Mental Health
and
Independent Housing Needs
Part 1
A Summary of the Research

Robin Peace, Susan Kell, Lynne Pere, Kate Marshall, Suzie Ballantyne
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Mental Health and Independent Housing Need: Part 1:
A Summary of the Research

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Ministry of Social Development

PO Box 12136
Wellington, New Zealand
Ph: +64-4-916-3300

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Mental health and housing needs – outline of the project

In June 2000 the Ad Hoc Cabinet Committee on Mental Health (AMH) established a work programme to address housing needs for people with mental illness. Housing New Zealand Corporation (HNZC) managed this work programme. The Ministries of Housing, Health and Social Development had responsibilities to complete individual items of work in the work programme. The Mental Health and Housing Research comprises two of the items on the work programme.[1]

The research was conducted in response to the Cabinet direction to:

- *quantify independent housing needs for people with mental illness in relation to adequacy of housing, affordability, and sustainability, including the role of support services in the retention of housing;* and
- *identify the extent of homelessness and transience amongst people with mental illness, and to identify housing options to meet their needs, and to consult with Te Puni Kōkiri to ensure a Māori perspective is fully considered.*

The outputs for this project from the Ministry of Social Development (MSD) have a number of components, including a summary report of the research that was delivered to HNZC, which comprises Part 1 of the five-part report series published by MSD and is titled:

- *Mental Health and Independent Housing Need Research: Part 1 A Summary of the Research.*

The other four parts include:

- *Mental Health and Independent Housing Need Research: Part 2 Expert voices – A Consultation Report;*
- *Mental Health and Independent Housing Need Research: Part 3: Affordable, Suitable, Sustainable Housing – A Literature Review;*
- *Mental Health and Independent Housing Need Research: Part 4 "It's the combination of things" – Group Interviews;*
- *Mental Health and Independent Housing Need Research: Part 5 Quantifying Independent Housing Needs – A Survey of Service Providers.*

As Part 1 of the series, this report summarises the findings from the four main components of the research.

[1] Since the research was commissioned, the AMH has been disestablished, the Housing Policy group from the Ministry of Social Policy (MSP) has moved to become part of HNZC and MSP has been incorporated into the Ministry of Social Development (MSD).

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1. Introduction

In June 2000 the Ad Hoc Cabinet Committee on Mental Health (AMH) established a work programme to address housing needs for people with mental illness (AMH (00) 29 June 2000). Housing New Zealand Corporation (HNZC) is managing this work programme. The Ministries of Housing, Health and Social Development have responsibilities to complete individual items of work in the work programme. The Mental Health and Housing Research comprises two of the items on the work programme.[2]

The research was conducted in response to the Cabinet direction to:

- *quantify independent housing needs for people with mental illness in relation to adequacy of housing, affordability, and sustainability, including the role of support services in the retention of housing; [and]*
- *identify the extent of homelessness and transience amongst people with mental illness, and to identify housing options to meet their needs, and to consult with Te Puni Kōkiri to ensure a Māori perspective is fully considered* (CAB (00) M 20/6 refers).

There are considerable difficulties in obtaining precise estimates of the level of housing needs of people with mental illness.[3] No currently available statistics are suitable for this purpose. Administrative statistics on housing and on mental health are largely independent of each other and there is no single source that combines data on mental health status and housing circumstances. Nor was it possible, within the compass of this project, to collect new information that would allow precise, reliable and robust estimates of housing need among this group.

Instead the research strategy adopted was to obtain information from a range of sources on the housing needs of consumers/tangata whai ora, using a mix of quantitative and qualitative methods. This was designed to permit both a rough estimate to be made of the size of the problem of housing need in this group, and a more detailed understanding to be developed about the nature of the difficulties consumers/tangata whai ora face. The study, undertaken between July 2000 and September 2001, comprised:

- a review of relevant literature;
- a one-day workshop with 23 consumers/tangata whai ora from around the country;
- a national survey of 800 mental health service providers (hereafter 'providers') about their perceptions of housing need; and

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[2] Since the research was commissioned, the AMH has been dis-established, the Housing Policy group from the Ministry of Social Policy (MSP) has moved to become part of HNZC and MSP has been incorporated into the Ministry of Social Development (MSD).

[3] During a workshop with consumers of mental health services, a preference was expressed for the term "consumers/tangata whai ora" when referring to people with mental illness. Advice from Te Taura Whiri i te Reo Māori is that "whai ora" means "in search of wellbeing". This term is used throughout the remainder of the report.

- interviews with 190 consumers/tangata whai ora and providers from around the country.

The research population

The target population of "people with mental illness" for this research is those people who were receiving mental health services in the three months from January 2001 – March 2001. The Mental Health Commission (MHC) (1998) reports that "… around 3% of people have serious, ongoing and disabling mental illness requiring treatment from specialist mental health and alcohol and drug services". The MHC Commissioner suggests, "the service delivery for adults stands at about 1.5 percent of the population – and the adult access target is 3 percent. So about half of what is needed for adults is provided" (Leibrich, 1998:3).[4]

In other words it is thought that there could be as many as 120,000 people in the general population, who have serious, ongoing and disabling mental illness that requires treatment from specialist mental health and alcohol and drug services. Using the MHC service delivery estimate for adults, it could be expected that about 60,000 people are receiving services. However, in the recent data collection completed by the New Zealand Health Information Service (NZHIS) an estimated 46,200[5] consumers/tangata whai ora were counted as receiving mental health services from District Health Board (DHB) providers in the March 2001 quarter. This equates to just over one percent (1.2 percent) of the total New Zealand population.

Key definitions

A direct measure of "housing needs" was difficult to develop because it encompassed many complex factors. It was decided to use an alternative concept of "housing difficulties", which was more amenable to measurement because it could be broken down into a number of components. The following definitions were developed for this concept:

- housing difficulties refer to the whole range of housing and related service access issues that consumers/tangata whai ora face. Important dimensions of housing difficulties are adequacy[6], suitability[7], affordability, and sustainability of housing arrangements;

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[4] Leibrich, J. 1998: *Recovery and Discrimination*. Paper presented at the Youth Mental Health Forum, Mental Health Commission.

[5] The NZHIS data for the March quarter 2001 excludes data from Capital and Coast, and the data for Hawkes Bay DHB covered one of the three months only. No NGO data was included in this count. We have estimated the number of consumers/tangata whai ora in Capital and Coast to be 3,500 and the numbers in Hawkes Bay to be 2,000 - based on the assumption that the number of consumers/tangata whai ora in each DHB is, on average, equal to 1.2 percent of the total population of the DHB.

[6] In the New Zealand Housing Indicators Project, "adequacy" is the concept used to encompass the "descriptors", "dimensions" and "drivers" identified in the model and is therefore a much broader concept than is indicated here. Affordability, suitability, habitability, crowding, discrimination and tenure are all dimensions of adequacy in the Indicators Project. The concept of habitability is the closest meaning of adequacy as it was used in this project.

[7] The concept of "suitability" arose early in the research as a term that could distinguish between housing that may have been physically adequate (i.e. not damp or cold etc.) but was not safe or appropriate for a person experiencing mental illness. It is also related to both affordability and housing supply.

- adequacy refers to the physical condition of a dwelling. Housing can be regarded as adequate when it is of good quality, does not cause discomfort because of a poor state of repair, dampness, dilapidation and pest infestations and is not overcrowded;
- suitability refers to the appropriateness of housing for the mental health recovery of consumers/tangata whai ora. Suitable housing needs to be physically adequate and located near sources of support – which may include clinical and non-clinical services, family/whānau and friends. Unsuitable housing refers to housing which, though it may be adequate in other respects, is not aligned with an individual's mental health recovery needs;
- affordability refers to the cost of housing in relation to income. It is important that assessments of affordability take into account not only the costs of rent or mortgage but also the additional costs imposed by illness – including costs of medication and costs (such as transport) incurred accessing support services; and
- sustainability refers to consumers'/tangata whai ora capacity to sustain independent living in the long term. Sustainability depends on the existence of an array of accessible material, service and social resources and a well-developed and monitored regulatory environment. These various supports need to be well configured to allow consumers/tangata whai ora not only to manage independently on a daily/weekly basis, but also to retain their housing arrangements during episodes of acute care, respite care or hospitalisation.

While it is possible to speak of adequate, suitable and affordable housing, the concept of sustainability is of a different order. This is not an attribute that can be applied to a particular house, but rather encompasses the wider environment of regulations and support services which surround accommodation arrangements of consumers/tangata whai ora. Thus a focus on the concept of sustainability leads to an analysis of the wider environment of these services and regulations.

In the survey of providers, the concepts of adequacy, suitability and affordability were not used directly. Rather, providers were provided with a list of particular types of housing difficulty – which incorporated different aspects of adequacy, affordability, and suitability – and asked a range of questions about consumers/tangata whai ora who were experiencing difficulties of these types. The listing of particular types of difficulties was as follows:

- substandard physical conditions - that is where factors such as a poor state of repair, dampness, dilapidation, inadequate sunlight, and/or pest infestations cause discomfort;
- overcrowding;
- lack of privacy;
- lack of choice about housing options;
- lack of personal safety;

- exposure to excessive noise;
- unsuitable location relative to support and/or family/whānau;
- insecurity of housing tenure;
- unaffordability of housing relative to income and medical costs;
- loss of independent accommodation during episodes of acute care or hospitalisation; and
- discrimination while finding and retaining housing.

2. Quantification of independent housing need

To respond to the Cabinet directive to quantify housing need, it was necessary to undertake empirical work since no currently available statistics were suitable for this purpose. It was not considered feasible to conduct a survey of consumers/tangata whai ora, because of the lack of an appropriate sampling frame and because of concerns about privacy. It was decided instead to providers to furnish estimates of the numbers of their consumers/tangata whai ora who were having housing difficulties of some sort.

Because there was no reliable database of providers of mental health services, it was necessary to construct a listing of current providers. It was not possible to produce a completely accurate and up-to-date database as providers do not always stay in business or stay at the same address. However, the 800 providers who were on the list were invited to participate in the survey and 513 (71 percent) responded.

It was recognised that provider*s*' responses would be subject to some imprecision, because some providers would know little about the housing circumstances of their consumers/tangata whai ora. Nevertheless, it was considered that this would permit a rough estimate to be made of the level of housing difficulties they were experiencing,

Estimating the extent of housing difficulties

Two approaches were taken to estimate the level of housing difficulties experienced by consumers/tangata whai ora:

- first, providers were asked to estimate the number of their consumers/tangata whai ora who had one or more housing difficulties; and
- second, providers were asked what approximate proportion of their consumers/tangata whai ora were experiencing each specified difficulty.

Summing across the responses received to the first set of questions, 3,182 consumers/tangata whai ora were considered by DHBs to be having housing difficulty, while 3,686 consumers/tangata whai ora were considered by Non-Government Organisations (NGOs) to be having housing difficulty. These two figures cannot be simply added together, since it is likely that they overlap to a considerable degree (as some consumers/tangata whai ora may be receiving services from both DHBs and NGOs) and as the extent of overlap is unknown.

Both figures almost certainly underestimate the true level of difficulty by a significant amount, because of missing responses. Among all providers who were asked to participate in the survey, 27 percent did not return their questionnaires and 20 percent of those who did respond did not answer the questions about the number of consumers/tangata whai ora who were having housing difficulties. In addition, many of the providers who did not provide responses were larger organisations, which meant that the estimates obtained covered an even smaller proportion of the total group of consumers/tangata whai ora.

It is possible to make an estimate of the extent of under-reporting of housing difficulty by benchmarking the survey responses against information from the NZHIS. Based on information supplied by the NZHIS, it is estimated that 46,200 people were receiving mental health services from DHBs during the period covered by the survey. Counting only responses from DHBs, respondents reported that they were providing services to a total of 22,261 consumers/tangata whai ora. This means that the survey responses from DHB providers cover only around 48 percent of the consumers/tangata whai ora who were actually receiving services from DHBs during the survey period.[8]

In addition, it is necessary to take account of the subset of respondents who did not answer the specific questions about the numbers of consumers/tangata whai ora who were experiencing housing difficulty. Adjusting for this further loss of information, it is likely that the DHB estimates of the numbers of consumers/tangata whai ora who were experiencing housing difficulty cover approximately 40 percent of the total pool of people who were receiving services from DHBs during the survey period.

If we assume that the rate of housing difficulty is similar across people who were included and excluded from the survey responses, this would mean that the true level of housing difficulty among consumers/tangata whai ora who are currently receiving DHB mental health services may be somewhere in the order of 8,000. This equates to around 17 percent of consumers/tangata whai ora who were receiving services from DHBs.

This figure is subject to considerable uncertainty, however. In addition to the problem of missing data, there was likely to be some imprecision in the figures that were supplied by respondents. To provide a measure of the quality of the information, respondents were asked how confident they felt about the figures they were providing. Only around a third of providers (36 percent) felt "highly confident" about their estimates of the number of consumers/tangata whai ora who were having housing difficulties and 17 percent said they were "not confident" about the figures. (The remaining 47 percent described themselves as "reasonably confident" about the figures.)

The responses to the second set of questions, however, led to a higher estimate of the extent of housing difficulties among consumers/tangata whai ora than

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[8] In order to develop some consistency in the benchmarking procedures, the researchers decided to use survey data that had been provided by DHBs only (rather than NGOs). The NZHIS data collection relies, at this stage, only on data provided by the DHBs. All the calculations given in this paper relating to the extent of housing difficulty are based on figures provided by the DHB respondents to the survey. More details of the survey methodology are spelled out in Part 5 of this series: *Quantifying independent housing needs*).

indicated by the 17 percent discussed above. These responses (once weighted) indicate that perhaps between a quarter and a third of consumers/tangata whai ora were having problems with affordability of housing, and a similar number were having problems with lack of choice.

While affordability and lack of choice stood out for providers as the most frequent areas of difficulty, a significant minority of consumers/tangata whai ora were considered to be affected by one or other of the remaining areas of difficulty. In particular, overcrowding was regarded as a significant problem for Pacific consumers/tangata whai ora, while discrimination, insecurity of tenure, unsuitable location of accommodation relative to support and/or family/whānau and loss of accommodation during acute illness or hospitalisation may have affected between 10 and 20 percent of consumers/tangata whai ora. Even assuming a significant overlap between these areas of housing difficulty, it is possible that as many as a half of consumers/tangata whai ora may be having one sort of housing difficulty or another.

A plausible (and conservative) interpretation of these results is that the first estimates (of numbers experiencing housing difficulty) represent a minimum estimate of the level of housing difficulty, encompassing those who were in most serious difficulty. The figures include cases that were serious enough to be recalled by the providers asked to think about consumers/tangata whai ora who were having housing difficulty.

The responses to the second set of questions indicate that beyond the group of people who were in more serious difficulty, there was a wider group – perhaps up to as many as a half of the population of consumers/tangata whai ora who were receiving services - who were having difficulties with particular aspects of their housing, especially affordability, lack of choice, and discrimination. Providers were able to recall and report on the experience of these difficulties.

Estimating the extent of homelessness (including those living in temporary or emergency accommodation)

Using a similar methodology to that outlined above, an estimate was also made of the number of people who were homeless/transient. DHB providers estimated that 833 consumers/tangata whai ora were homeless or living in emergency or temporary accommodation, while 659 consumers/tangata whai ora were considered by NGOs to be homeless or living in emergency or temporary accommodation.

Adjusting for missing responses, this translates to an estimate of somewhere in the order of 2,000 consumers/tangata whai ora receiving DHB mental health services who were homeless or living in emergency or temporary accommodation. This equates to around 4 percent of consumers/tangata whai ora receiving services from DHBs.

Once again, it should be noted that this figure is a rough estimate only, and is subject to considerable uncertainty. Only around a third of providers (35 percent) said they were "highly confident" about their estimates and 15 percent said they were "not confident" about the figures. And once again, there may be a similarly sized group of people with similar mental health conditions but not receiving services who are also homeless or living in temporary or emergency accommodation.

Estimating the risk of homelessness

In addition to people who are literally homeless, or living in temporary or emergency accommodation, Kearns, Smith and Abbott (1992) have used the term "incipient homeless" to describe people who are living in circumstances which are not necessarily stable in the long term, and may therefore involve a heightened risk of future homelessness. It was not possible in the present study to develop a precise measure of this concept that fits the definition developed by Kearns and his colleagues.

Although providers' responses to the final survey question on the types of accommodation consumers/tangata whai ora occupied were not well answered, it is possible to gain an insight into incipient homelessness from provider responses about the current housing circumstances of consumers/tangata whai ora.[9] The figures that follow are calculated out of the 8,687 consumers/tangata whai ora who were "assigned" by providers to particular types of accommodation other than the types of accommodation that constitute "homelessness" as discussed above.

Most consumers/tangata whai ora were living either in privately owned houses (22 percent) or rental accommodation (47 percent). These situations are not regarded as involving a heightened risk of future homelessness. The remaining 31 percent of consumers/tangata whai ora, however, were living in a range of circumstances that might involve a risk of incipient homelessness. Twenty percent were living in boarding houses and hostels on a long-term basis, 6 percent were living with friends or family on a long-term basis, 2 percent were living in hotels, motels, caravan parks or bed and breakfast houses on a long-term basis and 3 percent were in respite care.

While in many cases these arrangements may be suitable and enduring, it is likely that in many other cases, they are less so and may expose consumers/tangata whai ora to heightened levels of stress. Living with family or friends, for example, may result in overcrowding and may place a strain on these relationships. In many cases, too, the quality of the accommodation is likely to be poor, especially in situations such as caravan parks and some, although not all, boarding houses.

The heightened stress of such housing arrangements is likely to mean that this sub-group of consumers/tangata whai ora will move frequently. In most cases, they will be more motivated by a desire to escape from poor housing than by the prospect of achieving anything more suitable. This carries the risk of a form of "permanent mobility" which may ultimately result in literal homelessness.

DHB providers estimated that 2,676 consumers/tangata whai ora were living in a range of circumstances that might involve a heightened risk (or incipience) of homelessness: living on a long-term basis in boarding houses and hostels, with

[9] Question 39 "Types of Accommodation" in the survey was answered by fewest providers and many of the answers that were provided were incomplete. Some providers wrote comments on their returns to the effect that they were making very rough guesses about numbers or that they did not know about the types of accommodation consumers/tangata whai ora occupied in any great detail. Of the total of 22, 261 consumers/tangata whai ora reported on in the survey overall, only 8,687 (39 percent) are assigned to particular types of accommodation. The rating-up of responses takes account of the low item response rate.

friends or family, in hotels, motels, caravan parks or bed and breakfast houses or in respite care.[10] Using the same methodology as above, this translates to an estimate of somewhere in the order of 8,000 consumers/tangata whai ora who were receiving DHB services who can be considered as incipient homeless. While this group is distinct from the group of people who are currently homeless/transient, they can not be regarded as distinct from the group of people who are experiencing housing difficulties. It is likely that many of the people who were living in these circumstances would have been included in the above estimate of people who are experiencing housing difficulty.

If we assume that the rate of incipient homelessness is similar across people who were included and excluded from the survey responses, this would mean that the true level of incipient homelessness among consumers/tangata whai ora who are currently receiving DHB mental health services may be somewhere in the order of 8,000, which equates to around 17 percent of consumers/tangata whai ora who were receiving services from DHBs. This figure is subject to considerable uncertainty, however.

Summary

The estimates in this section may be an underestimate of the true extent of housing difficulty and homelessness/transience among people who are experiencing serious, ongoing and disabling mental illness, because it counts only people who are currently receiving treatment. Information from the MHC (MHC, 1998) indicates that perhaps only half of all people with ongoing disabling mental illnesses serious enough to warrant specialist treatment are in fact receiving treatment for their condition. This means that there may be another similarly sized group of people with similar conditions, but not receiving treatment, who are also experiencing housing difficulty. The survey did not attempt to elicit any information about this group.

In summary, we note that:

- it is difficult to obtain precise estimates of the level of housing need among consumers/tangata whai ora;
- DHB providers estimated that around 3,200 of their consumers/tangata whai ora were experiencing housing difficulties of some sort, 833 were homeless or living in emergency and/or temporary accommodation and 2,676 were living in circumstances that may involve a heightened risk of future homelessness;
- these are likely to be considerable underestimates, because of missing responses;
- assuming that the levels of housing difficulty, homelessness and transience were similar across the consumers/tangata whai ora reported by DHBs that did and did not provide this information, we estimate that somewhere in the order of:
  - 8,000 (17 percent of 46,200) consumers/tangata whai ora may be experiencing housing difficulties;

[10] The figure estimated by NGOs was 5,672 consumers/tangata whai ora.

  - between a quarter and a third of consumers/tangata whai ora were having problems with affordability of housing, and a similar number were having problems with lack of choice;
  - 2,000 (4 percent of 46,200) consumers/tangata whai ora may be homeless or living in temporary and/or emergency accommodation; and
  - in addition to the estimated 2,000 people who were currently transient/homeless, another 8,000 (17 percent of 46,200)[11] consumers/tangata whai ora were living in circumstances that may involve a heightened risk of future homelessness. Many of these people are likely to have been counted among those who were experiencing housing difficulties;
- these figures are rough estimates – the uncertainty arises mainly from two sources: missing responses; and insufficient detailed knowledge of providers about the housing circumstances of their customers.

3. Assessing the nature of housing need

The crude estimates about the extent of housing difficulty and homelessness and transience provide little insight into the nature of housing need among people with mental illness or the areas in which public policy needs to be further developed. The research strategy was also designed to deliver more detailed information about the nature of the housing difficulties faced by consumers/tangata whai ora. The following discussion draws on information from the consumer workshop, group interviews and provider survey, as well as from the international literature on mental health and housing.

New Zealand and international literature indicates that the relationship between mental health and housing is complex, and that each set of problems interacts with the other. Housing difficulties can be a factor in the deterioration in mental health among people with existing mental health conditions. On the other hand, serious mental illness can result in unsatisfactory housing outcomes because of the compounding effect that flows from the experience of mental illness – poverty, discrimination, disrupted education, employment problems, high residential mobility, physical health problems, alcohol/substance abuse, homelessness and detachment from clinical services.

The nature of housing difficulties identified by the provider survey, for all consumers/tangata whai ora regardless of ethnicity, age or gender, were:

- affordability of housing relative to income and medical costs;
- lack of choice in housing options; and
- discrimination while finding and retaining housing.

The analysis of the group interview discussions shows that the key issues identified by the providers in the survey were also key issues reported by

[11] Note that this 17 percent is different from the 31 percent cited on the previous page because it is calculated out of the total number of consumers/tangata whai ora, not simply those who are known to be living in particular types of accommodation.

consumers/tangata whai ora. Three main groups of inter-related issues were identified in the group interview discussions:

- problems with affordability of suitable housing;
- problems relating to benefit income and benefit debt; and
- the experience of discrimination.

There is considerable overlap between the views of both groups, particularly as consumers/tangata whai ora linked "lack of choice" with the cost of suitable housing plus their lack of money to pay for it. The issues can be classified as barriers to mental health recovery in the sense that they are beyond the scope of mental health service provision to remedy, relating more to a lack of material resource and/or regulatory protection than to service resourcing on its own.

Each of these factors is considered in more detail below.

Affordability

Problems with housing affordability were noted by approximately half of the DHB providers as affecting "some" or "about half" of their consumers/tangata whai ora. In particular:

- 41 percent of providers indicated that "most" of their tangata whai ora (Māori consumers) were experiencing difficulty related to affordability;
- 29 percent of providers indicated that "most" of their Pacific consumers/tangata whai ora were experiencing difficulty related to affordability; and
- 26 percent of providers indicated that affordability was an issue for "most" of all other consumers/tangata whai ora.

These responses (once weighted) indicate that between a quarter and a third of consumers/tangata whai ora may be experiencing problems relating to housing affordability, and that affordability was a more significant issue for Māori and Pacific peoples than it was for all other consumers/tangata whai ora.

In the group interviews, consumers/tangata whai ora noted the impact of low income on their ability to achieve better housing. In many respects the affordability issues facing consumers/tangata whai ora are no different from those that face anyone else living on a low income, but the effects of poverty and poor housing are exacerbated by the experience of mental illness. The experience of poor housing, financial stress and limited social contact contributes to depression and anxiety, and raises the probability of re-hospitalisation. In these circumstances, most consumers/tangata whai ora do not find it possible to accumulate savings, and any large bill presents problems. A number of particular issues were raised in the group interviews including the cost of housing, the impact of debt, the need to live alone and employment. Each of these is discussed in more detail below.

Cost of housing

The combination of the high cost of housing and low income makes it very difficult for many consumers/tangata whai ora to afford suitable housing, and insufficient income has pushed many into unsuitable housing options.

Impact of debt

Debt to the Department of Work and Income (DWI) is widespread amongst consumers/tangata whai ora. The problem of debt is intensified for consumers/tangata whai ora because they may need to ask DWI for Special Needs Grants for bonds and rent advances more than once a year, as they move in and out of acute care. They sometimes lose not only their accommodation but also their possessions when they are hospitalised. Outstanding debt makes it difficult to gain access to assistance such as Special Needs Grants.

Although grants are available to assist with advance payments of housing bonds and rent at the beginning of a tenancy, repayment requirements can easily precipitate DWI debt. Outstanding debt then closes the opportunity to access this form of funding to establish a new housing arrangement. The episodic nature of some mental illness can lead to frequent changes in housing circumstances. The group interviews reported that the limit on the frequency of the availability of grants to set up new housing arrangements can put the expense of moving to independent living completely beyond the available resources of some consumers/tangata whai ora.

Work and Income staff of MSD advise that when their staff are made aware of exceptional circumstances, they do have discretion to increase the frequency of such grants to more than once a year. In their experience, however, information about exceptional circumstances is not always forthcoming from consumers/tangata whai ora. A decision to provide more than one such grant within one year could be made to reflect increased levels of need, but would also have to take into account the resulting increase in the individual's level of debt. There is currently no discretion available to make these grants non-recoverable.

A review of these grants, and other third tier assistance, is currently being conducted by MSD Sector Policy staff. A paper seeking to clarify direction on a range of issues, including amounts, types of grants, and whether recoverability should be discretionary, will be forwarded to the Minister of Social Services and Employment in the very near future.

Living alone

Many people who experience mental illness need to live by themselves for recovery reasons, but a lack of suitable, affordable, single accommodation makes this independent option impossible. Living alone is also the least cost-effective living arrangement and few consumers/tangata whai ora can afford it.

Employment

Affordability of accommodation is closely linked to employment. Gaining employment not only improves self-esteem and a sense of "being normal" but also improves income levels, access to better housing and social/leisure activities for consumers/tangata whai ora. Discrimination against consumers/tangata whai ora in both gaining and sustaining employment is an issue for many.

Lack of choice

The lack of choice in housing options was noted as a problem by both providers and consumers/tangata whai ora, and is partly derived from gaps in housing

supply and the cost of suitable housing, relative to income. The effects of the financial constraint imposed by long-term reliance on benefit-level income and/or lack of employment opportunities, as discussed above, also contribute to the lack of choice in housing options and were discussed at length in the group interviews.

Consumers/tangata whai ora expressed the desire to live in ordinary housing like ordinary people. Lack of choice in housing can also result from there not being enough physically adequate housing that is also suitable for mental health recovery in the areas where consumers/tangata whai ora live. Furthermore, there may not be a wide enough range of housing options in particular areas to match the range of consumer/tangata whai ora requirements.

The survey data suggests that around a quarter to a third of consumers/tangata whai ora may be experiencing problems relating to the lack of choice about housing options. Choice of location (near family or support services, in a safe neighbourhood with options for privacy and quiet) and housing type (suitable for different types of consumers/tangata whai ora - single persons or couples with children, for example) are matters of significant concern to both consumers/tangata whai ora and providers.

Lack of choice in housing options often means that consumers/tangata whai ora are living in accommodation that is sometimes inadequate and often unsuitable. The concept of adequacy, for consumers/tangata whai ora, is a subset of the wider concept of suitability:

Adequacy

- In the group interviews consumers/tangata whai ora and providers discussed a range of issues relating to the physical adequacy of housing. Some mentioned specific problems with landlords who would not "replace rotten carpet" or "fix latches on doors". Some consumers/tangata whai ora mentioned problems with the basic security of their houses and belongings – outsiders having easy access to their houses and little respect for their possessions.
- Some consumers/tangata whai ora in the group interviews reported a lack of basic utilities such as electricity, running water and telephone in the houses they were able to afford, and between a quarter and a third of providers responding to the survey indicated that problems with the physical adequacy of housing affected "most" consumers/tangata whai ora using their services.

Suitability

- Some accommodation that consumers/tangata whai ora are offered is unsuitable for mental health recovery. Low-cost, high-rise apartment blocks in downtown areas, for example, may exacerbate mental illness because of lack of privacy, concerns about safety and personal security, and exposure to excessive noise. The frequent lack of design aesthetic in low-cost housing also makes such places less appealing.

- Consumers/tangata whai ora generally prefer not to be housed in low-cost blocks of flats alongside other mental health consumers/tangata whai ora. People who experience mental illness do not want to be further marginalised by being housed in "ghetto" areas.
- Being able to exercise choice about housing arrangements is valued highly by consumers/tangata whai ora. A house that is chosen is more likely to be suitable. Lack of choice in housing arrangements was also identified as a significant area of housing difficulty by providers. This was second only to affordability as a key area of difficulty. Around a quarter to a third of consumers/tangata whai ora were considered to have difficulties connected with lack of choice about their housing arrangements.
- What makes housing suitable depends on achieving the right balance between a range of different things that are important to the individual. Consumers/tangata whai ora report that finding a 'good' house sometimes results in being located far away from family/whānau and support, or not being able to keep a pet. Thus, even a house that may be in a good physical condition may nevertheless be unsuitable.

In the group interviews, consumers/tangata whai ora and providers made a connection between adequacy and suitability, and homelessness.

- Living in highly inadequate and/or unsuitable accommodation was a contributing factor to becoming homeless or transient and was also a form of homelessness for some people. Unsuitable housing did not meet consumer/tangata whai ora requirements of "being at home".

Discrimination

Discrimination was the third most highly ranked housing difficulty that providers noted and was discussed as a significant issue in *every* group interview. It was reported as being experienced in the housing market, the labour market, from flatmates, acquaintances, and also from some employees of the government agencies with which consumers/tangata whai ora need to interact.

Consumers/tangata whai ora reported that problems of multiple discrimination can be severe for Māori and Pacific peoples. In particular young Pacific and Māori males can experience discrimination on the basis of their age, sex, ethnic background and mental illness and consequently find it very difficult to access suitable housing.

The *Like Minds, Like Mine* programme (Ministry of Health, 2001) was acknowledged in the group interviews as being helpful. However, consumers/tangata whai ora noted that media reporting about the effects of mental illness was frequently inappropriate, encouraging negative and discriminatory community attitudes to mental illness.

Consumers/tangata whai ora and providers identified discrimination and stigma as both a barrier to independent living and as a factor that exacerbated their distress.

In the group interviews, consumers/tangata whai ora noted several particular facets of discrimination that affect their housing options:

- many consumers/tangata whai ora choose not to disclose that they experience mental illness because of prior experiences of disclosure leading to discriminatory responses from potential landlords;
- fear of discrimination inhibits consumers/tangata whai ora from accessing support and entitlements from state agencies and public services, but they are also prevented from accessing entitlements and supports because of bureaucratic processes and systems that create barriers;
- discrimination from flatmates, neighbours and the local community impacts on housing options (the so-called NIMBY - not in my backyard - syndrome); and
- discrimination that leads many consumers/tangata whai ora to accept unsuitable housing in caravan parks, boarding houses and "poor" neighbourhoods where housing may be substandard and unsafe.

The "not in my backyard" syndrome was noted in the group interviews, as well as by providers. Both groups of respondents expressed concern about the pressures being put on local councils by residents to have laws and by-laws changed in ways that would facilitate further discrimination against people who experience mental illness. Some groups currently lobbying for change to the Resource Management Act were cited as a particularly worrying example. Such pressure means that group housing, for example, may not be an effective solution for housing people with mental health problems, even in a temporary sense.

Public perception of the "high risk" to the safety of others created by "releasing" people who experience mental illness "into the community" is reinforced by the discourses of "danger" that are frequently used in media reporting. Part of the task of managing and changing public attitudes towards people who experience mental illness involves attention to aspects of safety assessment in discharging consumers/tangata whai ora from psychiatric settings. Public education about the nature of mental illness, and increasing public confidence in adequate safety assessment will be necessary for levels of discrimination to reduce.

Sustainability

Although sustainability is sometimes discussed in the same context as adequacy and affordability as a concept pertaining to housing, the research suggests that the term sustainability is more useful if it is applied to consumer/tangata whai ora capacity to sustain independent living in the long term. As noted in the key definitions section, sustainability is not so much an attribute of a particular housing unit, as concerned with the array of supports and resources that are

available to assist consumers/tangata whai ora to maintain independent living in the long term. Any consideration of sustainability therefore requires a focus on the arrangements of supports that are available to consumers/tangata whai ora. Sustaining independent living requires considerably more resource than simply having a house.

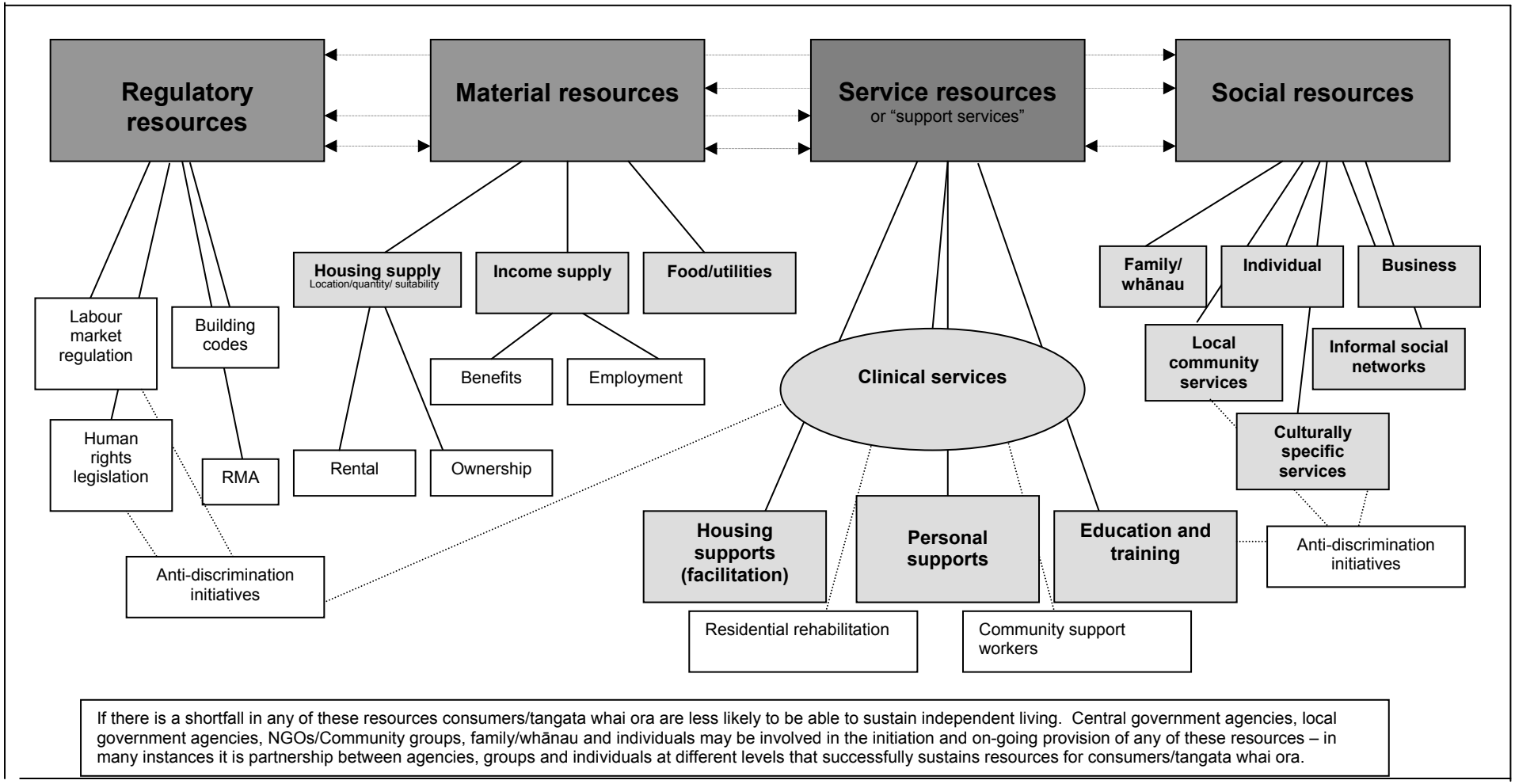
One of the outputs from the research has been the development of a conceptual framework to illustrate, not only the role of support services and the current range of services, but also a systematic framework in which the concept of resourcing in relation to individuals can be articulated. This was developed in the absence of an overarching policy framework that could demonstrate what resources are available, how they are interrelated, and what government agencies might be responsible for which areas. The "sustainability framework" developed for the research may serve as a first step towards filling this gap. It shows that clinical resources are only part of the picture, and that the provision of support services across a wide spectrum is needed if sustainable housing is to be a reality for consumers/tangata whai ora (see Diagram 1).

The framework identifies the range of supports required for independent housing to be sustainable:

- **regulatory resources** - statutory central and local government frameworks: human rights, anti-discrimination, labour market regulation, resource management, building codes and housing standards;
- **material resources** - including a supply of a range of adequate, suitable housing to choose from, sufficient income to afford to pay for it, and access to basic necessities such as food and utilities;
- **service resources** - including clinical services, housing facilitation services, and personal support services that can be tailored to meet individual need; and
- **social resources** - derived from belonging to the community and groups within it, living with the support of families/whānau and social networks, and having access to local and/or culturally specific networks and activities.

In the context of this framework it is evident that the current service provision emphasis continues to be on the clinical services provided through mental health funding to DHBs and NGOs. Some clinical services also include accommodation, but the move from this kind of "supported care" or "supported accommodation" is not a smooth one for consumers/tangata whai ora because the provision of services in the two settings does not mesh. A more detailed account of the role of support services is presented in the next section. The structure of the discussion is based on the four elements of the sustainability framework, but it is not possible to allocate all the findings to particular categories in the typology as there is considerable overlap between them and the framework was developed after the research had been completed. Had it been possible to develop the framework before the research was undertaken questions could have been asked in a way that elicited more congruent information.

Diagram 1: Sustainability framework: typology of resources necessary for consumers/tangata whai ora to sustain independent living.



4. Research findings: the role of support services

The role of support services

The discussion of the role of support services draws on all aspects of the research, including the literature review, the consumer workshop, the provider survey, and the group interviews with consumers/tangata whai ora and providers.

Regulatory resources

On the whole, the evidence in relation to regulatory resources is not clear-cut. Consumers/tangata whai ora and providers who participated in the group interviews and some of the literature identified a range of weaknesses in the current regulatory environment that were detrimental to the wellbeing of consumers/tangata whai ora. In particular, the following issues were raised:

- labour market regulation could do more to protect consumers/tangata whai ora as workers whose sickness-related histories often mean that part-time, low-paid or casual work is their only work option;
- plans to amend the Resource Management Act (RMA) (Resource Management Act Amendment Bill 1999[12]) are believed to entail the potential for discrimination against people with disabilities that cannot be rectified by recourse to the Human Rights Act (Bennion, 2000);
- the application of building codes has had unanticipated consequences - "group homes", for example, can be made to feel "institutionalised" through the display of exit signs and fire safety regulations, but also the lack of stringent monitoring means that some boarding houses have unsatisfactory fire safety procedures and equipment;
- lack of regulation of the media means that publication of negative images of consumers/tangata whai ora as intrinsically "violent" and/or "unsafe" continues without check despite evidence that some reporting contains substantial unfounded bias; and
- a shortage of advocacy services means that consumers/tangata whai ora often have difficulty dealing with bureaucracy and official information.

Consumers/tangata whai ora who participated in group interviews considered that anti-discrimination initiatives such as the *Like Minds, Like Mine* project are helpful.

Clear objectives in local authority plans can successfully provide leverage for local groups to develop options for particular groups. The success of this local leverage is evident in the housing policies of the Christchurch City Council. The Christchurch City Council[13] is developing robust policies for addressing issues such as a "Social Well-being Policy" and, within that, an "Equity and

[12] Resource Management Amendment Bill 1999, bill no. 313-2 CO. There has been no apparent progress with this Bill since the select committee report released 08 May 2001.

[13] There is a suite of documents available from the Christchurch City Council web site (www.ccc.govt.nz) that include the *Social Well-being Policy Report* and the *Draft Policy on Equity and Access for People with Disabilities.*

Access for People with Disabilities" policy. The draft policy proposes that "the Council will … develop partnerships with appropriate government and non-government organisations to ensure the delivery and co-ordination of necessary services [for people with disabilities] (for example, housing provision)."

Material resources

Material resources are those elements that support the basic infrastructure of life – *housing supply*, *income supply*, and *food supply and access to utilities*:

- there is a need for a wider range of suitable housing with more choices available to consumers/tangata whai ora (including the right to live long term in a boarding house, if that is what is genuinely preferred), and for these choices to be available for Māori and Pacific peoples as well as other specific population groups and in different localities;
- housing supply needs to be separated from clinical service provision;
- consumers/tangata whai ora and providers were clear that the role of residential accommodation was to provide support rather than housing *per se*;
- some consumers/tangata whai ora are either being referred to or remaining in residential accommodation because of barriers to accessing and sustaining independent housing;
- HNZC rental housing and local authority (council) housing is generally thought to be affordable and suitable by consumers/tangata whai ora, but it is not available in a number of localities – consumers/tangata whai ora and providers offered a range of ways of increasing options including:
    - addressing waiting lists;
    - clarifying the allocation criteria;
    - establishing an allocation/percentage of housing for consumers/tangata whai ora;
    - recognising the nature of mental illness in the allocation of housing/units;
    - the acquisition of a wide range of housing types to accommodate needs of single people, couples with children, sole parents, non-custodial parents, people with extended families or family/friend carers;
    - less group/high-rise housing; and
    - a wider range of housing located in the general community;
- boarding houses are known to be affordable sources of housing, in the short term at least, but more effective monitoring of safety

standards, building regulations and tenants' rights is needed.[14] According to consumers/tangata whai ora, the most suitable have good management and low tenant numbers. Others have problems with inadequate physical conditions, high room rates, poor safety procedures and poor personal safety for women residents in particular;

- home ownership was recognised as a very desirable housing option, but many consumers/tangata whai ora cannot successfully negotiate access to mortgage finance while receiving benefit income. For tangata whai ora, multiple ownership of Papakainga land can present different barriers to home ownership where the sheer complexity of negotiation required to gain agreement to use the land and to raise money to build on jointly owned land may deter people from pursuing this option;
- living with family/whānau can be a viable housing option for some, but pressures of overcrowding may threaten the long-term potential of such arrangements. Solutions are possible, however. Enhanced access to day care and respite care, and access to finance for housing adaptations such as an extra bedroom for the consumer/tangata whai ora would alleviate many of the overcrowding problems for some people;
- the views of most consumers/tangata whai ora expressed a clear preference not to have clustered/group housing specifically for consumers/tangata whai ora as a long term independent housing option. Furthermore, it was thought that there would be major problems for consumers/tangata whai ora with any housing option that was in any way punitive or coercive, or where there were too many rules or compulsory features that attached to the housing, such as compulsory employment or compulsory use of support services;
- consumers/tangata whai ora also raised the housing needs of older people who are homeless, or have been institutionalised for a large proportion of their lives, or who will always have high support needs. Their view was that such consumers/tangata whai ora need 'homes for life' i.e. sustainable independent housing with an ongoing support structure for older people that provides security of tenure as well as a balance of independence and support;
- gaps in housing supply that were identified in the group interviews included emergency housing, especially that which is appropriate for Māori, Pacific peoples, women, parents with dependent children, young people and people coming out of prison;

[14] Some of these issues are being addressed in other aspects of the Housing Policy Work Programme such as the examination of the feasibility of extending the Residential Tenancy Act 1986 to cover boarding houses.

- a specific gap is for short-term access housing without the barriers of rent-in-advance and bond payments, or of mental health needs assessment, such as 'easy-in-easy-out' housing options: hostels or shelters for emergency accommodation that consumers/tangata whai ora can come and go from as needed. Aspects of easy-access emergency housing that interview participants identified that would work well include:
  - a supportive management structure;
  - affordable short-term payment systems;
  - centrally located to supports and services;
  - safe [separate] environments for women, youth, and consumers/tangata whai ora with children;
  - non-clinical and non-coercive environments; and
  - access to information/links to mental health and general health services, government agencies and housing services if required;
- a number of consumers/tangata whai ora and providers who were interviewed commented that some form of short-term easy-access housing where residents would receive housing facilitation services to achieve the transition to long-term housing, would be valuable. Many homeless people, in particular, could be assisted by this transitional housing provision with housing facilitation services attached;
- affordability barriers severely restrict the choice of housing options. These barriers include:
  - needing assistance with access to education and employment which would reduce future income difficulties, especially employment protection during periods of acute illness;
  - needing support for the ongoing cost of medications, and transport costs for rural dwellers; and
  - problems in getting information about benefits entitlement;
- when income is inadequate, consumers'/tangata whai ora access to food and utilities is likely to be compromised – especially maintaining access to power and telephone utilities;
- water rates in some areas – notably Auckland –added an additional bill-paying burden;
- consumers/tangata whai ora sometimes rely on emergency foodbanks and community facilities such as soup kitchens;

Service resources

The literature studied during this research strongly indicates that a range of ongoing, flexible, comprehensive support services needs to be in place for people who experience mental illness to achieve independent living. The range of such services needs to include:

- housing support (facilitation) services, including practical help to find a house and set up the necessary systems to sustain occupancy; and
- personal support services to assist with development of daily living skills (including money management), social contact, peer support groups and other networks such as employment-related networks.

The information collected in the group interviews indicates that very many consumers/tangata whai ora are not at all clear what service resources are available, or which services they do receive. However, consumers/tangata whai ora perceive that:

- the range of service resources available to them differs significantly depending on whether or not they are receiving their clinical service in an accommodation setting (such as residential rehabilitation and group homes). Those who live in independent housing (not associated with the delivery of clinical services) have less successful access to personal support services that focus on daily living skills. Housing support (facilitation) services, however, are less accessible to consumers/tangata whai ora who are accommodated in clinical service settings:
- there are service gaps in particular locations, especially rural locations, so that tangata whai ora must choose between living with or near whānau and accessing support services; and
- there are gaps in the provision of service resources designed for specific population groups: Māori, Pacific peoples, rural people, young and older people, women, parents, and people discharged from forensic mental health services.

The data from the survey of providers also indicates that the provision of service resources for consumers/tangata whai ora cannot guarantee that the full range of services is available to each consumer/tangata whai ora. There is no unifying framework of support service provision to guide the funding, location and scope of the many services that are available from a number of different government agencies, a wide variety of community-based groups and NGOs, as well as from family/whānau.

Of those providers who offered housing-related services, 97 percent indicated that they offered one or more liaison/advocacy type services for consumers/tangata whai ora whereas only half of providers (48 percent) indicated they offered practical help. Practical help was often identified in the group interviews as a current service gap.

Information is available on a wide range of resources and services that are available to consumers/tangata whai ora in New Zealand. Many of these housing-related and personal support services provide obvious benefit to their recipients. A noticeably successful example is the ComCare Supported Rental Accommodation Service in Christchurch. Successful local initiatives such as this need to be studied more closely as examples of intersectoral partnerships at the local level.

Social resources

The mental health and independent housing need research was not designed to explore the specific contribution of social resources to sustainable independent housing for consumers/tangata whai ora. Despite this, it was evident from the group interviews that family/whānau play a significant role in supporting the material, service and social needs of family members who experience mental illness. In particular, Māori and Pacific families respond to different cultural imperatives in terms of family-based care. There is some evidence that a higher proportion of Māori and Pacific consumers/tangata whai ora than other consumers/tangata whai ora receive their primary support from family/whānau. The resulting effect, particularly the sometimes heavy economic impact on families, deserves further attention.

There was also strong evidence in the group interviews that many of the successful interventions in consumers'/tangata whai ora lives came from one-to-one interactions with people the consumers/tangata whai ora knew and trusted on a personal basis. These one-to-one relationships were established through informal social networks, local community services and/or culturally specific services.

The social development model outlined in the recent government statement *Pathways to Opportunity* (Maharey, 2001)[15] states that joint action between central government and the voluntary sector, along with local government and with business will generate positive results. The mental health sector already provides some examples of successful local partnerships. Further initiatives need to be encouraged at the local level.

Summary

A greater level of inter-agency coordination is clearly required for a greater proportion of consumers/tangata whai ora to achieve successful independent living. The lack of a strategic resource allocation/service provision framework means there is no current system in place to identify gaps in service resources.

Three key findings from the group interviews identify particular problems with service provision and/or service gaps that stand out for consumers/tangata whai ora:

- problems with interactions with government agencies, particularly access to information, and with understanding how administrative systems apply to individual circumstances;
- the need for services to help manage transitions between clinical service accommodation and independent living; and
- the continuing need for support services over the long term.

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[15] Maharey, Hon. Steve, Minister of Social Development (2001) *Pathways to Opportunity. Nga Ara Whai Oranga: from social welfare to social development.* Statement from the Minister of Social Development, Wellington.

Interactions with government agencies

In the group interviews, much difficulty was reported with accessing information from government agencies about what kind of assistance is available; about entitlements and eligibility, particularly about what is available to meet rent or mortgage payments while a person is in hospital; and about whether the new social allocation model will prioritise their own particular housing needs. Consumers/tangata whai ora reported a significant level of difficulty understanding how these administrative systems apply to their own circumstances. For those people living in rural areas, the sheer difficulty and expense of making repeated visits to town while unwell to see government officials one at a time brought a strong call for more coordination and the establishment of small but comprehensive government service centres in rural areas.

Housing transitions

The transition from residential to independent housing settings is a time of major difficulty for consumers/tangata whai ora, as it involves a transfer of service providers and types of service provision, as well the move to being responsible for their own accommodation. Conversely, a move into clinical service accommodation can, without support, result in the loss of an independent housing arrangement as well as personal possessions. It was reported that consumers/tangata whai ora who live in supported accommodation cannot easily access the practical housing support services they need to find and set up a new flat. The plea was made for more integration, as well as more emergency housing to provide a safety-net for these and other housing transitions.

Long-term support

The third major message from the group interviews was that practical support, advocacy and personal support to build up social and other networks are likely to be needed on a long-term basis to sustain occupancy of independent housing. This would help to avert crises, a number of which may begin as problems with housing, but can quickly turn into serious deterioration in mental health.

In addition, there are service gaps in particular locations, especially rural areas, so that tangata whai ora (and other consumers) are sometimes compelled to choose between living with or near whānau, and being able to access support services. There are gaps in the provision of service resources designed for particular population groups: Māori, Pacific peoples, rural people, younger people - particularly young men, older people who may have physical illnesses as well, women, single parents, and people discharged from forensic mental health services. It was reported that services designed to meet the needs of the average consumer/tangata whai ora are not sufficiently responsive to meet the needs of specific groups.

5. Housing need of specific population groups

A number of groups of consumers/tangata whai ora are in serious housing need that requires targeted intervention. The list of specific groups identified in this research includes:

- tangata whai ora (Māori consumers);
- Pacific peoples who are consumers;
- consumers/tangata whai ora who have been discharged from forensic mental health services;
- consumers/tangata whai ora in rural areas;
- consumers/tangata whai ora who are custodial and non-custodial parents;
- consumers/tangata whai ora who are older; and
- younger people who are consumers/tangata whai ora.

The group interviews with consumers/tangata whai ora and providers elicited information about all of these groups. The largest amount of information was reported in relation to Māori and Pacific peoples, and rural dwellers, although other groups, such as older people, young people, ex-prisoners, women, and parents of dependent children are known to experience specific housing problems.

Māori

Many providers (77 percent of the providers who responded to the survey) estimated that they were providing services to one or more Māori consumer/tangata whai ora who were experiencing one or more housing-related difficulty in the March quarter.

Forty-nine percent of providers indicated that Māori were most seriously affected by housing difficulties (compared with 7 percent who indicated Pacific peoples and 32 percent who indicated all others were most seriously affected).[16]

Consumers/tangata whai ora and providers report many examples of inadequate housing conditions experienced by tangata whai ora:

- housing without basic water and power utilities;
- high levels of homelessness and transience;
- acceptance of inadequate housing to avoid homelessness;
- overcrowding because of the size of many whānau;
- a shortage of housing in rural areas; and
- critical levels of rural housing need, not only in relation to substandard housing, but also because of isolation and lack of transport, resulting in decreased access to mental health services.

Consumers/tangata whai ora report that much of the disparity between Māori and non-Māori is directly attributable to stigma, discrimination and racism. Tangata whai ora report being offered less desirable accommodation than non-Māori consumers.

[16] A number of providers (11 percent) indicated that more than one group was most seriously affected. A number of providers either did not respond to the question or responded with "don't know".

Tangata whai ora and Māori providers expressed concern that the importance of whānau is not recognised by mainstream mental health services. The whānaungatanga model used by Kaupapa Māori mental health services supports the whole whānau, not just the tangata whai ora. This model can result in unfair advantage being taken of whānau who are not adequately recompensed for the resources and care they provide.

Pacific peoples

Fifty seven percent of providers indicated that one or more Pacific consumers/tangata whai ora was experiencing one or more housing-related difficulty in the March 2001 quarter. Seven percent of providers indicated that, of the three broad ethnic groups, Pacific consumers/tangata whai ora were most seriously affected by housing difficulties.[17]

Group discussions with Pacific mental health communities identified that housing need for Pacific consumers/tangata whai ora differs from that for non-Pacific consumers/tangata whai ora in the following ways:

- needs differ among different groups of Pacific peoples but this is not always recognised in service provision;
- stigma, discrimination and racism are widely experienced and relate to both the mental illness and the status of consumers/tangata whai ora as Pacific peoples;
- support is currently lacking for most Pacific consumers/tangata whai ora who continue to live with their families – unfair advantage can be taken of the families who are not adequately recompensed for the resources and care they provide;
- Pacific peoples generally have larger family sizes and overcrowding is a significant problem;
- strong cultural values of respect and honour can be given precedence over the needs of consumers/tangata whai ora – for example, consumers/tangata whai ora may end up living with families when their recovery might be enhanced by a different accommodation solution;
- cultural expectations that financial support will be provided to family in the Pacific Islands impacts on Pacific consumers/tangata whai ora who are mostly beneficiaries. This narrows housing choice because such remittances reduce available income; and

[17] There are some additional caveats in relation to the data collected in the survey about Pacific consumers that may have produced further problems of undercounting – in particular there are relatively few specialist mental health providers for Pacific consumers. Furthermore, we know that at least two of the larger providers did not respond to our survey. Where Pacific consumers access services available to all consumers/tangata whai ora their ethnic identity may be overlooked or unreported. There are smaller numbers of Pacific consumers in the population overall and they tend to be concentrated in particular geographic locations. There was a relatively low return rate from DHBs in Counties Manukau, Waitemata and Waikato where there are known to be higher concentrations of Pacific peoples in the general population and, by extrapolation, higher concentrations of Pacific consumers could be expected in these areas.

- some Pacific consumers/tangata whai ora are homeless - some choose this lifestyle to avoid cultural commitments of financial support to family.

Rural

Group participants noted that there are specific issues for consumers/tangata whai ora who live rurally, related to isolation and distance from mental health and housing services. Services generally are very limited in rural communities. Assumptions that consumers/tangata whai ora "should not live" in areas where support is limited are problematic because material, service and social support from family/whānau is also critical to mental health recovery.

Rural consumers/tangata whai ora who have to move from rural to urban centres to access hospital services, residential facilities or supported accommodation face particular difficulties either in establishing new housing and support networks or in returning to their communities. Returning to communities can be particularly difficult for consumers/tangata whai ora with alcohol and drug problems.

Use of alcohol and drugs

Consumers/tangata whai ora with alcohol and drug addictions often need to distance themselves from their previous community. This requires them to re-establish housing and community/social supports. Coming out of rehabilitation into independent housing, however, is extremely difficult for consumers/tangata whai ora with alcohol and drug addictions, who can face double discrimination. The chances of relapse are high without ongoing home-based support.

Homeless and transient

- Consumers/tangata whai ora who were reported to be most at risk of homelessness were:
- people coming out of prison and those receiving forensic mental health services;
- people with dual diagnosis (mental illness and alcohol and drug problems);
- people with a past history of institutionalisation; and
- people who were not linked into good social/community supports and not receiving mental health services.

6. Summary and conclusion

Housing difficulties, homelessness and transience are significant problems among people with mental illness. Information collected in the present study indicates that among consumers/tangata whai ora who were receiving mental health services from DHBs, the number who are experiencing housing difficulties could be in the order of 8,000 (17 percent), while the number who are literally homeless or living in temporary or emergency accommodation could be in the order of 2,000 (4 percent). A further 8,000 (17 percent) are estimated to be living in circumstances which may involve a heightened risk of homelessness, such as boarding houses, hostels, hotels, motels, bed and

breakfast houses and caravan parks. Many of the people living in such circumstances are likely also to have been identified among the group of people who were experiencing housing difficulties.

These rough estimates were based on the group of people receiving services from DHBs. It is known, however, that many people with ongoing and disabling mental illness serious enough to warrant specialist treatment are not in fact accessing mental health services. Estimates from the MHC (MHC, 1998) indicate that perhaps only around half do so. This means that there could be similar sized groups of people with similar conditions but not receiving services who are experiencing similar types of housing problems.

Perhaps more important than these crude estimates of the size of the problems are the findings of the study about the nature of the housing difficulties that are faced by consumers/tangata whai ora. The principal areas of difficulty were the unaffordability of housing, lack of choice in housing options, and discrimination as well as a wide range of factors that made housing unsuitable and unsustainable for consumers/tangata whai ora.

Affordability of housing is a significant area of difficulty for consumers/tangata whai ora, as reflected in both consumer and provider views. Many consumers/tangata whai ora exist on low incomes and the effects of poverty and poor quality housing are exacerbated by the experience of mental illness. This can lead to a negative cycle that eventually leads to re-hospitalisation. Debt to DWI is also widespread among consumers/tangata whai ora and places a further squeeze on financial circumstances both through the requirement to repay and through perceived difficulties in obtaining further assistance in the form of Special Needs Grants.

The adequacy and suitability of housing of consumers/tangata whai ora are also matters of significant concern. Some consumers/tangata whai ora reported a lack of basic utilities, while others were living in situations of material deprivation. Perhaps of even greater concern is the fact that many were living in circumstances that were not likely to promote their mental health recovery.

Consideration of the sustainability of housing arrangements raises broader issues about the range of support services that can assist consumers/tangata whai ora to maintain an independent housing arrangement. The evidence from the research suggests that there is a need for systematisation of support services for consumers/ tangata whai ora. Developing a coordinated inter-agency strategic framework for resource allocation/service provision to this group is a necessary step to ensuring comprehensive service provision to those who need it, and identification of service gaps.

These changes will be all the more effective if they take place in a context in which the unacceptably high levels of discrimination against consumers/tangata whai ora are being rapidly reduced.

Future provision of support services

During the research, the analysis of the "sustainability" issue in relation to housing arrangements raised broader issues about the range of support services that can assist consumers/tangata whai ora to maintain independent housing arrangements. The evidence from the research suggests that there is a need for systematisation of support services for consumers/tangata whai ora, so that a

less fragmented and more comprehensive range of support services is made available to all those who need them.

There is no current administrative framework that conceptualises the full range of support service provision for consumers/tangata whai ora, and also has the capacity to guide the funding, location and scope of the many services provided by a number of different government agencies, as well as the wide variety of those provided by community-based groups and NGOs, and family/whānau.

The sustainability framework developed for this research may serve as a first step towards developing a more cross-sectoral support service policy. Such a policy framework could include identification of service gaps as part of developing a strategic, coordinated inter-agency strategy for resource allocation, as well as ensuring comprehensive service provision to meet all of the support needs of consumers/tangata whai ora.

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