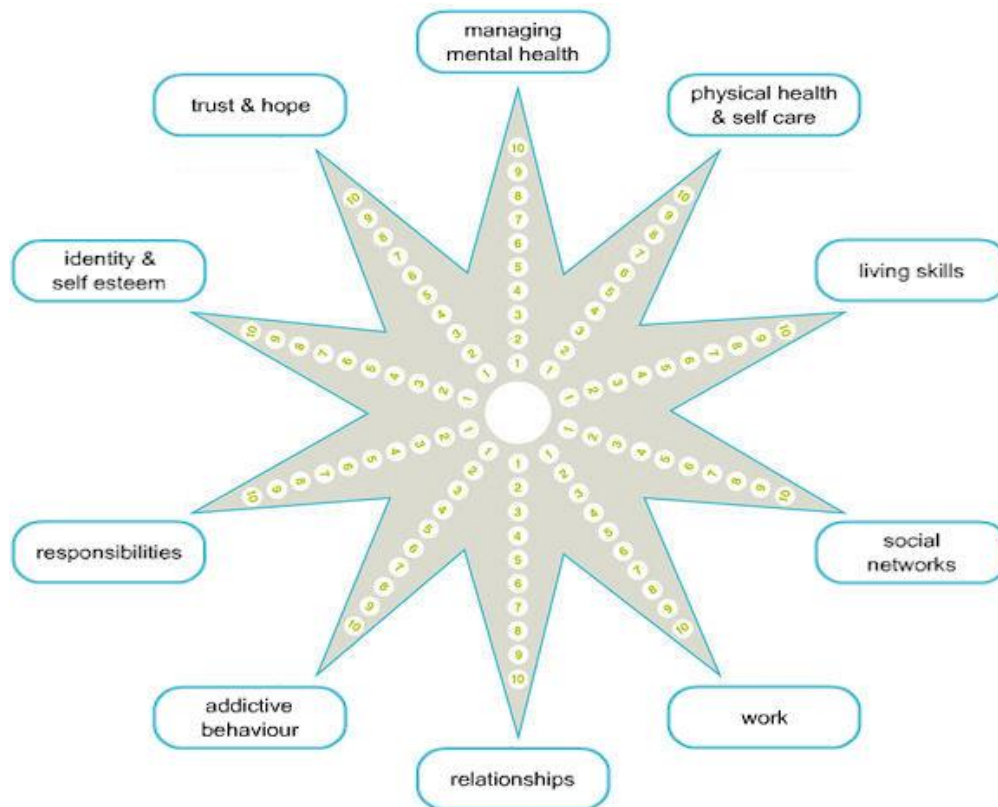
These kinds of arguments have inspired recent attempts to redefine the very idea of recovery in youth populations, away from the idea of a complete remission of symptoms in favour of the notion of 'managing' the illness across the life-course (Beeble & Salem 2009; Cattan & Tilford 2006). While this has caused some confusion regarding the diagnostic meaning of recovery, and no doubt advanced the proliferation of 'popular' understandings of the term, it does reflect the diversity of young people's experiences of mental illness and the fact that most youth who experience mental illness are able to manage their illness while successfully pursuing a range of significant life goals (Andresen et al. 2011; Hinshaw 2005; Hopper 2007; Rickwood et al. 2005; Rowling 2006; Sawyer et al. 2001). Such insights are reflected more formally in the range of recovery models in use in youth mental health services in Australia, such as the 'Boston Model', the 'Collaborative Model' and the 'Contra Costa County Recovery Model' (see Andresen et al. 2011). Despite differences of orientation and terminology, each of these models endorses a broad biopsychosocial approach in advancing mental health treatment modalities to support the recovery of adolescents and young adults affected by mental illness. While there is not the scope here to provide a fuller account of these recovery models and their application in the development of youth mental health services in Australia, it is possible to identify a set of common, underlying values, principles and orientations. It is worth briefly describing these common values in light of the significance of the notion of recovery for the wider empirical research aims associated with the present study (see Chapter 5). These principles also shed light on the role of informal community resources in promoting recovery for youth experiencing mental illness.

Briefly, almost all recovery models currently in use in the provision of youth mental health services in Australia endorse holistic understandings of recovery that go well beyond the healthy or normative psychological and physiological functioning of the individual to include an array of additional social, familial, cultural, existential and economic factors. The following six principles are common characteristics of recovery models used in the design and delivery of youth mental health care in Australia (see Andresen et al. 2011, pp.45–52; Boardman 2010, pp.37–41, Patel et al. 2007; and/or Rickwood et al. 2005 for a fuller review).

1. All recovery models stress that youth experiencing mental illness can learn, change, grow and recover. Recovery occurs through continued learning, experimentation, collaboration, hope and support.
2. Recovery models work from a 'strengths' and/or 'resiliency' framework to identify and promote the strengths, capabilities and aspirations of each young person. This contrasts with traditional 'outcomes' models that focus on alleviating symptoms and deficits. By building upon individual competencies, youth are affirmed in their capacity to contribute to their own recovery, to combat the specific effects of their illness, and to develop their identity.
3. Recovery models endorse an equal, open and collaborative relationship between youth consumers and health-care providers.
4. All recovery models emphasise a young person's agency and/or self-determination in establishing recovery tasks and goals, including the right to make choices that may lead to mistakes (sometimes called the 'dignity of risk').
5. Recovery models identify the wider community as the primary source of the resources needed to facilitate growth and recovery (as opposed to emphasising the 'helping' resources available in mental health services).
6. Recovery models insist that the most effective 'recovery work' occurs in the 'natural context' of a young person's private, family and community life.

Although not pertaining exclusively to *youth* mental health, the UK-based Mental Health Providers Forum has recently developed a series of assessment and evaluation tools based on the recovery principles described in the above list. The 'recovery star' reproduced at Figure 1 below summarises the holistic understandings of recovery reviewed above, as well as the range of domains in which recovery must take place for adolescents and young adults living with a mental illness (see MHPF 2011).

Figure 1: The recovery star



Increasingly, the principles and values encapsulated in the ‘recovery star’ above have come to underpin youth mental health care planning and policy-making in Australia (Boardman 2010, p.40; McGorry et al. 2007). For example, the 2009 Australian *National Mental Health Plan (2009–2014)* identifies five priority goals, explicitly endorsing recovery and social inclusion as over-arching policy drivers. Interestingly, the plan nominates as a priority the adoption of a ‘recovery oriented culture’ within mental health services, underpinned by appropriate values and service models’ (CofA 2009, p.24), although the plan does not clarify the nature of these values and models. Similarly, the 2009 *Victorian Mental Health Reform Strategy* identifies ‘recovery’ as one of four policy goals, and proposes a cultural shift in the way the mental health sector and the broader community understand the potential for individuals affected by mental illness to achieve recovery, and for mental health services to facilitate this.

### 3.1 Recovery, social inclusion and the community

One of the key features of the emergence and ongoing development of diverse ‘recovery’ models in youth mental health care treatment and policy has been the recognition of the importance of community participation and/or social inclusion for young people living with a mental illness. Indeed, principles 5 and 6 nominated in the list of ‘recovery values’ identified above, explicitly endorse the importance of community participation in promoting recovery from mental illness, primarily because of the specific (informal) resources that are purportedly available in the community to facilitate ‘recovery work’. In part, emerging interest in the importance of community participation and social inclusion reflects decades of research indicating that young people experiencing mental illness are at greater risk than other groups in society of being excluded from full participation in community life. This includes the risk of exclusion from post-secondary education; meaningful employment; wider social, peer and intimate relationships; and participation in voluntary and/or civil associations

(Boardman 2010, pp.22–5). In seeking to combat these risks, policy-makers and mental health service providers have put in train initiatives designed to mitigate the effects of social exclusion and promote increased participation in community life for youth living with a mental illness. In this sense, social inclusion and/or community integration are regarded as critical, both in terms of the personal health and wellbeing of young people living with a mental illness and in terms of their broader social, cultural and existential recovery. It might be argued further that social inclusion has become something of a synonym for recovery, given the movement noted above beyond simple ‘bio-medical’ accounts of recovery. Certainly social inclusion remains one of the most salient themes in the recent literature on the treatment of mental health problems in youth populations (see Boardman et al. 2010; Hopper 2007; McGorry et al. 2007; VICSERV 2008).

The apparent conflation of recovery and social inclusion nonetheless opens up the question of how local communities—and the wider society—actually promote or facilitate a young person’s recovery from mental illness. We have already noted the emphasis invested in both national and state mental health care policies in the idea of social inclusion and the importance of delivering high quality mental health care in the community. To briefly recap, the 2009 *Victorian Mental Health Strategy* emphasises the importance of integration and community participation to promote recovery for youth living with a mental illness (DHS 2009). To this end, the strategy prioritises the development of new and improved forms of community-based care, including increased funding for local Psychiatric Disability Rehabilitation and Support (PDRS) services and community health counselling to enhance youth access to local clinical and counselling supports. However, it is important to note that recent strategies like the Victorian and the Commonwealth plans go well beyond the issue of local access to medical and/or psychiatric care. Each strategy also endorses the *notionally therapeutic role of the community itself* in supporting and promoting recovery from mental illness for youth and adults. The Victorian Strategy, for example, endorses an explicit place-based recovery model, asserting the importance of everyday community environments in achieving mental health promotion (DHS 2009, pp.5–9). The strategy further refers to the need for ‘positive and safe environments’ in building self-esteem and confidence while minimising the precipitating factors to poor mental health. Similarly, reform area five (*Support in the Community*) aims to build foundations for recovery through the promotion of training and employment opportunities, and the development of stronger social connections to facilitate participation in the community (DHS 2009, pp.5–9). The strategy calls for strong action to address social exclusion among youth living with a mental illness, primarily through partnerships with sporting, recreational and arts bodies to encourage greater participation in community life.

However, these recent national and state-based strategies largely avoid explicit statements regarding the means by which community participation and increased social inclusion actually facilitates recovery from mental illness. Perhaps it is more charitable to observe that these strategies start from common assumptions about such links, given the work done over many years in diverse fields to establish the association between social inclusion, community participation and recovery. A lot of this research started in a more exploratory fashion with a general interest in clarifying the role of community participation in facilitating health, wellbeing and recovery from illness broadly defined (Cummins et al. 2007; Duff 2009, Duff 2010a; Macintyre et al. 2002; Williams 2007). This work has led to a series of insights into the links between place, social inclusion and health promotion, while generating a series of discrete theoretical models to explain these links. This has included research and theory concerning the idea of ‘therapeutic landscapes’ (Williams 2007), ‘restorative settings’ (Milligan & Bingley 2007) and ‘enabling environments’ (Steinfeld & Danford 1999).



Taken together, the study of what might collectively be referred to as *enabling places* (Duff 2009, 2010a, 2011), has revealed strong links between the community and recovery from primary health problems. This research has explored the significance of specific properties or features of local communities—such as places and settings, community services, the provision of resources and supports and the importance of family and peer relationships—in generating discrete therapeutic benefits (Cummins et al. 2007; Stockdale et al. 2007; Williams 2007). These studies suggest that many community settings incorporate unique therapeutic qualities or ‘stress-buffering mechanisms’, which facilitate wellbeing and mitigate health inequalities (Stockdale et al. 2007, p.1870). These community sites provide an array of resources, relationships, services and supports that potentially facilitate health and wellbeing.

While it is important to stress that the bulk of these studies have explored health in broad, generic terms, a small but rapidly growing literature indicates that these therapeutic qualities are also effective in facilitating recovery from mental illness (Cohen 2004; De Silva et al. 2005; Kawachi & Berkman 2001). This includes dedicated studies exploring these links in relation to youth mental health promotion and recovery (see Boyd et al. 2008; Curtis 2010; Hopper 2007; Rowling 2006). The link between community participation, social inclusion and recovery from mental illness in youth populations has primarily been demonstrated in relation to the impact of community life in moderating stress and anxiety (Korpela et al. 2008); increasing community ‘belonging’ and ‘life purpose’ (Boardman 2010; Williams 2002); boosting social interaction and the development of ‘social capital’ (Boyd et al. 2008); as well as elevating mood and general wellbeing (Rowling 2006). Each of these processes has been shown to facilitate young people’s recovery from mental illness in specific instances, including the promotion of physical health as well as enhanced psychological functioning and subjective wellbeing (Almedom 2005; Boardman 2010; Kawachi & Berkman 2001; McDermott et al. 2011; Meadows et al. 2007; Milligan & Bingley 2007; Parr 2007). All of this again suggests the significance of community and place attachment in facilitating recovery from mental illness while facilitating social inclusion for youth living with such conditions.

### **3.2 The role of the community in supporting social inclusion and recovery for youth experiencing mental illness**

The explicit promotion of social inclusion endorsed in recent Australian mental health strategies is symptomatic of the broader shift in academic research, noted above, regarding the experience of mental illness and the most effective ways of treating mental health problems in youth populations. The significance of social inclusion and community participation in promoting young people’s recovery from mental illness has been widely accepted in the post-deinstitutionalisation era (Wong & Soloman 2002). However, as we have noted, the specific ways in which community integration and social inclusion facilitate recovery from mental illness is rarely addressed in contemporary Australia policy statements. Evidence establishing such links must be collated from a variety of theoretical and empirical sources. Building on the emerging evidence canvassed in the last section, we start with the notion of community itself, before turning to consider the informal resources that communities make available to promote recovery and social inclusion for youth living with a mental illness.

Community and the related notion of community integration are amorphous concepts comprising discrete material, physical, social and psychological dimensions (Chamberlain et al. 2007; Hidalgo & Hernandez 2001; Wong & Soloman 2002). Importantly, community integration reflects a measure of social, economic and political *participation* in community life. The material dimension captures perhaps the most familiar aspect of community in describing the spatial coordinates that delimit

communities as discrete bounded entities. This dimension attempts to retain the specific geographical features of community life, even as research and popular understandings of community continue to move beyond these material scales to incorporate a range of additional social, cultural and affective dimensions. This material dimension is also relevant to discussions of the various mobilities that are common features of everyday community life (Cresswell 2010). This includes the discrete patterns of movement and mobility by which individuals and groups physically encounter or inhabit different sites and settings in their community. It also reflects the everyday patterns of mobility and movement by which individuals and groups are exposed to settings and places beyond their routine experience. Meanwhile, the social dimension of community and community participation describes interactions among community members both within and outside one's immediate peer, family and social networks. Finally, the psychological dimension of community involves the sense of attachment or belonging to the community, and the various sites and places within it that generate feelings of 'self and place identity' (Wong & Soloman 2002).

Each of these dimensions—the material, the physical, the social and the psychological—helps to clarify the significance of place and place attachments in promoting community participation and facilitating social inclusion for young people living with a mental illness (Boyd et al. 2008; Huxley & Thornicroft 2003). Community participation and social inclusion each entail a strengthening of one's place attachments and the degree to which one feels a sense of connection or belonging in place (Morgan 2010). Research in public health, environmental psychology, sociology and medical geography reveals a strong link between place-attachment, the experience of social connection, and enhanced physical and mental health for young people recovering from a mental illness (Boyd et al. 2008; Kawachi & Berkman 2001; Pryor 2011). This work indicates in general terms that young people derive a sense of wellbeing from select local places, which in turn promotes healing and recovery. More directly, increased attachment to place and community has been shown to yield a variety of resources that support specific mental health related goals and activities. This includes opportunities for 'bridging' social networks and further extending social ties (Kawachi & Berkman 2001); for personal reflection and the promotion of belonging and personal security (Hidalgo & Hernandez 2001); increased opportunities for leisure, aesthetic and/or recreational pursuits (Cattell et al. 2008; Manzo 2005); as well as relaxation and mental 'restoration' and the relief of stress and anxiety (Korpela et al. 2008). These kinds of research findings dovetail neatly with recent studies of neighbourhood experience, concentrations of economic and social disadvantage, and the array of housing supports needed for successful community integration for youth recovering from a mental illness. Each such study provides further indications of the role of the community in promoting social inclusion and facilitating recovery from mental illness for both adolescents and young adults (Townley et al. 2009; Wong & Soloman 2002; Yanos 2007).

Across these diverse literatures therefore, community integration, social inclusion and 'place-attachments' have been shown to be critical to young people's recovery from mental illness, inasmuch as specific community places furnish an array of discrete *material, social and affective resources* that facilitate 'recovery work' (Kawachi & Berkman 2001; Parr 2007; Stockdale et al. 2007). The available literature thus provides crucial insights into the ways that increased community participation and/or social inclusion promotes recovery from mental illness for young people. We would add that this literature helps to explain how increased community participation and greater social inclusion can promote stable housing outcomes for young people recovering from mental illness. More broadly, the varied experiences of recovery, wellbeing and social inclusion described in the studies reviewed above indicate the

need to generate more coherent conceptual models of the specific health-related resources available in discrete community settings and the wider significance of person-environment interactions in promoting recovery and facilitating stable housing outcomes. It follows that valuable insights regarding recovery are likely to result from improved understandings of the ways that recovery is produced in the community. In exploring these issues, Duff (2010a, 2011) has recently proposed a typology of informal community resources as a way of further elaborating the role of such resources in promoting young people's health and wellbeing, including recovery from mental health and addictions related problems. Drawing from diverse literatures, Duff (2011, pp.152–55) proposes three classes of informal community resources; social, material and affective resources. Examples of these 'enabling' resources include the social, financial and emotional resources provided in young people's family, peer and social networks; the benefits associated with participation in sporting clubs, church, cultural and community groups; involvement in online networks and so on (Duff 2010b).

Duff concludes that an analysis of these resources can help to generate insights into the ways that communities support or facilitate recovery for young people living with a mental illness, while promoting social inclusion and community participation (see also Conradson 2005; Parr et al. 2004; Parr 2007). Examples of these 'community effects' include the promotion of young people's health and wellbeing; opportunities for greater economic participation including employment and training opportunities; the development of social capital and social networks; and the promotion of social, emotional and cognitive development. Each of these processes is crucial in promoting young people's recovery from mental illness (Boardman et al. 2010). It is further likely that these same resources are involved in the successful transition into secure, independent housing for youth recovering from mental illness. With these broad aims in mind the next chapter provides a fuller discussion of the character of informal community resources, focusing on social, material and affective resources and the means of their generation, distribution and utilisation. This will include some consideration of the ways that these resources are potentially linked to more secure housing outcomes for youth living with a mental illness.

## 4 INFORMAL COMMUNITY RESOURCES: SOCIAL, MATERIAL AND AFFECTIVE

Chapters 2 and 3 have canvassed a range of research literatures in an attempt to trace the links between recovery, social inclusion and the promotion of stable housing outcomes for youth living with a mental illness. In considering how the housing needs of such youth might best be met, we have highlighted the critical importance of formal resources and supports, like those delivered through the NAHA initiative, although we have largely sought to clarify the role that informal community resources play in promoting recovery, social inclusion and stable housing. As noted, we have partially selected this focus in keeping with recent calls for increased attention to informal community resources and processes. Yet our main reason has been to consider in more direct terms the means by which increased community participation and greater social inclusion actually promote recovery from mental illness, while facilitating more stable housing outcomes for young people living with a mental illness. Our hypothesis is that increased community participation and greater social inclusion promote recovery and secure housing outcomes by *opening up access to the range of informal resources generated within, and sustained by, community life*. In a sense, the very notion of community might be understood in this way, as a mechanism or process by which diverse resources are generated, distributed, sustained and used by diverse individuals and groups in the pursuit of diverse ends (see Duff 2011, pp.152–55; Duff 2009). We would stress that three broad classes or categories of informal resources ought to be emphasised in this discussion; social, material and affective resources.

In the following sections we attempt to flesh out the characteristic features of these resources, touching on the specific ways in which they are generated and used in community life. Our objective is to clarify the various ways community participation and social inclusion promotes recovery and facilitates secure housing for young people recovering from a mental illness. This will include the presentation of a series of methodological propositions that will guide the various analyses to feature in the empirical component of the project (as described in Chapter 5). Central to the analysis offered in this chapter is a closer investigation of the meaning and status of ‘community’ and ‘resources’ and their role in the promotion of social inclusion in youth populations. As we argued in the previous chapter, it is helpful to conceive of young people’s communities as distinctive social, cultural, political, economic, affective and relational achievements (Miles 2000; Duff 2010b). Each such community is produced in diverse interactions as it is lived, experienced and made meaningful. Communities are, in other words, ‘made’ in youth conduct and interaction such that the material elements of place are constantly evolving in tandem with this social, cultural, economic and political activity (Casey 1993). This conceptualisation provides a way to account for the diverse elements comprising young people’s communities, just as it highlights the *enduring instability* of these communities. After all, pinning down the identity of community, even in terms of its actual physical coordinates, is a far from easy undertaking (Anderson 1983; ASIB 2011; Cummins et al. 2007).

Applied to the study of informal community resources and their role in promoting recovery and facilitating stable housing for young people living with mental illnesses, these arguments highlight the dynamic force of community development; the heterogeneous elements that comprise community; as well as the specific means by which youth communities are made in activity and practice (Duff 2010b; Hidalgo & Hernandez 2001; Manzo 2005). It follows that young people’s communities cannot be regarded as stable, homogenous entities—as effectively the same kinds of thing for all youth who encounter them—rather communities are made and remade in social and

cultural relations; in symbolic processes to do with the meaning of place, population and people; and in discrete material, economic and political processes (Miles 2000; Duff 2010b). In this light, the meaning and character of young people's communities, and the myriad people and places that comprise them, depend both on the behaviour of individuals and groups, as well as the diverse material, structural, social and cultural qualities and properties of such communities. These may seem like routine points, yet they lead to some important methodological insights.

First, to describe young people's communities in this way emphasises the *interaction* of person and community in contrast to narrower studies which treat each as discrete entities that converge in complex behaviours. Casey (2001) has argued that to assess people and places in isolation of one another is to miss the most significant processes in community life. It is better, in other words, to emphasise the relational nuances of community as it is lived or experienced, rather than to stick with the empirical or pragmatic privileging of either persons or places (Cummins, et al. 2007). This suggests a second proposition; if young people's communities are made as much as they are discovered, then the practice of community development, of place-making, requires greater scrutiny. Research in diverse fields suggests that community development in youth settings draws on a series of discrete resources, some of which emerge in the community itself, while others remain a product of the practices and interactions experienced in that context (Boyd et al. 2008; Casey 2001; Kawachi & Berkman 2001; Manzo 2005; Thrift 2007). These resources—both formal and informal—facilitate a richer or more meaningful experience of community and belonging for young people, furnishing a set of assets and tools useful for the realisation of specific actions, relations and feeling states (Williams 2007).

It is precisely in this sense that we would like to draw attention to the potentially therapeutic and/or enabling properties of community resources, particularly informal resources, for youth recovering from a mental illness (Crawford 2006; Curtis 2010; Duff 2011). Informal community resources can be regarded as therapeutic to the extent that they support particular kinds of health related activities, behaviours and interactions. Cohen, Underwood and Gottleib (2000) describe this as the 'main effect' of informal community resources, highlighting the discrete kinds of social support and 'normative guidance' provided in social networks, and the ways that these processes serve to improve psychological wellbeing and facilitate health-related activities. Such an understanding of informal community resources emphasises the fact that while not every aspect of young people's community life should be regarded as enabling, it is nonetheless plain that young people's communities do indeed serve certain therapeutic functions, under certain circumstances. This is true both for youth experiencing mental health problems and for those who are not (see Boyd et al. 2008; Duff 2009). The character of young people's communities vary widely of course, yet these communities always provide some kind of enabling benefit no matter how limited this might be in certain instances. The task, in this sense, is to *identify the specific instances and circumstances in which young people's community attachments can be shown to be enabling and/or health promoting*. We would argue that the key to such discrimination lies in determining the extent to which community attachments support the production and circulation of informal resources, which are then put to use in specific health-related practices and interactions. There is now a good deal of evidence indicating that informal community resources are vital to the promotion of mental health-related activities in youth communities, including the everyday experience of mental wellbeing; the mitigation of specific risks and vulnerabilities; the creation of 'stress buffering' relations and activities to protect against health 'stressors'; and the creation of healthier communities or 'enabling' places (Boyd et al. 2008; Cohen et al. 2000; Kawachi & Berkman 2001). A community

may therefore be regarded as enabling (or health promoting) to the extent that it provides access to informal resources which themselves support specific mental health-related activities. In examining the diverse literatures in which these kinds of claims have emerged, three classes of enabling resources ought to be emphasised—social, material and affective resources. Each will be reviewed in the sections to follow. Once these arguments have been established, the chapter will turn to consider the relevance of these kinds of claims for broader discussions regarding the significance of social inclusion and community participation for enhancing the security of young people's housing arrangements, including youth recovering from a mental illness. The chapter closes with a discussion of the ways that communities, and the enabling resources they support, may be mobilised in the design of innovative housing and social inclusion initiatives for youth recovering from mental illness.

#### **4.1 Social resources: networks and social capital in place**

Social resources describe the varied processes and interactions that support the creation and maintenance of social networks. Social resources thus concern the specific relational, affective, emotional, cognitive and physical competencies that sustain and extend social ties (Crawford 2006; Kawachi & Berkman 2001). The most significant theoretical and conceptual reference here is the notion of social capital and the related ideas of trust and reciprocity (Hawe & Shiell 2000; Portes 1998). Social capital as it is conventionally understood entails analysis of the myriad bonds of trust, reciprocity and cooperation that characterise social life (Portes 1998). It represents an attempt to conceptualise the impact of social networks through the study of the social, affective and material resources that circulate through them. While the specific resources that individuals derive from their networks remain diverse, one's overall stock of social capital is fundamentally linked to the size, number and diversity of one's network connections, and the ways that one can leverage these social ties through the use of other forms of financial, intellectual, cultural and/or symbolic capital (Bourdieu 1986; Cohen et al. 2000). Like these other forms of capital, social capital 'flows' through networks in a series of transactions and exchanges both formal and informal. As such, social capital is a fluid and potentially transferable resource useful for the realisation of various goals, actions and behaviours, including specific health-related goals (Hawe & Shiell 2000). Examples of social capital range from informational resources including job referrals, health care tips, relationship counselling and social networking, through to material resources such as informal access to loans, bartering and other non-market based forms of exchange (Almedom 2005; Boyd et al. 2008; Portes 1998).

Scholars in public health, the sociology of health and illness, medical anthropology, health psychology and related fields have long been interested in social capital given the way that social networks structure the distribution and use of specific social, affective and material resources known to mediate local health inequalities (Cummins et al. 2007; Hawe & Shiell 2000; Kawachi & Berkman 2001). More recently, this has included concerted efforts to elaborate the mental health related impacts of social capital formation and utilisation for broad population groups including youth (see Boyd et al. 2008; Curtis 2010; Rickwood et al. 2005). This work has been part of a broader push to explain the role of communities and neighbourhoods in shaping diverse mental health outcomes, and the particular social, economic and political mechanisms that mediate these outcomes in youth communities (Almedom 2005; Carpiano 2006; Lomas 1998). While social capital may be associated with a range of 'negative' or risky activities in youth communities—such as gang involvement, organised crime or drug dealing (Portes 1998)—the study of social capital and its impact on young people's mental health has largely emphasised the role of community networks in the

mitigation of health inequalities and the promotion of 'normative' health-related activities (Baum 2002; Boyd et al. 2008; Cohen et al. 2000; Hopper 2007).

In the main, social capital is regarded as a *protective buffer* against diverse mental health problems in youth communities, in that the greater one's social networks, the greater one's 'store' of social capital and associated resources is likely to be (Boyd et al. 2008). Research suggests that social capital is associated in this way with a range of protective, or *health promoting* resources, which limit the incidence and severity of various mental health-related risks and vulnerabilities in youth networks (Boyd et al. 2008; De Silva et al. 2005; Hawe & Shiell 2000). Developing these themes, Kawachi and Berkman (2001) highlight the array of informal resources (or 'social assets') generated in and through the social ties that bind social networks, and the ways these social ties promote mental health and wellbeing. Kawachi and Berkman (2001, pp.459–62) argue that there are two main ways in which social ties can promote mental health and/or facilitate recovery from mental health problems. First, social ties can promote specific mental health related activities like regular exercise, the moderation of alcohol consumption, the cessation of tobacco use, healthy diet and 'normative' attitudes regarding the nature and promotion of mental health and wellbeing. Kawachi and Berkman (2001, p.459) are quick to acknowledge that social ties can promote unhealthy attitudes and behaviours in relation to each of these activities, yet it is nonetheless true that social ties 'exert a salutary influence on mental health' by promoting various health-related activities, attitudes and processes. Secondly, social ties can promote mental health and wellbeing by promoting 'positive psychological states including a sense of purpose, belonging and security, as well as recognition of self worth' (Kawachi & Berkman 2001, p.459; see also Curtis 2010; Hildalgo & Hernandez 2001). We will examine these processes more fully in our discussion of affective resources below.

Without referring exclusively to youth, Richard Carpiano's (2006, 2007) work on social capital sheds further light on the nature and organisation of the various buffers and resources generated in social networks, and the ways that these buffers potentially promote mental health-related activities in youth populations. Carpiano identifies four forms of social capital relevant to the study of informal resources in local community settings: social support; social leverage; informal social control and organised participation. Social support 'refers to the forms of social capital individuals can draw upon to cope with daily problems' (Carpiano 2006, p.170). Social leverage describes the extent to which individuals are able to convert this social capital into effective material and/or informational resources; like the informal conversation that leads to a job interview or a referral to a local youth outreach service. Informal social control refers to a community's capacity to maintain order, social organisation and neighbourhood identity through the actions of individuals and collectives. These informal efforts differ from the more structured processes of 'neighbourhood organisation and participation' that make up the last of Carpiano's forms of social capital. Taken together, the four aspects of Carpiano's analysis constitute the actual material, informational, social and personal effects or outcomes, both positive and negative, of social capital accumulation. It is in this respect that Carpiano (2007, pp.641–42) links the analysis of social capital most explicitly to the study of health promotion for individuals and groups. In emphasising the ways that social networks structure the distribution of social, material and affective resources, Carpiano draws attention to the ways that social capital facilitates the generation of distinctive stress-buffering supports in local communities (see also Baum 2002; Curtis 2010). In short, the greater one's access to these resources, and the more effective one is in turning them to 'healthy' or therapeutic uses, the greater one's available stress buffering supports. While it is important to stress that the bulk of the social capital literature has

emphasised the generic health-related benefits that accrue from robust social ties and extended social networks, a rapidly growing literature is beginning to document the ways that these same informal resources support mental health and buffer mental health-related problems in discrete populations (Almedom 2005; Boyd et al. 2008; Rickwood et al. 2005). Social capital and its related notions of social ties and social support thus provide a heuristic template for studying the nature and organisation of stress-buffering supports in youth settings.

The available research suggests that social ties promote young people's mental health by providing an array of discrete resources that promote various mental health-related activities, relations and processes (Curtis 2010; Stockdale et al. 2007). It is likely that these same resources are implicated in the promotion of recovery from mental health problems (Cohen et al. 2000). Just as young people's social ties provide a network of support for the buffering of primary health-related stressors, they also promote psychological wellbeing while providing specific social, material and informational resources that can help youth to cope with mental health problems (Boyd et al. 2008). Indeed, there is much research to suggest that informal social ties are critical in preventing relatively minor and treatable mental health problems from escalating into more severe and debilitating conditions (Cohen et al. 2000). Such ties have also been shown to be critical in helping young people to manage many of the symptoms associated with mental illness, including increased compliance with pharmacotherapies (Curtis 2010); increased help-seeking behaviour (Rickwood et al. 2005); improved mental health literacy in relation to the nature of mental health-related problems (Boardman et al. 2010); as well as motivation and support for the ongoing work of recovery and wellbeing (Irwin et al. 2008). Yet ironically, these diverse supports and benefits confirm that the notion of social capital (and social resources) is not enough, on its own, to capture the full range of stress-buffering supports available in young people's communities to support their recovery and ongoing mental health (Cattell et al. 2008). Put simply, the notion of social capital does not exhaust the full gamut of informal community resources available in any one place. As the discussion above has foreshadowed, while social resources are critical, young people's communities also generate other resources that are equally important in promoting mental health and facilitating social inclusion and/or community participation. Informal material resources are equally important in this respect.

## **4.2 Material resources**

Material resources concern the diverse objects, assets and resources that circulate in and through local informal economic and social networks, as well as the material affordances that local community settings make possible (Marmot & Wilkinson 2006). Examples of the former include the myriad informal benefits, objects and resources that circulate in relations of bartering, gifting and exchange in local networks (Tawil et al. 1997). In relation to the aims of the present review, it is well known now that informal material resources can be important in facilitating the work of recovery and mental health promotion (Duff 2010a). Yet material resources should also be taken to include the specific mental health-related activities and relations that particular places afford or make possible in their very material structure (Gibson 1979). This might be as simple as the relaxation afforded in a local park, to the bridging of social networks afforded in a local café or train station, to the more specific recovery work afforded in a local mental health peer support fellowship (Clark & Uzzell 2002). Community places play a potentially critical role in promoting recovery and social inclusion to the extent that they provide material environments to support the everyday work of recovery. The analysis to follow will thus explore both the informal material resources that circulate in and through local social networks, as well as the material affordances



that local community settings make possible. Taken together, informal material resources support an array of local health promoting, or therapeutic processes, relevant to our discussion of social inclusion, recovery and housing for young people living with a mental illness (Baum 2002; Duff 2010a).

It is important at the outset however, to provide a commentary on the distinctive ways that informal material resources are identified and used in youth communities. Unlike formal material resources such as money, goods and services that are tangible and transferable (meaning that they can be transferred from one transaction to another while retaining the same intrinsic value), the value of informal material resources in youth networks are more typically *context specific* in their status and functional utility (Miles 2000). In other words, the value of a particular informal resource—such as a material object loaned through a social network, or the informal conversation that yields a material benefit in facilitating access to material resources outside of one's immediate network—is likely to have a highly unstable use value depending on its context and network status. Informal material resources conform in this way to an instrumental logic in that the identification, selection and use of informal material resources varies according to the goal-oriented behaviour of individuals and groups. The value of such resources therefore fluctuates according to the specificity of a young person's interests or goals, which frame the identification and utility of particular resources at particular times. This nexus linking goals and utility is central to the health-related status of all informal material resources in youth networks, in that these resources take on a health promoting function to the extent that they facilitate the realisation of specific enabling or health-promoting practices (Duff 2009, 2010a). It follows that the task of identifying informal material resources is often challenging with many such resources only becoming discernible in the effects they engender (Appadurai 1996). The identification of informal material resources in relation to recovery, housing and social inclusion thus requires analysis of the ways such resources are used, what they actually enable, and how this 'enabling' is linked to improved health and social inclusion outcomes in particular youth communities.

The case of material resources as they are typically understood in relation to youth housing services offers a useful illustration of this point. To briefly recap, it was noted in Chapter 2 that long-term housing security in youth populations requires access to adequate housing stock, *as well as* a series of less tangible social supports, resources and services. These support services are generally designed to transform the social environment of housing in ways that actively remove barriers or constraints to protective action. Each of these efforts seeks to increase the array of formal and informal material resources available to a young person in a particular setting to support the retention of secure housing. This includes tangible resources like subsidised housing initiatives, referrals to specialised housing agencies, access to medical benefits, and education and training opportunities, through to more informal resources like peer support, advocacy and assistance generating and extending a young person's informal social networks. The point here is that even formal services generate a range of both formal and informal material benefits and resources, even if the former is far more salient than the latter in most accounts of the utility of these services (see Cattell et al. 2008; Curtis 2010; Stockdale et al. 2007). The material resources associated with youth mental health services are equally complex, offering further illustrations of the unstable status of informal resources and their complicated role in the promotion of health, recovery, housing and social inclusion. Indeed, the value of material resources fluctuate according to the shifting contexts in which these resources are deployed; the goals to which they are oriented and the extent to which they advance these goals (Cattan & Tilford 2006; Rowling 2006). In cataloguing the array of informal material resources available in any particular setting, and assessing

their value in the promotion of recovery, secure housing and social inclusion, it is vital that these points are borne in mind (see Curtis 2010, pp.98–101).

Yet as we have noted, the informal material resources available in young people's communities also extend to the specific material affordances that individual settings in those communities make possible. This insight draws from James Gibson's (1979) pioneering work on the role of affordances in structuring person-environment interactions. Gibson (1979) defines affordances as properties of the physical environment considered in terms of the instrumental, goal-oriented behaviour of individuals and groups. Affordances denote what the environment 'offers the (individual), what it provides or furnishes, either for good or ill ... it implies the complementarity of the (individual) and the environment' (Gibson 1979, p.127). Affordances present opportunities for action-behaviours, for different responses to material and object stimuli in the environment. Importantly, affordances determine both the range of actions that might be possible within a particular environment, as well as the consequences of those actions (Michaels 2003, p.136). In highlighting the role of affordances in shaping, if not transforming, the experience of environmental interactions, Gibson's work has presented a novel framework for assessing the health promoting character of community places. Just as the study of social resources opens up new ways of thinking about the stress-buffering character of social networks, the study of affordances provides new ways of thinking about how the physical environment extends opportunities to further enhance these supports. A number of scholars have recently drawn from these insights in exploring the specific health-related affordances available in community settings. It is interesting to note that much of this research has focused on the health-related affordances available to children and adolescents (see Kyyta 2002; Clarke & Uzzell 2002). In relation to young people's mental health, the study of affordances has inspired useful insights into the ways that an individual's 'place relationships' afford opportunities for the development of various stress buffering supports and the promotion of mental health-related activities (Kyyta 2002; Spencer & Woolley 2000). In reviewing this literature, Clark and Uzzell (2002) note how Gibson's model draws attention to the ways that community sites afford opportunities for mental health promotion by facilitating the acquisition of specific skills and competencies necessary to sustain mental health and wellbeing.

Clark and Uzzell's (2002) research explores the ways that individuals and groups interact with local environments in achieving certain health-related activities ranging from social and relational goals to more self-oriented or 'retreat' tasks. This includes the ways that individuals seek out places that afford interactions with peers, friends and strangers, potentially facilitating the bridging and extending of social networks; places that afford entertainment, physical activity, respite and solitude; security, reflection and contemplation; intimacy with close friends; personal expression and so on. Clark and Uzzell (2002, pp.106–7) conclude that to the extent that local community places afford these kinds of processes, the community can be shown to directly facilitate the development of social, emotional, cognitive and behavioural competencies essential to 'healthy' social interactions and the development of personal relationships, as well as the capacity for self-awareness and moral reflection. In supporting the acquisition of these specific social and health-related skills, we would add that community/place affordances provide an array of informal material resources and supports that potentially promote health and recovery by extending the range of stress buffering supports available to young people. As we have noted, this might be as simple as the relaxation and leisure afforded in a local park, to the bridging of social networks afforded in a local café, to the more specific recovery work afforded in a local mental health peer support fellowship. In each instance, the community plays a potentially critical role in promoting recovery and mental health

promotion to the extent that it provides material and physical environments to support such processes. It is further possible that these kinds of local material affordances are important in promoting the security and stability of young people's housing arrangements by providing opportunities to strengthen and deepen young people's local place attachments and their broader community identifications. This points to the material dimensions of place attachment and community participation, even though it fails to capture much of the lived experience of being attached to place, of actually participating in community life. Clarifying these more subjective experiences requires the idea of affect.

### **4.3 Affective resources**

The study of affect and affective resources provides a means of characterising some of the most distinctive 'felt' and 'lived' dimensions of everyday community life (Thrift 2004). Affect captures something of the *resonant feeling of community*, alluded to in notions of place attachment and community belonging (Manzo 2005). Importantly, affects and affective resources are generated both in the physical and/or material experience of community, and in the social and relational aspects of these experiences. As such, every community place, every physical site or setting, generates diverse feelings or emotions, which themselves give manifest form to our visceral experience of place. Similarly, every social interaction, every encounter, is 'shaded' in the same way by a series of affects and feelings. Hence, every community encounter—in both a physical and a social sense—generates affective responses, from the joy that one experiences when unexpectedly 'bumping into' an old friend in the street to the unease that one might experience in a crowded train station at rush hour, to the boredom of being stuck in a traffic jam (Thrift 2004). Affect, in each instance, captures the manifold variations in mood, feelings and emotion that inflect all such encounters, including encounters with individuals and groups, as well as objects, processes, places and things. Ben Anderson (2009) refers to the discrete 'affective atmospheres' generated in place in an attempt to capture something of this process, understood as the means by which places come to have distinctive resonances and attachments. Anderson's analysis suggests that the very meaning of community belonging, and social inclusion more broadly, lies in these emotional resonances. It is arguably for this reason, moreover, that notions of place attachment and community belonging have become so important to the study of recovery and social inclusion for youth living with a mental illness (Boyd et al. 2008; Hopper 2007). For each attempts to reveal something of the subjective experience, the feeling, of being included in a community and the ways this feeling facilitates the everyday work of recovery.

The recent literature on place attachment and community belonging provides a series of important insights into the character of affect and affective resources and their role in promoting recovery and social inclusion for young people. We will start with the broad character of these relationships before turning to consider their significance in the more specific context of young people's recovery from mental illness and the stability (or otherwise) of their housing arrangements. Place attachment is generally understood as an affective, emotional and sometimes sentimental response to either the physical and material aspects of place, the social relations sustained within place, or both (Hidalgo & Hernandez 2001, p.275). Place attachments always involve a distinctive affective dimension experienced in terms of the array of feeling states generated in that place, both in the physical setting and the various interactions supported therein. More directly then, place attachment is typically regarded as a psychological and/or affective concept involving particular responses to the material character of individual places, and the history of social relations experienced in that place (with particular emphasis on the affective bearing of these experiences). High

place attachment may in turn, be understood as a product of strong affective responses to the character and amenity of a particular place, as well as enduring memories and affective attachments to the people and social encounters supported in that place. Such attachments are said to generate 'rootedness' in place and community in terms of one's personal identifications, and 'involvement' with community in terms of the breadth of one's social networks in place and the history and emotional tenor of these relations (Taylor et al. 1985, pp.528–30). Place attachments are in these ways, intimately embedded in the ongoing development of personal and collective identities. This process is often referred to in the literature as 'place identity' or 'place dependence' (Williams & Vaske 2003).

Place identity is a component feature (or 'sub structure') of an individual's self-identity, and is typically understood to consist of person-environment interactions and related affects, moods and cognitions, which shape an individual's sense of self (Proshansky et al. 1983). Place identity describes the way person-environment bonds come to shape the symbolic importance of a place, where place is understood as a repository for emotions and relationships that give meaning and purpose to life (Williams & Vaske 2003). The other dimension of place attachment, 'place dependence', describes the perceived strength of the connection between people and place and a person's desired activities and goals in place (Stokols & Shumaker 1981). Hence, place dependence is sometimes referred to as 'functional place attachment' in an effort to capture the functional utility of place and the ways place attachments are mediated by the specific things, activities and interactions that individual places enable or facilitate. This notion should further clarify our discussion of 'affordances' in the previous section. For example, places that provide individuals with enduring, positive affective responses have been shown to promote (or afford) the development of strong place attachments over time, with a subsequent increase in place identity and place attachment (Korpela et al. 2001). References to the functional utility of place and place attachment also help to illustrate the character and production of affective resources, insofar as it clarifies not only the ways places come to be associated with particular affects and feeling states, but also the ways that particular community places and settings support particular kinds of activities and interactions that themselves generate particular kinds of affective responses. The critical idea here is that places not only generate affective states and moods, but that they also generate affective resources that support and/or promote particular activities and interactions, including health-related activities and interactions.

Perhaps the most useful example of these processes can be found in contemporary research on the relationship between place attachments and what have come to be called 'restorative experiences' (see Korpela et al. 2008). First emerging in research in environmental psychology, this work investigates the various health-related benefits that may be associated with place attachment and community belonging. Again, the critical idea is that place attachments are more than simple emotional and/or affective bonds, for they also deliver discrete health-related benefits (Kaplan & Kaplan 1989). The research on 'restorative experiences' suggests that they primarily do this by helping to reduce stress; by moderating mood and emotional balance; by restoring 'directed attention' and reducing fatigue; and by boosting 'positive' affects like joy, hope and wonder, while reducing 'negative' affects like anger, frustration and irritability (see Herzog et al. 1997; Kaplan 2001; Korpela et al. 2001; Korpela & Ylen 2009; Kuo & Sullivan 2001). The strongest evidence documenting a link between place attachment and improved mental health and wellbeing pertains to the relationship between place attachment and psycho-physiological stress reduction. First established in pioneering research by Roger Ulrich (1983), it is now known that places that generate strong feelings of attachment, belonging and functional utility

also generate strong positive affects while reducing fatigue and stress and restoring the attentional capacities necessary for all cognitive effort (Kaplan & Kaplan 1989; Regan & Horn 2005). It is in this sense that we would argue that places can generate affective resources—in this case, resources to support the relief of stress and fatigue—that are directly implicated in the promotion of recovery and mental health. However, we would hasten to add that place attachments and community belonging have been shown to produce a range of additional affective resources important for mental health promotion in various populations and settings.

Our discussion of these additional affective resources—like hope, confidence and optimism—draws from the understanding that affects are never merely feeling states or passive moods. They are also intimately involved in our ‘capacity for action’, understood in terms of the modulations of motivation and our intention to act in response to particular affective stimuli. Indeed, research shows that every affect is experienced both as a particular feeling state, but also as a distinctive variation in one’s willingness or capacity to act in response to this state (see Gregg & Seigworth 2010; Massumi 2002; Thrift 2004). The affects associated with the experience of hope offer useful examples of this complicated process. Ben Anderson (2006, pp.733–5) argues that hope is always a belief in ‘something more’, a belief in that which has ‘not yet become’. Hope is, in this sense, a distinctive belief about the future in relation to the present, and an expectation that this future will somehow improve upon the present. Yet hope is also a powerful motivating force, equal to the force of one’s hopeful feelings about the future. Hope is a distinctive store of action-potential, of motivation to act, to change or to strive for particular outcomes (Scioli et al. 1997). As one becomes hopeful, a whole array of ‘capacities and capabilities are enabled’ (Anderson 2006, pp.733–5), priming one for action and presenting a series of pathways and strategies for the realisation of particular goals, for that which is hoped for. To feel hopeful about the future is to feel more capable of directing that future and more certain about the most effective strategies for realising specific life goals.

There is now a good deal of evidence indicating that hope and optimism are critically important in the promotion and maintenance of good mental health (see Duff 2010a; Parr 2007). A number of researchers have recently demonstrated that hope in particular is critical to recovery from all mental illnesses (Bernays et al. 2007; Rose & Novas 2005). In reference first to the onset of mental illness, hope has been shown to shadow almost all aspects of illness episodes from the onset of symptoms to help seeking, compliance with treatment modalities and post intervention recovery (Bernays et al. 2007; Elliott & Oliver 2007; Horvath 2000; Rickwood et al. 2005). To feel hopeful about one’s prognosis is to more assertively seek treatment for one’s condition, to adhere to any treatments offered, and to work more assiduously on one’s recovery. Hope is in this way ‘linked to the capacity for behaviour change’ (Bernays et al. 2007, S7) and the prospects for a return to good mental health. Hope is not just a feeling; it’s also an expression of one’s preparedness to act in relation to one’s future health status. The sources of this hope are diverse; from the illness representations discernible in popular culture, to the attitudes of one’s family and friends, the conduct of formal mental health care providers and the wider political, social and economic contexts that frame mental illness. Each of these sources potentially furnishes resources for the sustenance of hope, just as they might undermine it (Elliott & Oliver 2007). The evidence regarding the utility of hope is just as strong in relation to mental health promotion, in that hope has been shown to be associated with increased participation in mental health-related activities like regular exercise; the moderation of alcohol consumption; the cessation of tobacco use; healthy nutrition and diet; and ‘normative’ attitudes regarding healthy lifestyles and mental health promotion more generally (Richman et al. 2005; Scioli et al. 1997).

Optimism and self-confidence are additional affective resources that have been linked to mental health promotion and recovery, again for much the same reasons that hope has been shown to be health promoting in its own right. Confidence and optimism further illustrate the relationship between affect and motivation (understood as one's distinctive capacity for action) in that greater self-confidence and increased optimism are each associated with an increased predilection for action or activity. The question then is: Where do affective resources like hope, optimism, confidence and relief come from, and how can the generation and distribution of such resources be linked to our earlier discussion of place attachment and community belonging in youth populations? The short answer is that just as everyday encounters in and with the community generate affective responses, every such encounter also generates affective resources, in both a positive and negative sense. This response relies on our earlier observation that affects need to be understood in a dual sense, both as variations in feelings states, and as variations in one's capacity to act in response to these states. So, for example, the range of therapeutic or restorative community encounters that punctuate a young person's daily life, whether such an encounter takes place in a café, a street-corner, a park or a library, must be understood to involve *the generation of affective resources that are then deployed in the course of therapeutic experience*. Moreover, the experience of stress-reduction, to draw on Ulrich (1983) and the Kaplans' (1989) work on place-attachment, involves the generation and/or utilisation of affective resources like hope, relief, absorption, release, joy, satisfaction and so on in order for any such stress reduction to take place. The literature on restorative experiences is quite clear on this point in stressing that the person-environment interactions that underpin all such experiences involve particular affective engagements with place, which in turn provide attentional resources vital to mental health promotion and stress-reduction (see Bechtel & Churchman 2002; Korpela et al. 2008). The point, in other words, is that community places and settings are potentially rich sources of affective resources vital to the everyday work of mental health promotion and recovery from mental illness in youth communities. This is especially true of those community settings for which a young person has particularly strong place attachments, in that the very process of developing affective attachments to place generates an array of affective resources important for social inclusion and community belonging. While it is true that most of the extant literature has tested these propositions in relation to health and wellbeing broadly defined, it is important to acknowledge the promise of the emerging literature indicating the significance of affective resources in relation also to mental health (Almedom 2005; Dalgard & Tambs 1997; Duff 2011; Goldstrom et al. 2006; Herrman 2001; Irwin et al. 2008; Parr 2007; Wasserman & Clair 2011).

To briefly recap, affective resources describe those attitudes, practices, processes and relations that sustain (or undermine) the capacity or preparedness to act in pursuit of one's mental health and recovery. For adults and for youth, these resources emerge in diverse encounters in community places, shaping one's feeling states, just as they transform one's capacity to act in relation to one's mental health now and into the future. It is in framing this capacity to act that affective resources take on an enabling or therapeutic quality. Critically, these resources are differentially distributed in space and time, signaling the need for 'place-based' assessments of affective resources, their production and circulation. We will briefly touch on the research and policy implications of these arguments before turning to the final chapter to describe the original, empirical enquiry that will form the major component of this project.

## 4.4 New horizons for research and practice

The review of informal community resources presented in this chapter provides a basis for investigating the ways young people's communities—understood in relation both to community belonging and place attachment—potentially improve housing outcomes for youth living with a mental illness. Our review indicates that increased community participation opens up young people's access to the array of social, material and affective resources generated in community life; resources that the extant evidence suggests are intimately involved in the process of recovery, stress reduction and mental health promotion. It is arguable that these same informal resources are important factors in determining young people's housing security and the relative tenure of their accommodation arrangements. Just as informal community resources provide important support for the everyday work of recovery and mental health promotion, these same resources can be shown to reinforce a young person's sense of community belonging and place attachments in ways that actively support their long-term housing security. The literature on housing and vulnerable youth has for some time indicated that young people's place attachments and community identifications play an important role in determining the security of their housing arrangements while moderating their risk of homelessness. Critically, the model of informal community resources we have presented here sets out a clear and compelling logic to explain how these community and place relationships are established and cultivated. This logic also presents a basis for identifying novel housing interventions that might work to strengthen these place relationships and thus enhance young people's housing security over the longer term. We have thus attempted to explain in more direct terms, how and under what circumstances increased community participation and greater social inclusion actually promotes recovery from mental illness while facilitating stable and secure housing outcomes for young people living with a mental illness. This analysis has a range of important implications for housing policy, particularly in relation to housing tenure, housing transitions, location and allocation policies, some of which we will briefly discuss here.

To begin with, the analysis presented above builds on existing research and practice in suggesting new strategies for enhancing social inclusion and community participation for young people living with a mental illness. We have also canvassed ideas for promoting 'recovery work' in the community and for providing innovative support services to promote more secure housing outcomes for youth in recovery. Critically, our reading of the available evidence suggests the need for policy innovations that augment existing community level social, cultural, political and economic processes in order to enhance stress-buffering supports for youth in recovery. Policies need to be developed that open up access to available informal community resources by extending and enhancing young people's social networks and linking them more effectively across time and place. It is particularly important for young people recovering from a mental illness that any such effort to open up their social networks prioritises the development of connections both with youth who have some experience of mental illness and with those who do not. For research suggests that it is the *diversity of social networks* that is most critical in promoting recovery and increasing community participation for youth living with a mental illness (see Kawachi & Berkman 2001; Boyd et al. 2008). This analysis has important implications for housing location and allocation policies and for the management of key service and housing transitions in young people's accommodation arrangements. For it may well indicate why some young people's allocated housing ultimately fails to generate housing security. In circumstances where housing allocations fail to take sufficient heed of the availability of informal community resources in a particular site—like those associated with social networks and their attendant social resources—the research

reviewed above indicates very strongly that housing security is likely to be compromised. Equally important is the diversification of young people's place attachments, both to open up access to material and affective resources, but also to enhance feelings of community belonging and social inclusion. Each of these resources are likely to be critical in buffering some of the known risks associated with service and housing transitions for young people recovering from a mental illness (Peace & Kell 2001). In the next chapter, we outline the various methods that will be used to address these kinds of issues in the empirical component of our project.



## **5 STUDY APPROACH (AIMS, METHODS, TIMELINE)**

The review of the literature presented in each of the previous chapters has made explicit the links between social inclusion, community participation and recovery for young people living with a mental illness. We have argued throughout that these links are equally significant in relation to the security of young people's housing arrangements. It is nonetheless evident that research regarding the links between informal community resources and the promotion of stable housing outcomes for youth recovering from a mental illness is still very much in its infancy. This suggests the need for more detailed enquiry regarding the nature and distribution of the various informal resources available in local community settings to support young people's recovery and the security of their housing arrangements (Townley et al. 2009; Yanos 2007). The specific factors associated with successful community integration for youth experiencing mental illness—and the subsequent development of belonging and place attachments—remain ambiguous in the literature (Duff 2010a; Parr 2007). Greater understanding of these factors should help clarify the ways the informal resources generated through increased community integration can be mobilised to support the acquisition and retention of stable housing for youth in recovery. This kind of research is especially timely in light of recent calls in both the research and policy literature for greater attention to place-based housing policy models (see ASIB 2011).

This project takes up this challenge in seeking to identify the informal resources that local community settings and contexts provide to promote stable housing outcomes, to support recovery, and to foster social inclusion and community integration for youth living with a mental illness. It is hoped that the findings of this exploratory study will contribute to existing debates regarding the ways that informal community resources might be mobilised in the design of innovative housing supports for young people experiencing mental illness, while further clarifying the role of places and communities in facilitating young people's recovery. In addition, the use of an innovative qualitative research design will help foster a better understanding of the causal mechanisms that underpin the therapeutic utility of local places in young people's communities. The research will likely have additional implications for the treatment of mental health problems in youth populations, especially following discharge from clinical care.

### **5.1 Research aims**

Our empirical investigation will compare and contrast the sources, distribution and availability of informal community resources in two locales (Melbourne and Launceston), and assess their role in facilitating the acquisition and retention of stable housing for youth recovering from a mental illness. The research aims are to:

- Identify the informal community resources, relationships and supports that facilitate the acquisition and retention of stable housing for youth in recovery.
- Identify the various ways youth recovering from a mental illness use these informal resources and relationships in support of stable housing.
- Identify ways that these resources might be mobilised in the design of novel housing and social inclusion initiatives for youth in recovery.

The study aims will be achieved in two phases (see below) with research conducted in Melbourne and Launceston to enable the collection of data in diverse housing and community contexts. Melbourne and Launceston are ideal sites for the proposed research given differences in each site in the orientation and profile of existing housing and mental health services for youth recovering from a mental illness. Conducting field research in Melbourne and Launceston will also facilitate the analysis

of the kinds of informal community resources available in large metropolitan settings compared with a smaller regional site. In Melbourne, participants will be recruited in diverse sites in the Northern and Western suburbs to capture important socio-economic differences in local housing contexts and their impact in diverse youth populations. The final selection of recruitment sites in Melbourne and Launceston will be determined in consultation between the research team and local housing policy-makers and practitioners to enhance the policy relevance of the findings.

## **5.2 Methods and procedures**

Given the gaps in the literature on housing, social inclusion and recovery noted above, the proposed study will remain exploratory and inductive in nature. While there now exists a compelling research literature documenting the role of the community in promoting young people's recovery from mental illness, very little of this research has explored these links in relation to housing policy and service innovation in youth settings in Australia (Rickwood et al. 2005). The proposed study seeks to draw out the links between the community, recovery and housing for youth experiencing mental illness, focusing in particular on the identification of informal community resources and the ways that youth use these resources to facilitate the everyday work of recovery and promote more stable housing outcomes. To this end, the study will adopt a series of innovative qualitative methods to generate rich descriptions of participant's experience of recovery, community and housing. This will include observational, interview and photographic methods to document local communities and to describe the experience of recovery in the community. Field research will be conducted according to a sequential exploratory strategy (Creswell 2003), in which data will be gathered in iterative phases with each completed phase informing subsequent phases. This sequential strategy typically involves the movement from general, exploratory research activities to more refined data collection in later phases. This approach is common to qualitative studies seeking to maintain flexibility in the research design to accommodate unexpected research findings emerging in early phases of data collection (Creswell 2003). With respect to our own study, it is anticipated that all data will hold equal weight in the subsequent analysis and reporting of findings. To overcome the challenges we are likely to face in the integration of diverse data sources, we will use Yin's (2006) data integration model to facilitate analysis and reporting. This model involves the integration of methods across research questions, units of analysis, sampling, procedures and analytic strategies. This model has been employed in similar social research to improve the complementary nature of individual methods and to aid data integration and analysis (Woolley 2009, pp.9–12). Following is a description of the various methods to be used in the first study phase.

*Phase One* will involve the recruitment of youth aged 18–30 and recovering from a diagnosed mental illness. We will employ the widest possible demographic definition of 'youth' in order to trace the significance of key transitions in young people's housing careers (see Peace & Kell 2001). It is arguable that conventional definitions of 'youth' and 'young adulthood', which typically set the somewhat arbitrary age of 24 as the upper limit of 'young adult', fail to capture the character of the transition into adulthood for youth living with a mental illness (see Boyd et al. 2008; Rowling 2006). Setting an upper inclusion limit of 30 years of age will thus enable us to explore a broader range of topics relevant to our research aims. It is also important to note that in light of existing controversies regarding the establishment of formal clinical criteria for determining or identifying those in recovery from a mental illness (see Bradshaw et al. 2007), prospective participants will be asked only to 'self-identify' as in-recovery on the basis of their experience, subjective wellbeing and self-identity. This kind of

operationalisation of the notion of recovery is common in existing studies involving youth and young adults (Beeble & Salem 2009; Parr 2007).

Up to 20 youths will be recruited in each site (N=40 in total), including homeless youth, youth currently living in supported accommodation, and youth living independently. Given our focus on the links between access to informal community resources and the acquisition and retention of stable housing, recruitment will emphasise youths currently living in supported accommodation and youths living independently. Participants will also be required to have lived in either Melbourne or Launceston for at least six months prior to their enrolment in the study to enable more refined analysis of the character and distribution of informal community resources in each research setting. This focus should also enable greater attention to the relationship between informal community resources and housing status among our participants. Finally, it is important to note that prospective participants will be excluded from the study if they are in an acute phase of mental illness such that they are highly dependent on medical care; if they are suicidal or engaging in regular self-harming behaviour, or if they exhibit disruptive or violent behaviour. We will rely on support and advice from staff at each of the organisations selected to assist with participant recruitment in order to ensure that these recruitment procedures are adhered to throughout the course of data collection. Every effort will be made to ensure the safety both of participants and researchers, with the proposed study protocol subject to rigorous ethical review at each of the universities participating in this study. It is likely that further reviews will be conducted at the various community based mental health organisations to be approached to assist with recruitment. Each step will ensure that clear risk management strategies remain in place throughout the study, and that the research team have clear guidelines for managing any risks that might eventuate in the course of data collection.

As we have noted, data collection in this first phase will involve various innovative qualitative methods to identify the informal resources and assets available in young people's communities to facilitate the transition to stable housing while promoting recovery and social inclusion. Our objective throughout will be to trace the diverse links between community belonging, social inclusion and the process of recovery and health promotion for our participants. We will seek to identify the subjective and objective dimensions of community identification and place-making, incorporating individual and group accounts of place, as well as broader neighbourhood or community level features (Ahram 2011; Cummins et al. 2007). This work should provide a series of compelling new insights into the links between housing, recovery and social inclusion in local community settings. Our empirical research will be grounded in a review of the relevant academic literature (described above) and a brief community scan of existing recovery oriented mental health programming and service delivery arrangements in each research site. Field research will be conducted according to the same procedures in each site and will feature the following methods:

1. The study will first involve a *mapping exercise* in which participants will be asked to identify the characteristic features of their community, noting the specific relationship between housing and the experience of community. This will include the identification of places, settings, people, relationships and resources that facilitate the experience of belonging and security in housing.
2. The study will then feature a *walking tour* of the various sites identified in each participant's maps. Participants will be asked to elaborate on informal features of their community that support or promote stable housing and promote recovery.

3. All participants will be invited to compile a *photo-journal* documenting their local community, including places, settings, people, relationships and activities that are thought to promote the acquisition and retention of stable housing.
4. Participants will then discuss their journal in a *formal interview* to facilitate analysis of the role of informal resources in promoting housing, recovery and social inclusion.

All field data will be integrated and analysed to identify emerging themes as they relate to the research questions, with mentoring and support to be provided by the research team for all participants to ensure that data are collected in a timely and reliable manner. The focus will remain on generating rich accounts of the dynamics of our participant's community relations, with a particular emphasis on the analysis of the production, distribution and use of informal community resources. This should yield novel insights into the pathways from homelessness and supported accommodation to independent housing for youth recovering from a mental illness. This will also involve comparative analyses exploring the differences (if any) between these resources in large metropolitan settings (Melbourne) and a smaller regional centre (Launceston).

*Phase Two* will involve four focus groups (two in Melbourne and two in Launceston) with housing and mental health policy-makers, practitioners and service providers. These sessions will explore how the informal resources and 'social assets' identified in phase one might be mobilised in the design of novel housing initiatives for youth in recovery. Participants will be provided with a summary of the findings generated in phase one and a set of key policy questions prior to the focus group to facilitate discussion. Potential focus group participants will include representatives from local community housing, mental illness and social inclusion services and agencies. Housing policy-makers from relevant state and federal agencies will also be invited, including representatives from Housing Tasmania and the Office of Housing, Department of Human Services, Victoria. The table below summarises how data will be sourced and the methods of analysis used to answer the four research questions.

**Table 1: Methods of analysis**

<b><i>Research Question</i></b>	<b><i>Data sources</i></b>	<b><i>Methodology (including data sources)</i></b>
<i>Research Question 1</i> What kinds of places, and informal relationships, resources and supports facilitate the acquisition and retention of independent housing for youth in recovery?	Academic, policy literature. Original data (maps, interviews, photo-journals). Expert focus groups.	Critical review of the literature. Thematic and content analysis of original research data. Analysis of focus group data.
<i>Research Question 2</i> How do youth recovering from a mental illness identify and deploy informal resources and relationships in support of independent housing?	Academic, policy literature. Original data (maps, interviews, photo-journals).	Critical review of the literature. Thematic and content analysis of original research data.
<i>Research Question 3</i> How might these resources be mobilised in the design of novel housing and social inclusion initiatives for youth in recovery?	Academic, policy literature. Original data (maps, interviews, photo-journals). Expert focus groups.	Critical review of the literature. Thematic and content analysis of original research data. Analysis of focus group data.

### **5.3 Potential findings and capacity to inform housing policy development**

As we have noted throughout this Positioning Paper, this project aims to support housing policy interventions that strengthen the array of informal resources available in communities to support independent housing for youth recovering from a mental illness. The study will build on emerging international evidence demonstrating links between access to informal resources, recovery from a mental illness, and the acquisition and maintenance of stable housing. We are also interested in identifying and further clarifying the characteristics of communities and neighbourhoods that generate social inclusion, economic opportunities and wellbeing. We will consider the ways that informal resources can be mobilised to facilitate the acquisition and retention of stable housing for youth in recovery. In identifying resources and supports that are not typically considered in housing research, it is likely that this project will furnish recommendations for the reform of housing and psycho-social support services to incorporate a wider array of community relationships, activities and processes. We anticipate that this will include ideas for the development of novel service delivery partnerships to involve non-traditional stakeholders in the provision of housing programs for youth in recovery. This analysis will no doubt have a series of additional implications for housing policy in Australia, particularly in relation to housing tenure, housing transitions, location and allocation policies for youth recovering from a mental illness. In exploring these issues and problems, the project will generate important evidence to support policy innovation designed to prevent homelessness and promote wellbeing and stable housing outcomes for youth living with a mental illness.

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