Mental Health and Independent Housing Needs
Part 5
Quantifying Independent Housing Needs
A Survey of Service Providers

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Ministry of Social Development

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Mental Health and Housing Needs Research: Part 5
Quantifying Independent Housing Needs – A Survey of Service Providers

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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:

A summary report of the research that was delivered to HNZC comprises Part 1 of the five-part report series published by MSD and is titled:

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

The other four parts include:

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

As Part 5 of this series, this report provides a summary of the findings from the national survey of 800 mental health service providers undertaken in April – July 2001.

[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

Context for the survey

The context for this research on the independent housing needs of people with mental illness was set by a work programme established by the Government in June 2000 as part of a Cabinet directive to a range of government agencies[2] to undertake policy work in relation to 11 aspects of housing needs for people with mental illness. The Research Unit of MSP[3] was invited by the then Housing Policy Unit of MSP to undertake the two research items from the work programme: 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.*

Objectives of the survey

The main goal for the mental health and independent housing needs research was to complete a small-scale, exploratory piece of work that would synthesise findings about the extent and nature of housing need among people who experience mental illness.[4] The synthesis would derive from an examination of relevant literature and existing data sources, from a one-day workshop with consumers and providers, from in-depth interviews with mental health consumers, and from a national survey of mental health service providers.

The *first objective* for the national survey of mental health service providers was to quantify independent housing need of consumers/tangata whai ora, and also the extent of homelessness and transience. As a way of providing an approximate estimate of the size of the problem, providers were asked to estimate:

- the number of consumers/tangata whai ora who were experiencing housing difficulties; and
- the number of consumers/tangata whai ora who were homeless/transient.

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[2] The government agencies called on to undertake this work were the then Ministry of Social policy (MSP), Community Housing Ltd. (CHL), Housing New Zealand (HNZ), Department of Work and Income (DWI), the Ministry of Health (MoH), the Health Funding Authority (HFA), the Treasury, and the Department of Child, Youth and Family Services (CYF).

[3] Since the research was commissioned, the Housing Policy group from the Ministry of Social Policy (MSP) has moved with CHL and HNZ to become part of HNZC, DWI and MSP have been incorporated into the Ministry of Social Development (MSD), and the HFA has merged with MoH.

[4] This goal was agreed to after discussions with the Housing Policy Unit of the Ministry of Social Policy, with a Consultative Committee of Consumers and Providers and an Advisory Committee (that had been set up for the project and included a wide range of government agency representatives) and with 20 consumers/tangata whai ora in a one-day workshop held at Stella Maris, Wellington, in February 2001 (see part 2 this series – a consultation report).

The *second objective* of the survey was to seek evidence of the nature of housing difficulties. The survey sought to identify the proportion of consumers/tangata whai ora who experienced particular aspects of housing difficulty. It was necessary to develop an item bank of housing difficulties against which the extent of housing need could be assessed on a five-point scale. The scale was expressed in terms of 'none', 'some', 'about half', and 'most'. Providers were asked to rank the proportion of consumers/tangata whai ora affected by each of the housing difficulty items. A 'don't know' option was also given in the scale.

The *third objective* was to determine the extent to which the experience of housing difficulties had impact on different consumer/tangata whai ora constituencies – particularly by ethnic group, gender and age. Providers were asked to identify which group, in terms of ethnicity, gender and age, was most seriously affected by housing difficulties and by homelessness and transience.

A set of *subsidiary objectives* was also incorporated. These included the possibility that data from the survey could be used to examine:

- the extent to which mental health services provided housing-related assistance to consumers/tangata whai ora;
- the extent of service provision to consumers/tangata whai ora in rural areas;
- the extent of regional differentiation in service provision between District Health Board (DHB) areas;
- the types of accommodation occupied by consumers/tangata whai ora; and
- the types of accommodation-related services provided by mental health service providers.

The qualitative information collected through the one-day workshop and the in-depth interviews was designed to complement and amplify the quantitative work (see Parts 2 and 4 in this series). The literature was also examined to see if there were any other New Zealand or international evidence suggesting similar findings (see Part 3 – a literature review).

Description of the survey

The survey was a short, forced-option, self-completion questionnaire that was sent to 800 DHB and Non-Governmental Organisation (NGO) mental health service providers. Service providers who were not funded by mental health services were excluded from the survey on two grounds. First, they did not target consumers/tangata whai ora and therefore could report less specifically on mental health consumers/tangata whai ora. Second, we anticipated being able to compare our data with that collected by the New Zealand Health Information Service (NZHIS)[5] and its database was restricted to mental health service providers.

[5] The New Zealand Health Information Service (NZHIS), under the auspices of MoH has instituted a mandatory quarterly reporting regime for DHBs and has just completed its first cycle of data collection. Part of this data collection is the Mental Health Information National Collection (MHINC), which although

The pilot survey went into the field in late April 2001 and the main survey a month later. The original closing date for the return of the survey was extended[6] and the analysis did not begin until August 2001.

Target population for this research

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 to March 2001. Although the total number in the target population is not known, it includes somewhere between 1 per cent and 3 per cent of the total population.[7] In other words it is thought that there could be as many as 120,000 people who have serious, ongoing and disabling mental illness, who require treatment from specialist mental health and alcohol and drug services. It is likely, therefore, that about 40,000 are receiving mental health services at any one time. The NZHIS (1998 and 1999) reports an estimated 46,200[8] consumers/tangata whai ora receiving mental health services from DHB providers in the March 2001 quarter. This equates to 1.2 per cent of the total New Zealand population.[9]

It was beyond the scope of this research to count the numbers of consumers/tangata whai ora who are not receiving services, or to describe their housing circumstances. As noted above however, there may be as many as twice as many consumers/tangata whai ora in the community than the number currently receiving support from mental health service providers. Any findings reported from those who are receiving services will underestimate the circumstances of consumers/tangata whai ora overall. Kearns and Reinken (1994) have commented on the likelihood of under-counting even in official statistics such as the Census. Any data presented here on the extent of housing need and the extent of homelessness and transience in the consumer/tangata whai ora population reflect this underestimation.

Rationale for a survey of mental health service providers

Quantification of independent housing needs of consumers/tangata whai ora at the national level in New Zealand has not been done before. The MSD research team undertook a national survey of mental health service providers as one way of gathering a modest set of information about the housing needs of people who

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not completely reliable (note the MoH disclaimers to the NZHIS data) provides the most comprehensive set of mental health data available in New Zealand.

[6] The return date was extended until early June when it became apparent that there were a large number of questionnaires outstanding. A letter was sent to all the providers at the end of April to extend the timeframe and the five-person telephone interview team also telephoned all providers who had not returned their questionnaires as at the end of June.

[7] The Mental Health Commission (1998) reports '… around 3 per cent of people have serious, ongoing and disabling mental illness requiring treatment from specialist mental health and alcohol and drug services … '. Furthermore, the Mental Health Commission (2001) reports that it is estimated that less than 1.5 per cent receive treatment.

[8] The NZHIS data for the March quarter 2001 excludes data from Capital & Coast, and the data for Hawkes Bay DHB covered one of the three months only. No NGO data were included in this count. (The data from these two DHBs had not been filed with the MoH at the time this analysis was done). We have estimated the number of consumers/tangata whai ora in Capital & 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 per cent of the total population of the DHB. n.b. Kearns and Joseph (2000) have also used this approach in mental health research in Auckland.

[9] The total New Zealand population at June 2001 was provisionally estimated at 3,849,000 (Statistics New Zealand online).

experience mental illness. The research team considered it inadvisable to attempt to collect data directly from mental health service consumers, given the time constraints on this project. To obtain similar information from a nationally representative population of mental health consumers would have required networking and trust-building with consumers and their advocates over a lengthy period of time to build a sample frame. Privacy considerations would have made it necessary to develop elaborate and time-consuming processes for distributing a survey through a third party.[10]

Although it was acknowledged that service providers would only be able to report their perceptions of consumers/tangata whai ora housing need, it was felt that matching the results from the survey against data being collected through the NZHIS (1998 and 1999) would allow some estimate of data reliability.

Mental health service providers were considered an appropriate proxy source for information about housing difficulties for consumers/tangata whai ora.[11] In order to provide information that reflected the perspective of consumers/tangata whai ora there was wide consultation about the survey content with consumers/tangata whai ora. A schedule of 190 interviews with consumers/tangata whai ora and service providers in 26 locations around the country complemented the survey findings (see Part 4 – Group Interviews).

Sample frame

The national list of mental health service providers used for the survey was compiled from partial lists provided by 14 different agencies and organisations. A large number of organisations (1,329) were listed on the final database. The providers were contacted by telephone to determine their eligibility to participate in the survey and some (324) were excluded from the database because they were not eligible.[12] A further 205 organisations were removed from the database for four different reasons. Some (131) had insufficient contact information to be contacted in any way. Some (62) were returned to MSD by New Zealand Post as undeliverable. A few (12), were returned with the specific information written on the envelope that the organisation no longer existed. Overall, 529 listings were removed from the database and the survey was sent out to 800 organisations in May 2001.

Accuracy of provider list

There was no way of ensuring that the database of mental health service providers MSD developed was complete. The services provided by the DHBs were checked with the CEO of each DHB, and we have reasonable confidence in the accuracy of the DHB list that was compiled. The information that was provided to MSD for building the database was less accurate in relation to the

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[10] A precedent for reliance on provider estimates can be found in National Housing Commission (1988).

[11] A similar approach of surveying providers to gain information about the circumstances of consumers/tangata whai ora has been used in recent research, e.g. in a 1997 Health Funding Authority study conducted by North Health, and in a 2000 University of Otago study conducted by the Department of Psychological Medicine at the Wellington Clinical School (both studies described in University of Otago 2000).

[12] Eligibility was based on three filter questions: whether their organisation provided services to mental health consumers/tangata whai ora living independently in the community and/or in residential or supported accommodation, whether their organisation had been operating for more than three months and whether they were funded by an NGO or a DHB.

NGO sector, and providers in this sector are generally more mobile and less constant. Some NGO providers come into being and are disestablished in response to the success or failure of their funding applications in any given year. Some organisations are very small (serving fewer than 10 clients), do not operate with any administrative support and are not easy to contact.

Response rate

Inducements were offered to the providers to increase the response rate. First an atmosphere of compliance was encouraged through the individual phone calls made by a small team of six telephone interviewers. Every provider on the database who could be contacted by phone was invited to participate and in agreeing to be part of the survey at the outset had already made a commitment to the project. Fewer than five of the providers who were phoned declined to participate. The telephone interviewers also telephoned providers who were late in sending back their returns. These personal approaches made a significant difference to the response rate. Second, a self-addressed envelope was provided with every survey and a return slip invited providers to indicate whether or not they wanted a copy of the summary results.

By the end of July 2001 after a two-month period, 587 of the 800 surveys (73 per cent) had been returned. Seventy-four of the surveys were not included in the final count as they related to services that did not deal directly with consumers/tangata whai ora, but rather with their families and support communities. Information included in these 74 surveys and in the final open-ended question of the survey (Question 41 – See Appendix 1 for a copy of the survey) was incorporated into the analysis of the qualitative research results (see *Part 4 - Group Interviews* – group interviews). A total of 513 (71 per cent) responses were entered onto SAS data screens.

The survey was divided into two parts. Questions 1-12 were answered by all respondents and included a range of questions about the nature of the provider organisation – where it was located, what mental health services it provided, and what types of accommodation services it provided. Only those respondents whose organisations were supporting consumers/tangata whai ora to live independently in the community answered questions 13-40. In the responses received, 336 organisations indicated that they offered services to consumers/tangata whai ora living independently in the community.

The item non-response rate varied throughout the survey. The most frequently answered questions were those at the beginning of the survey about the provider organisation and the numbers of consumers/tangata whai ora using their services. The questions toward the end of the survey were less well answered – especially the questions on homelessness and transience and types of accommodation occupied by consumers/tangata whai ora. Written feedback from some participants suggested that the deteriorating item response rate was due both to respondent fatigue and to the questions being increasingly difficult for providers to answer. Some respondents indicated in written comments that they had less knowledge about homelessness and kinds of tenancies than they had about their own services or numbers of clients.

The survey instrument (the questionnaire)

The survey instrument was developed as a 41-question document that canvassed 10 core themes:

- the proportion at a national level between health and hospital (HHS) and NGO services, of service provision to consumers/tangata whai ora;
- the proportion of residential and non-residential service provision to consumers/tangata whai ora nationally;
- the distribution of health services to consumers/tangata whai ora nationally - the location of providers gives some idea of the geographical spread, local/regional variances, density of service provision, 'hot spots' and priority areas;
- the extent of service provision to rural areas and small rural centres - the consumer workshop (on 7 February 2001- see part 2 of this series – a consultation report) had noted that service provision to rural areas was poor;
- the types of mental health service provision - including specialist clinical services, specific Kaupapa Māori and Pacific services, alcohol and drug services, and residential and community services;
- the types of accommodation support service provision, the extent of support provided, the contractual basis of these services (informal evidence suggests that some services provide ancillary support to consumers/tangata whai ora that is not specifically funded) and provider views on whether there is a need for more accommodation support services;
- the numbers of consumers/tangata whai ora accessing mental health services disaggregated by broad ethnic categories (Māori, Pacific,[13] Other[14]), sex (male, female), and age (0-19, 20-64, over 65 years);
- Providers' estimates of proportions of consumers/tangata whai ora experiencing housing difficulties in relation to the core concepts specified in the research questions - adequacy, affordability and sustainability:
    - substandard physical conditions - that is where factors such as a poor state of repair, dampness, dilapidation, inadequate sunlight, and/or pest infestations cause discomfort - (i.e. inadequate housing);
    - lack of privacy, lack of choice about housing options, lack of personal safety, exposure to excessive noise, unsuitable

[13] The category 'Pacific' is an umbrella term that covers Pacific peoples living in New Zealand. The service providers collect information under this term and thus are being asked to provide information that conforms to their collection procedures.

[14] The category Other is an umbrella term that covers all consumers/tangata whai ora who are neither Māori nor Pacific people, including all New Zealand European (Pakeha), and other tauiwi immigrant groups. In the remainder of this document this group is referred to as Other or 'all Other' consumers/tangata whai ora.

location relative to support and/or family/whānau, and overcrowding (i.e. unsuitable housing – see below);

- unaffordability of housing relative to income and medical costs (i.e. unaffordable housing); and
- insecurity of housing tenure, loss of independent accommodation during episodes of acute care or hospitalisation and discrimination in finding and retaining housing (i.e. unsustainable housing –see below);

- the numbers of consumers/tangata whai ora that providers estimate to be homeless or transient disaggregated by Māori, Pacific and Other categories, and by sex, age (under/over 65 years) and provider views on which groups are considered in most serious housing need; and
- provider's perceptions of the kinds of accommodation being occupied by consumers/tangata whai ora.

Suitability, in the context of this research, 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, although it may be adequate in other respects, is not aligned with an individual's mental health recovery needs.

Sustainability, as it was conceived in this research, 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 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. (See Part 3 – a literature review, for an account of the development of the sustainability framework.)

The quantification task was very difficult since mental health service providers do not typically collect formal data on the housing circumstances of consumers/tangata whai ora. The research was thus surveying providers as 'experts in the field' with some knowledge about housing as well as knowledge about their clients' circumstances.

Housing difficulty defined

Housing difficulties were described in the body of the survey (see Table 1).

Table 1: Description of housing difficulties as presented in the survey[15]

Housing difficulties for consumers/tangata whai ora are those housing conditions that hinder mental health recovery and maintenance of wellbeing and include **any or all** of the following:

- Substandard physical conditions - that is where factors such as a poor state of repair, dampness, dilapidation, inadequate sunlight, and/or pest infestations cause discomfort
- 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
- Overcrowding
- Insecurity of housing tenure
- Unaffordability of housing relative to income and medical costs
- Loss of independent accommodation during episodes of acute care or hospitalisation
- Discrimination in finding and retaining housing.

Measures of housing difficulty

To obtain a set of 'quantifiers' about housing difficulty and homelessness and transience, providers were asked three things:

1. To estimate the **total numbers** of consumers/tangata whai ora who experienced **housing difficulty** and the **total numbers** of consumers who were **homeless and transient**.

It was decided to ask mental health service providers to furnish estimates of the numbers of consumers of their services who were experiencing housing difficulties, or who were homeless or transient. It was recognised that providers' responses would be subject to some imprecision, because some providers might know little about the housing circumstances of their consumers. Nevertheless, it was considered that this would permit a set of rough estimates to be made of the level of housing need among this group. (See following for more detail).

2. To identify **which consumers/tangata whai ora were 'most seriously affected** by housing difficulties'.

The survey asked providers to identify the groups (ethnic, sex and age) that were "most seriously affected by housing difficulties" (Questions 25, 26, 27 and, with slightly different wording[16] Questions 36, 37, 38). There is no sure

[15] The list of housing difficulties was derived partly from factors investigated by Kearns, Smith and Abbott (1991) and partly from housing issues identified by the Mental Health Commission (1999).

[16] For questions 35-37 the wording was "For what group of consumers/tangata whai ora, in your view, was homelessness/transience most serious?".

way of knowing how providers interpreted the phrase "seriously affected", but written comments from providers would tend to suggest that the phrase was taken to mean the numbers of consumers/tangata whai ora affected in the suggested categories. Providers hand-wrote on their survey-return comments such as "there are far more men affected than women" or "mostly young people". These results are reported in Part 4 – Group Interviews.

3. To identify the **proportion of consumers/tangata whai ora experiencing housing difficulties** of different kinds.

In addition to the 'count' of consumers experiencing difficulty, the housing difficulty descriptors (set out above in Table 1) were used to ask providers to identify what proportion of consumers/tangata whai ora experienced each of the housing difficulties. For this calculation, providers were given a list of housing difficulties and were asked to rate whether 'none', 'some', 'about half' or 'most' of the consumers/tangata whai ora they provided services to experienced each of the difficulties. Providers were also given the option of 'don't know'. These survey results on proportions are reported later in this paper.

Data quality

The research team was aware that the data collected through the survey instrument would not be a reliable national count. There are three main reasons: undercounting, double counting, and the quality of individual responses.

Undercounting

Raw figures from the national survey almost certainly underestimated the numbers of consumers/tangata whai ora by a significant amount, because of missing responses.[17] The under-reporting came from two sources: the non-return of some questionnaires; and non-responses to selected questions by those who did return questionnaires. In order to take account of this under-reporting in the results some up-rating was required. Up-rating assumes that the characteristics of those included and excluded from survey responses are similar. The approach to up-rating is described below.

An estimate of the extent of under-reporting due to non-return of the questionnaire was made by benchmarking the survey responses against the information from DHBs collected by the NZHIS (1998).[18]

- The national survey relied on the voluntary response of DHBs. Reporting from DHBs to the NZHIS is mandatory.
- The DHB survey respondents[19] reported that they were providing services to a total of 22,261 consumers/tangata whai ora in the March quarter of 2001.

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[17] Undercounting is difficult to avoid – see Kearns and Reinken 1994 for an account of Census undercounting.

[18] The NZHIS (see 1998 and 1999) is a new, mandatory data-collection process that requires DHBs to report data relating to health service use by individuals (matched by national health index [NHI] numbers). Mental health service use is collected as part of this system. It is proposed to extend this data collection to NGO services in the near future.

[19] There were 203 surveys returned from DHBs which represented 40 per cent of the total return from all respondents. There were at least 355 DHB services in the sample frame (although this not be a complete record as the services from each DHB had to be compiled by the team from telephone and email conversations and some of the information provided was contradictory – furthermore, the services and

- The NZHIS data report that an estimated 46,200 people were receiving mental health services in the March quarter 2001 (or slightly less than half the number (48 per cent) reported by the DHBs responding to the survey).
- We have therefore up-rated our survey results by a factor of 2.07 (46,200/22,261).[20]

The under-reporting resulting from non-response to specific survey questions varied from question to question.

The calculations for each of the up-rates used in the survey are set out below.

- Questions 21-23 asked providers to estimate the total numbers of Māori, Pacific and all other consumers/tangata whai ora who had one or more housing difficulties.
    - 38 of the DHB service respondents failed to respond to this question, which meant that the circumstances of 4,181 of the 22,261 consumers/tangata whai ora were not taken into account on this question (4,181/22,261 $\times 100 \div 1 = 18.78\%$).
    - This means that 81 per cent of consumers/tangata whai ora were therefore accounted for in the DHB count of housing difficulty (100 – 18.78 = 81.22%).
    - We therefore adjusted our survey results for these questions by a further factor of 1.23 (100/81.22 = 1.23).
- Questions 32-34 asked providers to estimate the total numbers of Māori, Pacific and all other consumers/tangata whai ora who were homeless/transient.
    - 42 of the DHB service respondents did not answer this question, which meant that the circumstances of 5,011 of the 22,261 consumers/tangata whai ora were not taken into account on this question (5,011/22,261 $\times 100 \div 1 = 22.5\%$).
    - This means that 77 per cent of consumers/tangata whai ora were accounted for in the DHB count of housing difficulty (100 – 22.5 = 77.5%).
    - We therefore adjusted our survey results for these questions by a further factor of 1.29 (100/77.5 = 1.29).
- Question 39 asked providers to estimate the total number of consumers/ tangata whai ora (irrespective of ethnic group) who were living in particular types of accommodation (and were not already counted as homeless/transient in Questions 32-34).

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service teams do not stay constant over time). It would appear that the DHB return rate in relation to services provided in the DHB sector was of the order of 57 per cent. A number of factors may have contributed to this lower return rate: where a single individual in a DHB took responsibility for distributing the survey it was easy for the whole package of surveys to be mislaid; the DHBs were under pressure to respond to the MHINC data collection in a similar timeframe to this survey and the compliance costs may have been too high to do justice to both; some DHB services indicated that they would not respond because they did not collect the kind of information we were seeking.

[20] The up-rating was calculated by the MSD Research Unit statistician.

- 58 DHBs did not answer this question, which meant that the circumstances of 7,365 of the 22,261 consumers/tangata whai ora were not taken into account on this question (7,365/22,261 $\times 100 \div 1 = 33.1\%$).
- This means that 67 per cent of consumers/tangata whai ora were accounted for in the DHB count of housing difficulty ($100 - 33.1 = 66.9\%$).
- We therefore adjusted our survey results for these questions by a further factor of 1.49 ($100 \div 66.9 = 1.49$).

The calculations in the boxes below illustrate the application of the up-rating process based on the two assumptions outlined above.

1. Up rating of housing difficulty *(housdiff)* for Māori (*mhousdiff*), Pacific (*phousdiff*), and all other consumers/tangata whai ora (*ohousdiff*) - from DHB counts

Housing difficulty	*N°*	*Cumulative total*
mhousdiff	*932*	932
phousdiff	*183*	1,115
ohousdiff	*2,067*	*3,182*

The estimated figure based on up rating: 3,182 × 2.07 × 1.23 = *7,827.72 ≈ 8,000*

2. Up-rating for homelessness *(homeless)* for Māori (*mhomeless*), Pacific (*phomeless*), and all other consumers/tangata whai ora (*ohomeless*) - from DHB counts

Housing difficulty	*N°*	*Cumulative total*
mhomeless	*401*	401
phomeless	*47*	448
ohomeless =	*385*	*833*

The estimated figure based on up-rating: 833 × 2.07 × 1.29 = 2,224.36 ≈ *2,000*

3. Up-rating for type of accommodation - boarding houses or hostels long term (*boarding*), hotels, motels, caravan parks and B&Bs long term (*hotel*), respite care (*liverespite*), arrangements with family/whānau, friends or carers long term and not of their choice (*livefamily)* from DHB counts

Housing difficulty	*N°*	*Cumulative total*
boarding	*1,706*	1,706
hotel	*148*	1,854
liverespite	*268*	2,122
livefamily	*554*	*2,676*

The estimated figure based on up-rating: 2,676 x 2.07 x 1.49 = 7,974.48 ≈ *8,000*

Double counting

Double counting is a separate issue from undercounting. Many consumers who access mental health services through one DHB service may also access services through another DHB service, or may access additional services through NGOs – individual consumers/tangata whai ora may therefore be double-counted in some of the survey responses. There was no way to discriminate between individuals who are counted more than once other than

through the elaborate ethical procedures undertaken by the NZHIS, where data are collected on the basis of individual NHI numbers.[21] The impact of double counting in the survey results is somewhat offset by the undercounting. It does, however, introduce another element of unreliability to the statistical findings.

Response quality

The quality of responses was variable – it is important to note that individual responses from DHBs and NGOs differed in the completeness and accuracy of question answers.[22] A smaller number of the returns came from DHBs (203, or 40 per cent) than from NGO providers (310, or 60 per cent).

However, although a higher proportion of NGOs than DHBs returned surveys, many of the DHB returns collated information about large numbers of providers, whereas many of the NGOs collated information from a very small client base. In total, the DHBs reported 22,261 consumers/tangata whai ora using their services whereas the NGOs reported only 10,704. This reinforced our decision to rely more on the data returned from the DHBs.

In addition, mental health service providers had little confident knowledge of the housing difficulties of consumers/tangata whai ora. They are not required to collect housing-related data, and even though many providers work closely with consumers/ tangata whai ora they do not have recourse to any records of their housing circumstances. As well, providers were not confident about the extent of homelessness and transience amongst the consumer/tangata whai ora population (see later for a further discussion of provider confidence).

2. Quantification of independent housing needs

The analysis of the numbers of consumers/tangata whai ora experiencing housing difficulty relies on the methodological directions and constraints outlined in the previous section. The key question of the research was the quantification of independent housing need. To meet this information need, providers were asked to estimate the number of consumers/tangata whai ora who were experiencing housing difficulties, and to estimate the number of consumers/tangata whai ora who were homeless/transient. In the survey these questions were expressed as:

> Using the definitions [of housing difficulties] above, what is your best estimate of the total number of: tangata whai ora (Māori consumers); Pacific consumers; and Other consumers (i.e. those who are not Māori or Pacific people) who had one or more housing difficulties? (Questions 21-23 Survey of mental health service providers).
>
> Using the definitions [of homelessness and transience] above, what is your best estimate of the total number of: tangata whai ora (Māori consumers); Pacific consumers; and Other consumers (i.e. those who are not Māori or

[21] " The NHI provides a mechanism to uniquely identify healthcare users. It was developed to help protect personally identifying health data, particularly data held on computer systems, and to enable linkage between different information systems whilst still protecting privacy" (www.nzhis.govt.nz/Service_guide.html accessed 8/12/01).

[22] Some of the responses required information to add up: for example, the numbers of males + females needed to be equal to the sum of consumers counted by ethnic category and both these sets of figures needed to be the same as the sum by age category.

> Pacific people) who were homeless/transient? (Questions 32-34 Survey of mental health service providers).
>
> Using the definitions of homelessness and transience provided …, what is your best estimate of the total number of consumers/tangata whai ora, who were NOT homeless/transient, and who lived for all or most of March in [boarding houses and hostels long-term, council rented accommodation, hotels, motels, caravan parks or B&Bs long term, Housing New Zealand rental accommodation, private rental accommodation, privately owned home, respite care, arrangements with family/whānau, friends or carers long term and not of their choice] (Question 39 Survey of mental health service providers).

The data used to produce the results were derived only from the counts provided by the DHB providers and was up-rated as described previously.

Estimates of housing difficulty

Summing across the responses received, 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 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 per cent did not return their questionnaires and 20 per cent 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 were likely to have covered an even smaller proportion of the total group of consumers/tangata whai ora.

During the research it became 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 covered only around 48 per cent of the consumers/tangata whai ora who were actually receiving services from DHBs during the survey period.

In addition, it is necessary to take account of the sub-set 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 estimated that the DHB estimates of the numbers of consumers/tangata whai ora experiencing housing difficulty covered only around 40 per cent 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 was similar across people who were included and excluded from the survey responses, and taking into account

all the above grounds for underestimation, this would mean that the true level of housing difficulty among consumers/tangata whai ora currently receiving DHB mental health services may be somewhere in the order of 8,000, which equates to around 17 per cent 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 also 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 per cent) felt "highly confident" about their estimates of the number of consumers/tangata whai ora having housing difficulties, and 17 per cent said they were "not confident" about the figures. (The remaining 47 per cent described themselves as "reasonably confident" about the figures.)

It should also be noted that the above figure of 8,000 consumers/tangata whai ora may be an underestimate of the true extent of housing difficulty among people who are experiencing serious, ongoing and disabling mental illness, because it counts only people who are currently receiving treatment. Information from the Mental Health Commission (1998 and 2000) 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.

Estimating the extent of homelessness

Using a similar methodology to that outlined above, an estimate was also made of the number of people who were homeless/transient (see later for further discussion of homelessness/transience). 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 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 per cent 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 per cent) said they were "highly confident" about their estimates and 15 per cent said they were "not confident" about the figures. 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 extent of those at 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 potentially unstable, 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. Nevertheless, the term is one that might usefully be applied in the present study, in a more ad hoc fashion.

Although providers' responses to the final survey question on the types of accommodation consumers/tangata whai ora occupied was 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.[23] 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 per cent) or rental accommodation (47 per cent). These situations are not regarded as involving a heightened risk of future homelessness. The remaining 31 per cent of consumers/tangata whai ora, however, were living in a range of circumstances that might involve a risk of homelessness. Twenty per cent were living in boarding houses and hostels on a long-term basis; 6 per cent were living with friends or family on a long-term basis; 2 per cent were living in hotels, motels, caravan parks or bed and breakfast houses on a long-term basis; and 3 per cent were in respite care.[24]

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 motivated more by a desire to escape from poor housing than by the prospect of achieving anything more suitable.[25] This carries the risk of a form of permanent mobility or transience, 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

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[23] 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 per cent) are assigned to particular types of accommodation. The rating-up of responses takes account of the low item response rate.

[24] Because this was a survey of consumers/tangata whai ora living independently in the community, it did not seek information about numbers living in supported accommodation or residential facilities of any kind. This means that the extent of incipient homelessness among this group was unmeasured.

[25] A further reason to escape unsuitable housing may relate to the desire for distance from the behaviour of other tenants. See *Part 3 – A Literature Review*, for discussion of this issue in Kearns Smith and Abbott (1991), and in Robinson (1996a and 1996b).

friends or family, in hotels, motels, caravan parks, bed and breakfast houses, or in respite care.[26] Using the same methodology as above, this translated to an estimate of somewhere in the order of 8,000 consumers/tangata whai ora who were receiving DHB services who could be considered as incipient homeless. While this group was distinct from the group of people who were currently homeless/ transient, they could not be regarded as distinct from the group of people who were 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 was similar across people who were included and excluded from the survey responses, and if we take into account the grounds for underestimation outlined above, 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 per cent of consumers/tangata whai ora who were receiving services from DHBs. This figure is subject to considerable uncertainty, however.

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 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 reported by DHBs that did and did not provide this information, we estimate that somewhere in the order of:
    - 8,000 (17 per cent of 46,200) consumers/tangata whai ora may be experiencing housing difficulties; and
    - 2,000 (4 per cent 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 per cent of 46,200)[27] consumers/tangata whai ora were living in circumstances that may involve a heightened risk of future homelessness. Many of these

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

[27] Note that this 17 per cent is different from the 31 per cent cited on the previous page as not living in either privately owned houses or in rental accommodation 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.

people are likely to have been counted among those who were experiencing housing difficulties;

- these figures are rough estimates and are subject to considerable uncertainty; and
- there may in addition be similarly-sized groups of people with similar conditions but not receiving treatment who are also experiencing housing difficulties, or are homeless or transient.

3. Assessing the nature of housing need

The analysis of the nature of housing need relies on the methodological directions and constraints outlined in the previous section. The key questions behind this section of the research were whether or not there was any differentiation between ethnic groups, gender and age in the experience of housing difficulties, and whether or not some difficulties were perceived to be more significant than others. The survey questions required providers to identify the category (by ethnicity, gender and age) they believed was most seriously affected by housing difficulties.

Differentiation between ethnic groups, sex and age

In the survey the first set of questions were expressed as:

> In your view, what group of consumers/tangata whai ora is most seriously affected by housing difficulties [tangata whai ora, Pacific, Other]? (Question 25);
>
> What sex, in your view, is most seriously affected by housing difficulties [male, female]? (Question 26); and
>
> What age group, in your view, is most seriously affected by housing difficulties [1-19 years, 20-64 years, 65 years and over]? (Question 27).

The distribution pattern across the different ethnic, sex and age disaggregations is broadly comparable with the patterns identified in the NZHIS data (as discussed below). What we can conclude from this is that the MSD survey data do not seem to contain any bias in terms of these basic demographic characteristics. On the basis of the relative absence of bias, it is likely that we can assume a degree of confidence in the MSD survey results in relation to assessments of housing need.

The results in relation to housing difficulty are reported by broad 'ethnic' categories (Māori, Pacific and all other), sex and age.

The questions on which group experienced the most serious housing difficulty had a very high non-response, 'don't know' or 'not applicable' rate (24 per cent of the responses in relation to broad ethnic groups and sex, and 21 per cent in relation to age) so these findings need to be treated with considerable caution. The high non-response rate may reflect the fact that providers were asked to specify numbers accurately, which may well have required time-consuming reference to records.

Housing difficulty by ethnic group

In the MSD survey, DHB providers reported that, of the total number of consumers/tangata whai ora receiving services, 17 per cent were Māori, 2.5 per

cent were Pacific peoples and 80 per cent were from all other ethnic groups. NZHIS data reports 15 per cent Māori, 2.5 per cent Pacific people and 83 per cent all other clients, so the proportions by broad ethnic group are comparable. This comparability holds for sex and age breakdown as well.

Although providers were asked to nominate **one** broad ethnic group that was most seriously affected by housing difficulty, 11 per cent of providers nominated more than one group. Similar statements are made elsewhere in the report in relation to sex and age and these should also be noted.

Māori

Many providers (77 per cent) estimated that they were providing services to one or more Māori consumers/tangata whai ora experiencing one or more housing related difficulties in the March quarter. Forty-nine per cent of providers indicated that Māori were most seriously affected by housing difficulties.

Pacific

A smaller proportion of providers (57 per cent) indicated that one or more Pacific consumers were experiencing one or more housing-related difficulties in that same time period. Only 5 per cent of providers suggested that Pacific consumers were most seriously affected. Fewer providers (46 per cent) reported on Pacific consumers, and the greatest proportion (97 per cent) of these were small service providers reporting on fewer than 50 consumers each.

Overall, therefore, there were fewer providers with any knowledge of the situation for Pacific consumers and less information was collected about them. In addition, cultural differences in the reporting of housing difficulty as well as cultural differences in the provision of housing and consumer expectations may have skewed this response.

Other

The largest number of providers (81 per cent) indicated that one or more of Other consumers/tangata whai ora experienced one or more housing related difficulties. Thirty-two per cent of providers indicated that 'other consumers/tangata whai ora' was the group most seriously affected by housing difficulty.

Housing difficulty by sex

DHB providers reported a total of 53 per cent male and 47 per cent female consumers/tangata whai ora receiving services. The NZHIS data reports 51 per cent males and 48 per cent females. The proportion of male to female consumers/tangata whai ora is similar to the relative proportions in benefit uptake, where slightly more males are reported to be in receipt of Invalids Benefit or Sickness Benefit for psychological or psychiatric (serious mental illness requiring medical treatment) reasons.[28]

Fifty-nine per cent of providers reported that males were most seriously affected, and 37 per cent reported that females were most seriously affected by

[28] The demographic data from the DWI SWIFTT (Social Welfare Information for Tomorrow Today) database records 9,255 (54 per cent) males and 7,624 (45 per cent) females accessing Sickness Benefit (SB) or Invalids Benefit (IB) at some time in the three months to 31 March 2001.

housing difficulties. This finding was confirmed in many of the group interviews with consumers, where both men and women described the particular difficulties that male consumers/tangata whai ora experienced in relation to housing (see *Part 4 – Group Interviews*).

Although providers were asked to nominate **which** sex was most seriously affected by housing difficulty, 4 per cent of providers nominated both.

Housing difficulty by age

In the age category data, MSD survey information identified 15 per cent of consumers/tangata whai ora receiving DHB mental health services as under the age of 19, 74 per cent in the 20 - 64 year-old group and 11 per cent as over 65 years old. The total by age does not match the overall total as not all providers completed data for this section. Once again, there is a degree of comparability with NZHIS (1998) where the reported figures indicate 18 per cent of consumers were under 19 years of age, 77 per cent between 20 and 69 years of age and 6 per cent over 70 years of age. The MSD figures are not directly comparable with NZHIS figures at the upper end, as the age categories for NZHIS at the upper end are 60-69 and 70+ whereas the MSD survey used the category of 65 years and over.[29]

In terms of age group most seriously affected, it was not surprising that 83 per cent of providers indicated that those between 20 and 64 years were most seriously affected. This was unsurprising because most of the survey returns reported on this age group. As discussed earlier, there are significant issues in relation to housing for both younger and older consumers/tangata whai ora, but these have not been highlighted in this survey and require further research.

Although providers were asked to nominate **one** age group that was most seriously affected by housing difficulty, 3 per cent of providers nominated more than one.

Summary

Housing difficulty was clearly indicated as an issue that affected Māori and male consumers/tangata whai ora particularly. This finding was also confirmed in the group interviews as well as in the MSD survey. However, although many providers perceived housing difficulty to 'less seriously affect' other ethnic groups and women, there was still a quite high proportion of providers who identified Pacific peoples, all other groups and women to be 'most seriously affected'. Given what has been stated previously about the issue of 'serious affect' we have assumed this means that some providers do consider that housing difficulty affects more non-Māori and non-male consumers. Although this evidence appears contradictory, the differences may stem from the particular location of provider groups and/or the particular kinds of consumers/tangata whai ora that they deal with. Specialist providers offering

[29] Services for over 65-year-olds are generally funded from Disability Support Services (DSS) rather than Mental Health sources and this may account for the low level of reporting on services to older people in the survey. Most psycho-geriatric statistics incorporate not only those for whom the onset of mental illness is an onset age-related event (such as dementia) but also those who have experienced mental illness through their life course.

services, for example, to Pacific peoples or to women only are bound to see that housing difficulties affect their particular client base the most.

Provider perception of housing difficulty by age category is biased by the fact that most of the existing service providers cater to consumers/tangata whai ora between the ages of 20 and 65. There are still relatively few mental health services for youth, and much of the provision of services to older people is not funded by Mental Health but by Disability Support Services.

4. Providers' perceptions of housing difficulty

A further set of questions asked providers to consider each of the 11 items in the housing difficulty list and suggest which proportion of consumers/tangata whai ora were affected in each. The analysis in this section of the report is divided into five sections. Section one highlights the questions that were asked and the method used to derive an average scale score from the raw data. Section two examines the results in relation to tangata whai ora only, and reports on both the average scale score results and the results from providers reporting on most of their consumers. Section three examines the results for Pacific consumers only, using the same two sets of data. Section four examines the results for all Other consumers. Section five takes a slightly different approach and examines some element of regional differences in the data in relation to the four items of housing difficulty that stood out in the analysis: unaffordability, lack of choice, discrimination and substandard physical conditions.

Questions and methods

The 11 housing difficulty items (see table 1) were presented as five-point scales and providers were asked to tick whether **none**, **some, about half** or **most** of their consumers/tangata whai ora were affected by each of the housing difficulties listed. A 'don't know' option was also provided. The questions were also designed to identify some of the particular elements of housing difficulty that affected consumers/tangata whai ora in each of the broad ethnic groups – Māori, Pacific and Other.

To determine results from the survey responses to the item scale of housing difficulty (Questions 28-30) a scale score was constructed from the responses to each item of difficulty. The scale score was derived by allocating values to each of the item responses. If the provider ticked **none** this was valued at 0. If the provider ticked **some**, this was valued at 1. A response to **about half** was valued at 2 and a response to **most** was valued at 3. These values were then summed and averaged for each item. The 'don't knows' were not included in the calculation. A derived score then facilitated a ranking of the difficulties for each ethnic group. The results are discussed for each ethnic group in turn. The results from the scale scores are also compared with the results from those providers who indicated that **most** of their consumers/tangata whai ora experienced any particular item (these are listed under the sub-headings: Item score - **most** – results). The point of this comparison is to highlight those areas where providers were aware that the particular housing difficulty in question affected most of the consumers/tangata whai ora.

Providers' perceptions of housing difficulty - tangata whai ora

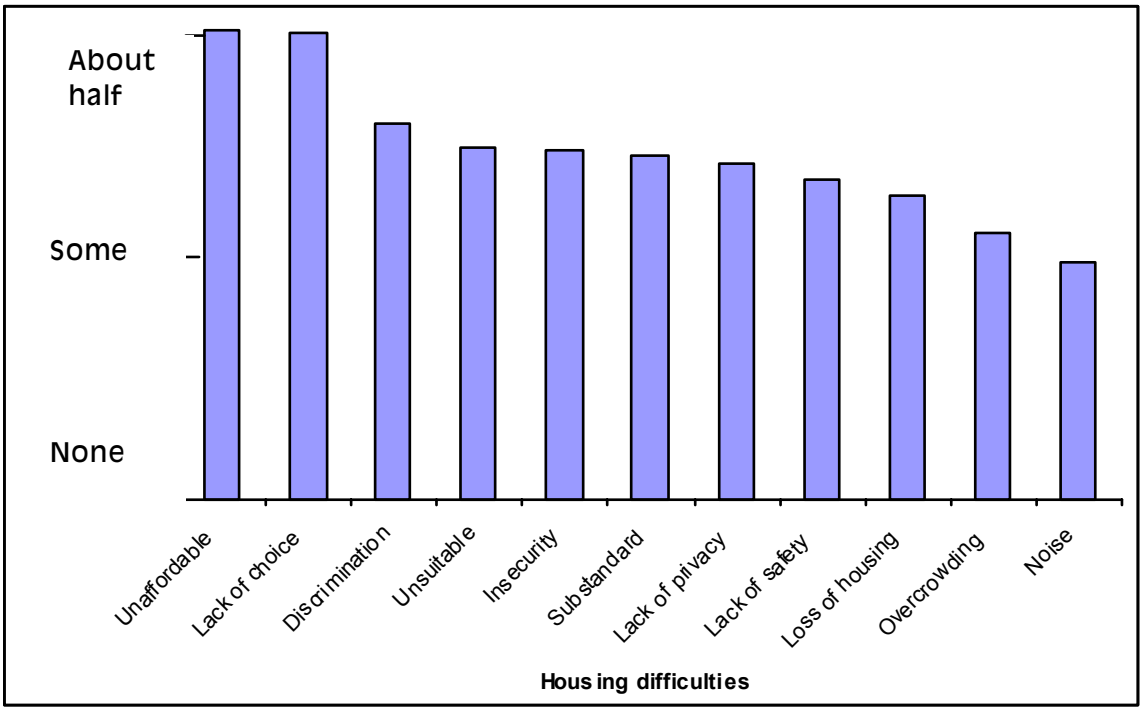
Scale score results

The results indicate that providers ranked the **unaffordability of housing** relative to income and medical costs and **lack of choice** in housing as the two items that affect the greatest proportion of tangata whai ora (see Graph 1 below).

On average, providers indicated that both unaffordability and lack of choice affected **about half** of tangata whai ora.

A cluster of items were identified as being housing difficulties for less than **half** but more than **some** of the tangata whai ora. **Discrimination in finding and retaining housing** was clearly ranked third by providers, although it was seen as less significant than unaffordability and lack of choice.

Graph 1: Providers' perceptions of housing difficulty for tangata whai ora (Māori consumers)



The next four items, **unsuitable location relative to support** and/or family/whānau, **insecurity of housing tenure**, **substandard physical condition**, and **lack of privacy** were ranked very similarly by providers but still suggested that clearly more than **some** tangata whai ora were affected.

The scoring of the next two items, **lack of personal safety** and **loss of accommodation during acute illness or hospitalisation** began to tail off and the final two items, **overcrowding** and **exposure to excessive noise** were ranked as affecting the smallest proportion of tangata whai ora.

In the group interviews (see *Part 4 – Group Interviews*) loss of accommodation during acute illness or hospitalisation was much discussed, and it is surprising to see its low ranking on the scale score. One possible explanation for this is that loss of housing during acute illness is an issue that is not widely reported by

consumers to providers. The providers who deal with a person coming back into the community after illness may not be the same ones who were supporting the consumer prior to the acute episode, and indeed the consumer may have had to shift from one DHB area to another in order to get hospital care. It may also reflect that loss of housing does not occur very frequently, but when it does it has very serious implications for consumers/tangata whai ora. Both of these explanations are speculative, however, since we do not have good data on this matter (see also Graph 2 results).

Item score – most - results

We gain another perspective on housing difficulties by examining the proportion of providers that reported that **most** of their consumers experienced difficulties in each of the listed items (i.e. providers ranked **most** consumers as experiencing housing difficulty on that scale item) (see Graph 2).

The same two items appear in the top two positions, although their order is reversed in response to a small margin of difference. Between 40 and 45 per cent of providers reported that **lack of choice** and **unaffordability** affect **most** tangata whai ora.

Discrimination was also the third most highly ranked item, and was identified by 29 per cent of providers as affecting **most** tangata whai ora.

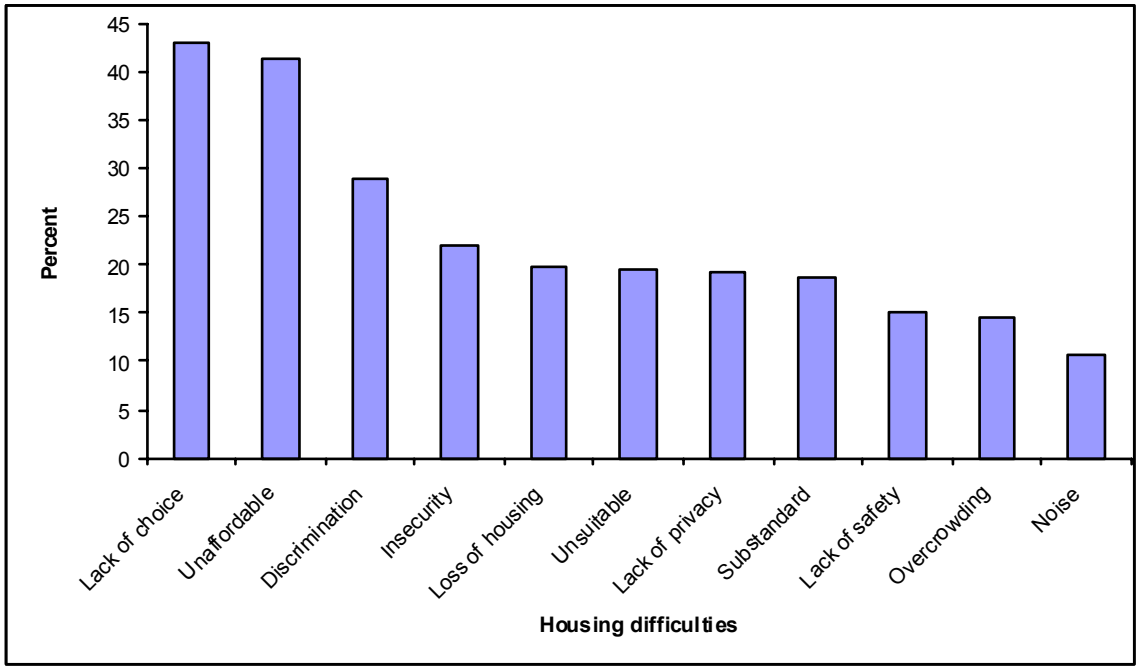
Insecurity of tenure was reported by 22 per cent of service providers, and **loss of accommodation during acute illness** or hospitalisation by 20 per cent of providers as affecting **most** tangata whai ora.

Although there is only a 1 per cent difference between the previous two items and the next three, they are separated here because all three of the next items cluster at 19 per cent. Providers' responses indicated that 19 per cent viewed the **unsuitability of housing in relation to support** services and whānau, **lack of privacy** and **substandard accommodation** as affecting **most** of the tangata whai ora using their services.

Lack of personal safety and **overcrowding** were reported by a smaller number of providers (15 per cent each) as something that affected **most** tangata whai ora. Only 11 per cent of providers reported **exposure to excessive noise** as affecting **most** tangata whai ora.

When the item results are compared with results from Kaupapa Māori services only, a similar ranking is also evident. The ranking of the three most highly ranked items, affordability, choice and discrimination, remains the same. Kaupapa Māori providers, however, ranked the substandard physical conditions of housing and insecurity of tenure ahead of location relative to support and or family/whānau.

*Graph 2: Percentage of providers reporting **most** of their tangata whai ora (Māori consumers) experiencing housing difficulties*



Providers' perceptions of housing difficulty - Pacific consumers

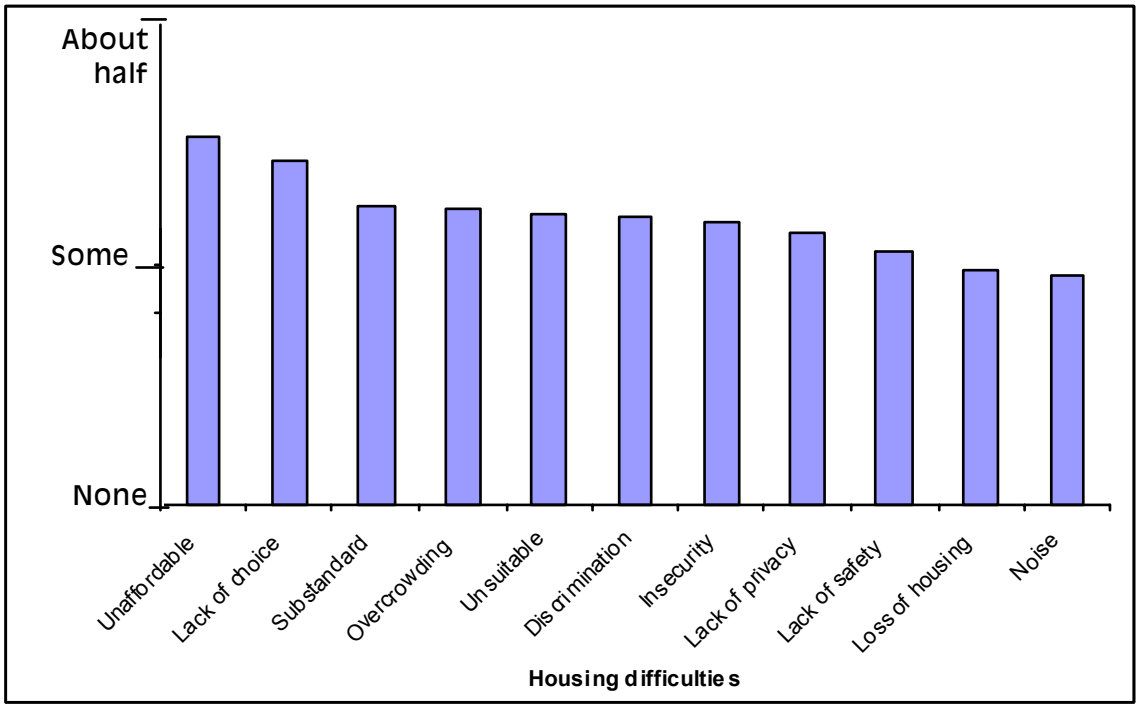
Scale score results

Although the ranking of housing difficulty by providers to Pacific consumers/tangata whai ora is broadly similar to that of Māori, there are notable differences. The **unaffordability of housing** occupies the first rank and the **lack of choice** about housing options is positioned very closely second (see Graph 3).

Once again there is a clustering of scores. **Substandard housing**, **overcrowding**, **unsuitable location relative to support** and/or family/whānau, **discrimination**, **insecurity of tenure**, and **lack of privacy** all had very similar scale scores.

Substandard physical conditions of housing may reflect the reality of the high numbers of Pacific consumers ora living in expensive but run-down housing stock in Auckland's outer suburbs.

Graph 3: Providers perceptions of housing difficulty for Pacific consumers/tangata whai ora ranked by scale score



Overcrowding is also in this cluster, however, although it was not for Māori. The high ranking by providers of overcrowding for Pacific people may indicate a number of factors. We know from other evidence[30] that overcrowding is more common in Pacific and Māori households than in those of New Zealanders of other ethnic backgrounds, and that overcrowding is particularly emphasised in relation to Pacific households. It is possible that an awareness of such secondary evidence, rather than direct knowledge of the housing circumstances of their consumers, may have conditioned providers' responses. The high ranking may also reflect the reluctance of Pacific families to access care outside the extended family, as well as strong cultural differences about what is appropriate care and living circumstances for consumers/tangata whai ora who are part of established Pacific households. This is a topic worthy of further research. It may also be that overcrowding is a response to the high burden of accommodation costs for a population sector that has relatively low levels of average income. A more sophisticated research instrument would be needed to determine how and why

[30] "*Pacific Islands people living in New Zealand are the most likely to live in multi-family households (22 per cent) and the least likely to live as couples without children (5 per cent) ... Pacific Island people were the most likely to live in extended families, with 41 per cent in this situation ... Māori and Pacific Islands people, who together represent 20.1 per cent of the resident population, are highly over-represented among those defined as living in crowded conditions. In 1996, 74.6 per cent of people living in crowded homes identified as belonging to Māori or Pacific Islands ethnic groups. The Pacific Islands group included 18,600 Samoan people (23.7 per cent of the Samoan population living in New Zealand). Rates were also high for Tokelauan people (31.2 per cent), and for the Tongan (27.1 per cent), Niuean (21.0 per cent) and Cook Islands (18.6 per cent) ethnic groups. The 42,100 Māori living in crowded housing represented 8.8 per cent of the Māori ethnic group. In contrast, only 0.7 of people with sole European ethnicity lived in crowded homes*" (DSW 1999: 64 and 71).

overcrowding is ranked so highly by those who provide services to Pacific consumers/tangata whai ora.

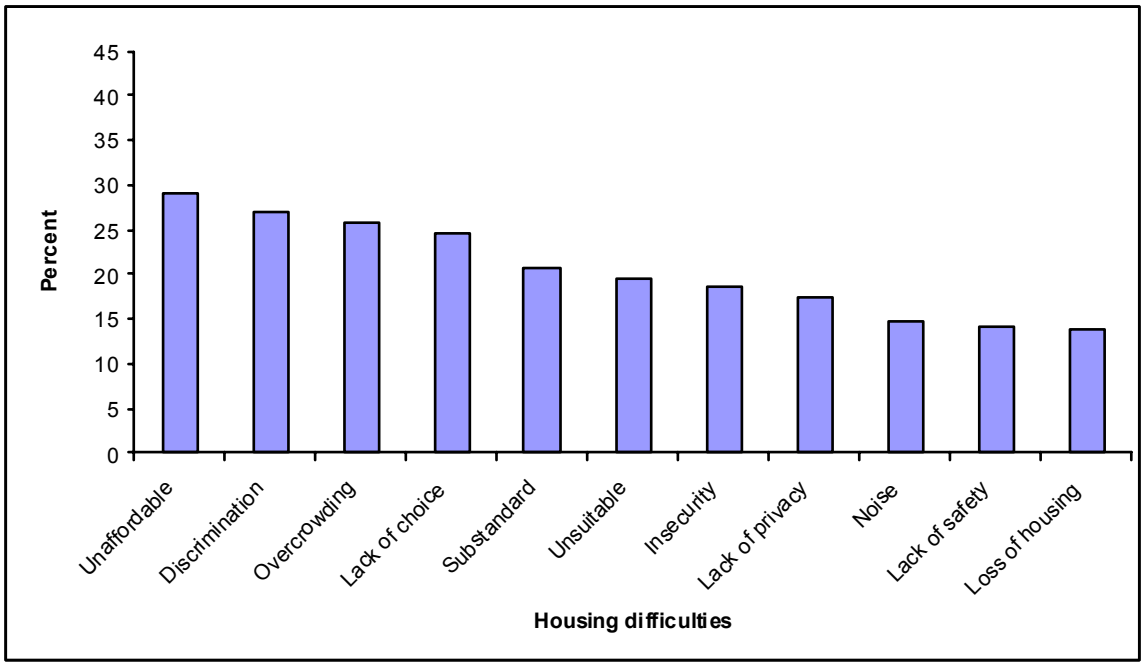
Loss of housing because of hospitalisation was not ranked highly in relation to Pacific consumers, and neither was exposure to excessive noise.

It is notable that all the ratings are lower than they were for tangata whai ora (see Graph 3). This reflects both a low return rate of information about Pacific consumers,[31] and the possibility that Pacific consumers are less exposed to service provision so providers would consequently have a less clear picture of their housing difficulties. Providers' lack of awareness of difficulties for Pacific consumers was frequently noted in the group interviews (see *Part 4– Group Interviews*).

item score – most – results

If the housing difficulty items (see Graph 4) are presented in terms of percentages of providers indicating that **most** of their consumers were affected by particular difficulties, a pattern emerges that is different from the reporting in relation to tangata whai ora.

*Graph 4: Percentage of providers reporting **most** of their Pacific consumers experiencing housing difficulties*



These results tend to fall into three broad groups. First there is a group of four items where more than 24 per cent of providers identified that **most** consumers experienced difficulties: **unaffordability of housing** (noted by 29 per cent of providers); **overcrowding** (noted by 26 per cent of providers); **discrimination** (noted by 27 per cent of providers); and **lack of choice in housing options** (noted by 25 per cent). Thus, unaffordability was again the top ranked item, and

[31] The low rate of return for Pacific peoples was in part incurred through a low overall return rate from the Waitemata DHB where the NZHIS (1998) figures record 303 Pacific consumers but the MSP survey only recorded 67 (or 22 per cent of the NZHIS figure).

in contrast to the results for Māori, lack of choice was now ranked fourth because both discrimination and overcrowding were more highly ranked for the Pacific peoples group than for Māori.

A second cluster of responses fell between 15 and 21 per cent and indicated that smaller percentages of **most** Pacific consumers were affected by **substandard housing** (21 per cent), **unsuitable location in relation to support** and/or family/whānau (20 per cent), **insecurity of tenure** (19 per cent) and **lack of privacy** (17 per cent).

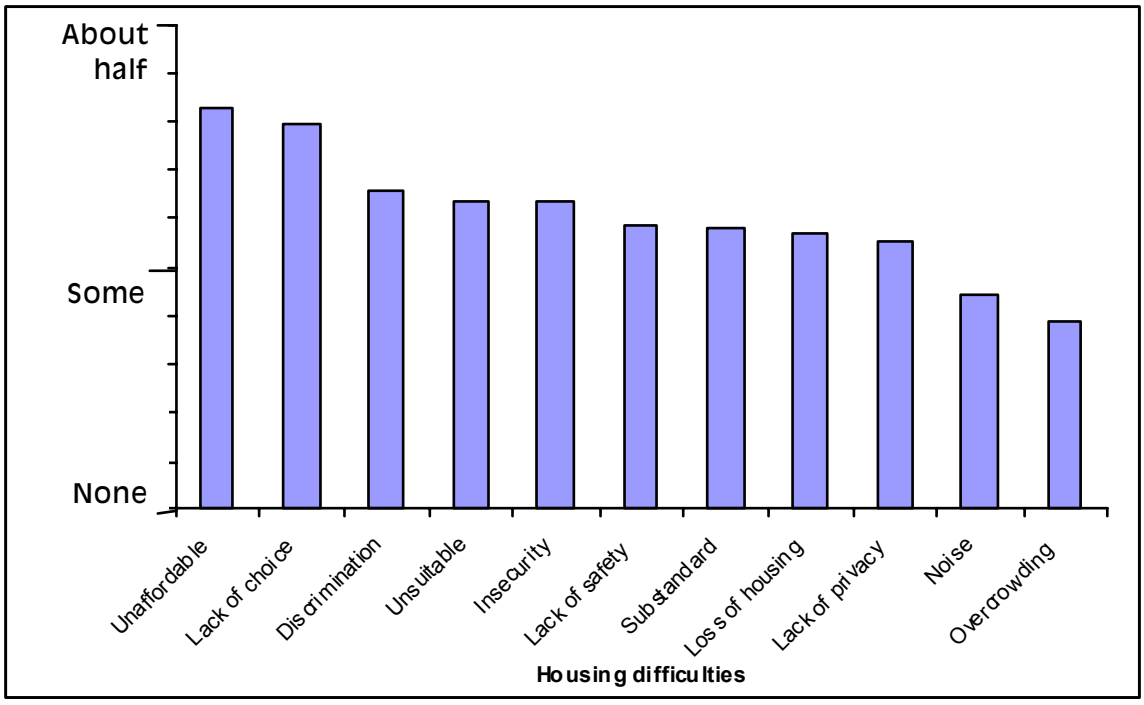
A third cluster of responses fell below 15 per cent and included **exposure to excessive noise** (15 per cent), **lack of personal safety** (14 per cent) and **loss of housing due to hospitalisation** (14 per cent). In contrast to the results for Māori, loss of housing due to acute illness or hospitalisation is now ranked lowest. What is worth noting is that none of the items on the housing difficulty list were scored at zero for either tangata whai ora or Pacific consumers. At least some or all the providers are in circumstances where **most** of the people they see experience housing difficulties across the range.

Providers' perceptions of housing difficulty - all Others

Scale score results

As with tangata whai ora and Pacific consumers, the **unaffordability of housing** and **lack of choice** in housing options for all Other consumers/tangata whai ora are ranked most highly by providers (see Graph 5). **Unaffordability of housing** is once again the most highly ranked item.

Graph 5: Providers' perceptions of housing difficulty for all Other consumers/tangata whai ora ranked by scale score



There are two clusters of responses in the middle ground, with a degree of distinction between them. In the first group, on average providers indicated that

some to **about half** of all Other consumers experienced **discrimination** in finding and retaining housing, **unsuitable location relative to support** and/or family/whānau, and **insecurity of tenure.** These three items were ranked slightly ahead of the four items in the second group: **lack of safety**, **substandard physical condition**, **loss of housing** due to acute illness and hospitalisation and **lack of privacy**.

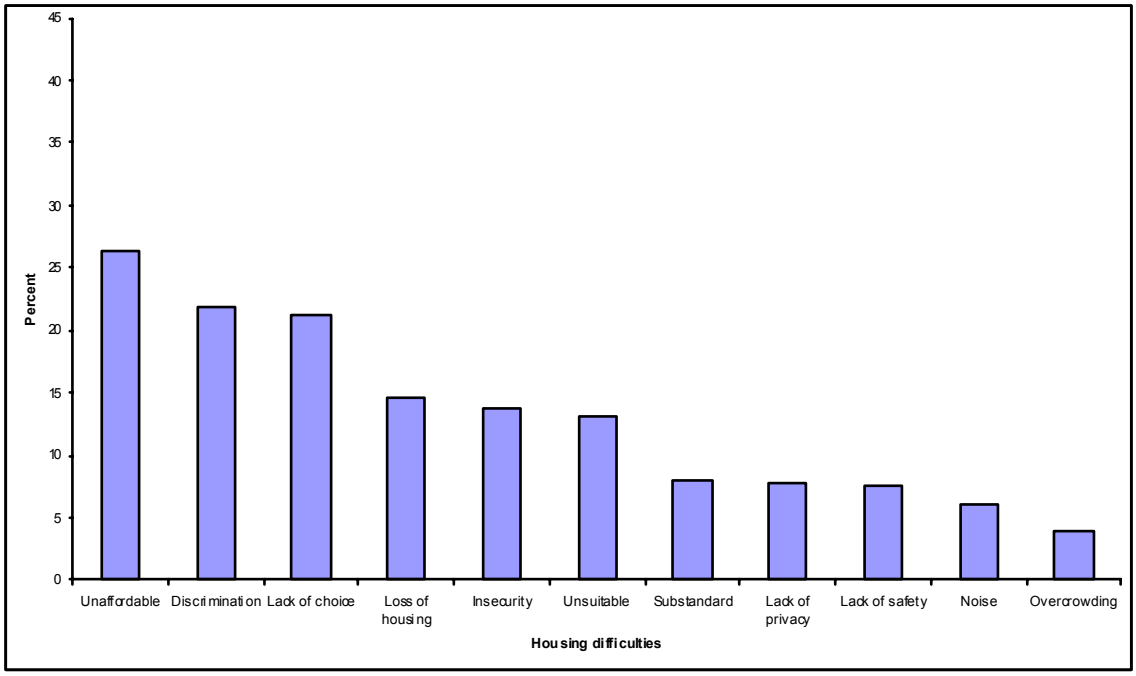
It is notable that overcrowding was, on average, scored low by providers for non-Māori and non-Pacific (i.e. all Other) consumers/tangata whai ora.

Exposure to excessive noise, although rated less highly by providers in relation to all groups, was still found to affect some consumers. To some degree, excessive noise is a product of lack of privacy, substandard physical conditions and overcrowding.

Item score – most - results

If the housing difficulty items (see Graph 6) for Other consumers are presented in terms of percentages of providers indicating that **most** of their consumers were affected by particular difficulties a pattern emerges that is different again from either that reported for tangata whai ora or for Pacific consumers.

*Graph 6: Percentage of providers reporting **most** of all Other consumers experiencing housing difficulties*



Overall, the percentage of providers reporting that **most** of their all Other consumers were in various kinds of housing difficulty was lower than for either Māori or Pacific. It is notably lower than for Māori on the three top scores: 43 per cent of providers reported **most** tangata whai ora lacked choice in their housing options whereas only 21 of providers noted this as a problem for **most** Other consumers; 41 per cent of providers reported **most** tangata whai ora found housing unaffordable but only 26 per cent reported it was a problem for **most** Other consumers; and 29 per cent of providers reported that discrimination

affected **most** tangata whai ora whereas 22 per cent of providers reported that it affected **most** of all Other consumers.

Unaffordability of housing relative to income and medical costs was noted by the highest percentage of providers (26 per cent). **Discrimination** in finding and retaining housing was clearly ranked second (noted by 22 per cent of providers) and **lack of choice** about housing options ranked third (noted by 21 per cent of providers).

Apart from unaffordability, discrimination and lack of choice, which were identified by the highest percentage of providers as being problems for **most** of all other consumers, there was a cluster of second order problems identified for Other consumers.

Loss of accommodation during acute illness or hospitalisation (15 per cent), insecurity of tenure (14 per cent) and unsuitable location relative to support and/or family/whānau (13 per cent) were all identified by providers as affecting **most** Other consumers.

There was a larger number of items that a smaller percentage of providers noted as being difficulties for Other consumers, than for either tangata whai ora or Pacific consumers. Only 8 per cent of providers reported that substandard housing, lack of privacy and lack of personal safety was an issue for **most** Other consumers. Exposure to excessive noise was reported by 6 per cent and overcrowding by 4 per cent.

This either reflects different perceptions by providers offering services to the wider population, or is a reflection of the extent to which Māori and Pacific consumers/tangata whai ora are significantly more disadvantaged in relation to housing need.

There is considerable room for speculation about the reasons for the scale score results across all groups. There is a need for greater in-depth research into the proportions of consumers/tangata whai ora experiencing particular kinds of housing difficulty, the reasons for it, and the degree of regional variation across the country. Such research would complement and supplement the more locally based work carried out by Kearns and Smith (1994) (see *Part 3 – A Literature Review*) that provided the basis for the scale items when the MSD survey was developed.

While there was some variation in the scale scores in general, on average they indicate that providers perceived between **some** and **about half** of all consumers/tangata whai ora were experiencing problems on each of the different measures of housing difficulty.

Providers' perceptions of regional differences

The scale scores were calculated for each DHB area to see if there were any noticeable variations in the responses between one part of the country and another.[32]

[32] In DHB areas where the return rate was low, the figures derived for the average scale scores have been discounted (this includes Lakes, Taranaki, Wairarapa, South Canterbury and the West Coast in particular). In most cases, reporting relates to the three top rankings (except where more than three had an average

The unaffordability of housing relative to income and medical costs

The cost of housing was ranked as a factor affecting a higher proportion of consumers/tangata whai ora in some areas than in others. For Māori consumers, those areas appeared to be widespread: Mid Central, Northland, Whanganui, Canterbury, Counties Manukau, Auckland, Hawkes Bay, Hutt, Nelson/Marlborough and Waikato.

For Pacific consumers, Auckland, Counties Manukau and Waikato were identified by providers (although, once again these scores may simply reflect the higher level of reporting on Pacific consumers from these areas). No information was available for Pacific consumers for Mid Central or Tairawhiti.

For Other consumers, Nelson/Marlborough was indicated as having the highest proportion of providers perceiving cost constraints on housing for consumers, but all other areas also indicated some evidence. The appearance of Nelson/Marlborough as an area of unaffordable housing for consumers other than Māori and Pacific may need further investigation, but it may reflect the presence of high numbers of over 65-year-olds in the population and relatively high levels of unemployment, coupled with so-called lifestyle choices of people who have moved to Nelson/Marlborough from other areas.

Lack of choice in housing options

The lack of choice in housing options is a problematic notion for a number of reasons. The first is that people on low incomes generally do not have much choice in housing options. Nor is it usually considered unusual that there is not much choice.

Second, and this is a more abstract point, notions of the deserving and undeserving poor[33] are embedded in public notions of welfare recipients in a way that ensures that the discourse of 'choice' often sits uneasily with the discourse of 'benefit entitlement'. There is an implicit assumption that receipt of a 'benefit' precludes a person's right to 'choice' in that benefit recipients are 'undeserving' and therefore do not deserve to have choice.

Third, 'choice' is very much tied to expectation and cultural preference, and these are not aspects that have been able to be explored in this survey. It is another area where further research could be useful.

For people who experience mental illness, however, housing 'choice' is very much a part of the suitability of housing and local environment for wellbeing and potential recovery (as is discussed in *Part 3 – A Literature Review*).

Bearing these issues in mind, the data do indicate some elements of regional difference in relation to housing choice. Providers of services to Māori tangata whai ora indicate that lack of housing choice is a widespread problem that affects a high proportion of consumers in Northland, Mid Central, Capital & Coast, Hutt, Waikato, Bay of Plenty, Tairawhiti and in Hawkes Bay. Providers to Pacific consumers indicated the problem of choice affected the highest proportions of consumers/tangata whai ora in Capital & Coast and the Waikato.

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scale score of more than 2) for each item in each DHB area. These rankings are examined only in relation to unaffordability, lack of choice, discrimination, and substandard housing.

[33] See, for example, Gilens (1999).

Providers of services to Other consumers/tangata whai ora reported less often (at the regional level) that lack of choice in housing options affected most consumers. Areas that stood out were Nelson, Canterbury and the Bay of Plenty.

Discrimination

At a regional level, evidence of discrimination in relation to finding and retaining housing is hard to assess. Although the average scale scores do point to some differences between areas, it difficult to know what providers may have been identifying as the particular causes of discrimination in their own particular environments that would lead them to report that a high proportion of consumers tangata whai ora experienced discrimination as a problem.

Few areas stood out as having a problem with discrimination that affected a high proportion of consumers/tangata whai ora, but the notable examples were: for Māori, the areas of Mid Central, Waitemata, and Hawkes Bay; for Pacific peoples, the Waikato, and for Other consumers the Hawkes Bay was reported.

Substandard physical conditions

Higher rankings for the Waikato, Northland, Mid Central, and Hawkes Bay DHB areas identified these as areas where substandard housing for Māori tangata whai ora was more easily noticed. Predictably (because of the higher populations of Pacific people in the areas specified), the Counties Manukau, Waikato and Capital & Coast DHB areas indicated higher rankings for Pacific consumers/tangata whai ora. No areas particularly stood out in terms of substandard housing for Other consumers/tangata whai ora.

5. Homelessness and transience

The final section of the survey attempted to collect information about the extent of homelessness and transience amongst people who experience mental illness. A definition of homelessness and transience was set out in the survey (see Table 2 below) and providers were asked to ensure that the numbers they gave matched the numbers they had already given in response to Questions 13-15 about total numbers of consumers/tangata whai ora by ethnicity. Providers were also asked to assess again the level of confidence they had in their own responses (see later reporting). Again, the caveats regarding the potential for double-counting and under-counting need to be borne in mind. Many studies of homelessness in New Zealand and overseas identify that consumers/tangata whai ora make up only a portion of the homeless population (see *Part 3 – A Literature Review*).

For the purposes of this study, homelessness was defined in accordance with what consumers/tangata whai ora reported constituted homelessness for them.[34] It was defined broadly to include consumers/tangata whai ora living in

[34] The issue of what constituted homelessness was discussed by consumers/tangata whai ora in the one-day workshop (see *Part 2 – Expert Voices*) and in the group interviews (see *Part 4 – Group Interviews*). Although official definitions of homelessness in New Zealand refer to the situation of people having to live out of doors ('rooflessness') or 'without walls' consumers/tangata whai ora rejected this narrow definition. For example the Ministry of Housing (online) states: "Literal homelessness is extremely difficult to measure, although it is not a major problem in New Zealand by international standards. The number of people who reported 'No Fixed Abode' in March 1996 was 964. Where homelessness does occur in New Zealand, it is often linked to psychiatric disability or illness and is temporary in nature" (*The New Zealand Housing Situation*).

temporary or emergency accommodation, as well as those living 'without walls' or in no fixed abode. Residential mobility or transience was included in the discussion with homelessness, because the two factors are closely inter-related in the consumer/tangata whai ora population. Not having security of tenure, either because of factors associated with housing unsuitability or because of discrimination in the housing market or other reasons, means that consumers/tangata whai ora often move from one place to another. There is evidence (see *Part 3 – A Literature Review*) that high levels of residential mobility are often a precursor to 'literal homelessness'. The definition used in the survey appears in Table 2.

Table 2: Definition of homelessness and transience as used in the national survey

Homelessness/transience refers to**:**
either

- being without shelter of any kind
- having 'no fixed abode'
- or 'sleeping rough',
- **or**
- living in emergency and temporary accommodation (which may include night shelters, boarding houses and hostels).

Homeless consumers/tangata whai ora also includes those**:**

- remaining in residential institutions simply because there is no suitable alternative accommodation, and
- those living in temporary or insecure accommodation that is unsuitable for long-stay.

In New Zealand, it is difficult to identify homelessness through either mental health statistics (because it is a housing issue) or housing statistics (because mental health status remains confidential).[35]

Estimates of numbers

Comparison with two other empirical studies is set out below as well as some additional information about homelessness and transience by ethnic group.

The situation in the lower North Island

It was more difficult to assess the reliability of the data in relation to homelessness and transience as the information collected from this section of the survey was less complete than elsewhere. Fewer respondents provided information and the information that was provided did not appear to be completely accurate.[36]

[35] Although some consumers/tangata whai ora prefer to live in boarding houses as a long-term housing option because it does not tie them down too much, many are doing so only because it is a financially feasible option.

[36] One strategy for determining accuracy in the survey data were the requirement that the figures provided in response to one set of questions were matched against the figures provided in response to another set. For example, providers were asked to "please check that the combined total for Section D, plus the total for Section E is the same as total A".

In order to assess the reliability, we compared the results collected in the survey with the University of Otago study (2000). We also referred to a second study (Buttle 1999) which, although not directly comparable, also provided further insight into the extent of homelessness for consumers/tangata whai ora.

The University of Otago (2000) study identified that of those with severe mental illness in the Central HFA region (now defined by Capital & Coast, Hutt, Wairarapa, Mid Central, Hawkes Bay, Tairawhiti, and Whanganui), lack of accommodation was a 'serious need' for 155 people who experience mental illness. There was no clear indication in the Otago report that these 155 were 'homeless' but we have assumed that its definition of 'serious housing need' conforms with our definition of homelessness.

Buttle (1999) identified 299 mental health consumers and 100 people with drug and alcohol abuse problems in Wellington, Auckland and Christchurch who were 'living in the open or in public areas or accessing shelters' i.e. 399 were 'homeless' by our definition. Buttle's study of homelessness in Auckland, Wellington and Christchurch is not directly comparable, as his figures only refer to metropolitan areas.

The NGO providers in the MSD national survey reported 198 consumers/tangata whai ora who were homeless for the seven areas that were part of the Central Regional Health Authority (RHA) region. Providers from five of the seven DHBs in the same area reported 291 consumers/tangata whai ora to be homeless. The figure reported from the NGO data is not dissimilar to the 155 identified in the Otago research, but the DHB figure is almost twice as large and was derived from data where two DHBs had provided no information at all. We already know that the DHB data are more likely to be comprehensive than the NGO data, as almost twice as many consumers were reported on by DHBs overall than by the NGOs and most of the NGO responses came from small providers.

There are some further important caveats to this information. Only 36 per cent of DHB services which returned data gave complete information in response to the homelessness questions. Of those DHBs that responded, only three of the returned surveys represented large services (with more than 100 consumers/tangata whai ora). These caveats would suggest that there was more under-reporting in the homeless and transience section of the survey than in other parts of the survey.

Although the quality of data from the DHBs was poor because of incompleteness, the reported level of homelessness from those that did provide quality data was higher than that suggested by either the Otago study or the Buttle study.

Numbers of homeless and transient by ethnic group

Overall, the DHB respondents in the survey reported that 48 per cent of the homeless were Māori, 6 per cent were Pacific people and 46 per cent were Other consumers/tangata whai ora. The proportions were similar for the figures reported by the NGOs but a slightly higher percentage were Māori (49 per cent), a significantly higher percentage were Pacific people (10 per cent) and a consequently lower percentage (40 per cent) were Other consumers/tangata whai ora.

The estimate that 48 per cent of tangata whai ora reported by DHBs were homeless and transient does not allow for any regional disaggregation. There is some indication that areas with high numbers of Māori in low decile areas in the general population are likely to have high levels of homelessness and transience amongst the consumer/tangata whai ora population who live in those areas.

As could be expected, the highest concentrations of the 6 per cent homeless and transient who were Pacific consumers appear to be in areas where there are concentrations of Pacific people in the general population: Capital & Coast, Counties Manukau and Auckland.

A regional breakdown of the 46 per cent of Other consumers/tangata whai ora who were homeless and transient indicates they appear to be concentrated in the Capital & Coast, Canterbury and Auckland DHB areas. Given the reservations about the quality of the data from the survey, further research would be needed to confirm these observations about the regional distributions of homelessness and transience amongst consumers/tangata whai ora.

Of the 162 providers who responded to the questions about which ethnic group was most seriously affected by homelessness and transience, 86 providers (51 per cent) indicated that it was most serious for tangata whai ora. Only seven (4 per cent) of the providers suggested that the Pacific group was most seriously affected. A further 69 providers (41 per cent) suggested that Other consumers were most seriously affected. Once again, the low rate of reporting on Pacific consumers/tangata whai ora may have skewed this result. Five (3 per cent) providers noted that more than one group was most seriously affected. A further 10 providers reported that they did not know; 28 stated that the question was 'not applicable' and 130 providers did not respond to the question at all.

The gender breakdown, although incomplete in terms of responses (116 providers did not respond to this question), clearly revealed that providers believed males to be more seriously affected than females by homelessness and transience. Of the 188 providers who responded to the question about sex and homelessness, 139 providers (74 per cent) identified that the issue was most serious for men compared with 39 providers (21 per cent) identifying it for women. A further 10 providers (5 per cent) suggested that both males and females were affected.

It is perhaps unsurprising that providers did not identify female consumers/tangata whai ora or female sole parents as having particular difficulties with homelessness, although the problems facing both males and females were discussed in the group interview discussions (see *Part 4 – Group Interviews*). The analysis of the literature (see *Part 3 - A Literature Review*, especially Bines (1997) and Hutson and Clapham (1999)) indicated that women, particularly women with children, are more likely than men to achieve temporary solutions to their homelessness by staying with friends and relatives. Only young, single white women's homelessness patterns resembled men's. To a large extent, therefore, women's homelessness problems are less likely to be visible to providers than men's.

Although there was also a clear consensus amongst providers about the age group most affected by issues of homelessness and transience, this response is muddied by the few returned survey questionnaires that reported on the

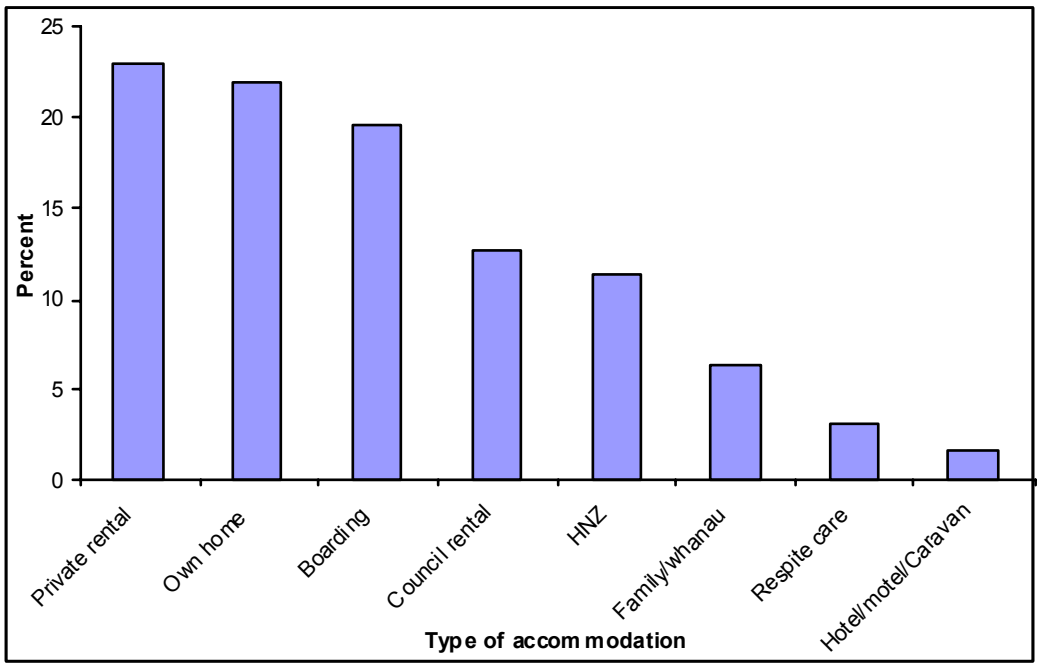
situations of either younger (19 years and younger) or older (over 65 years) consumers/tangata whai ora. Of the 198 providers who responded to the question about age and homelessness, 171 providers (86 per cent) indicated that homelessness and transience most seriously affected people between the ages of 20 and 64 years. Twenty-one providers (11 per cent) identified homelessness and transience as an issue that most seriously affected young people and three providers suggested that it was an issue that most seriously affected older people.

The lack of sound age-related data indicates that this also is an area where more research is needed to determine what influence age has on the experience of homelessness and transience.

6. Types of accommodation

The final section of the survey (Questions 39-40) sought to establish a picture of the kinds of accommodation currently occupied by consumers/tangata whai ora around the country, and the degree of confidence that providers had in their knowledge of the type of accommodation occupied by consumers/tangata whai ora. At best this data is indicative, as many providers (37 per cent) either did not respond, did not know or reported that the question was 'not applicable'. Furthermore, their confidence ratings were low. Only 32 per cent of providers were highly confident of the information they supplied in relation to the types of accommodation consumers/tangata whai ora occupy. This is unsurprising, as providers do not typically collect this information.

Graph 7: Providers' reporting of types of accommodation occupied by consumers/tangata whai ora



The categories used in the survey and reported in Graph 7 were:

- Private rental accommodation (Private rental)
- Privately owned home (Own home)
- Boarding houses or hostels long term (Boarding)
- Council rental accommodation (Council rental)
- Housing New Zealand rental accommodation (HNZ)
- Arrangements with family/whānau, friends or carers long term and not of their choice (family/whānau)
- Respite care (Respite)
- Hotels, motels, caravan parks, B&Bs long term (hotel/motel/caravan

In the 1996 Census 22 per cent of the total population were reported as living in rental or leased accommodation compared with 68 per cent who lived in "owned (with and without mortgage) homes".[37] The home ownership rates of consumers/tangata whai ora look low by comparison. Similarly, the 69 per cent of consumers/tangata whai ora reported in the survey as living in one form of rental accommodation or another (private rental, boarding, council rental, HNZ or hotel/motel/caravan) compares with the picture of 32 per cent (1996 Census) for the general population. In other words, the survey estimates suggest that twice as many consumers/tangata whai ora are living in rental accommodation compared with the general population.

Accommodation service provision

In this section, the provision of mental health and accommodation-related services offered by mental health service providers is reported.

Mental health services

One of the issues that has an impact on the kind of housing support that is available to people who experience mental illness is the relationship between Health-funded services and Housing-funded services. Most consumers/tangata whai ora access their support systems through the mental health system. Those who access residential rehabilitation care have some experience of being housed as part of their package of clinical (mental health) services. It is unclear how broad the brief of mental health funding is in relation to accommodation-related services, but housing is certainly not core business for the Health sector.

A range of mental health service descriptors are listed in the mandatory reporting schedules for DHB and NGO mental health service providers, but no accommodation services other than residential care options are listed as part of this schedule (see Table 3). These standard service descriptors were used in the survey to gain an understanding of the kinds of services offered by providers.

The MSD survey responses indicate that (of the 30 services in the schedule), activities such as Activity-Based Rehabilitation/Day Activity and Living Skills are offered by the largest number of providers (235) along with Community Mental Health Services (180) and Family/Whānau Support Services (154) (see Table 3 for the most frequently reported services provided by the survey respondents).

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[37] Statistics New Zealand 2000:116.

Residential services vary in relation to the specialist nature of the service. For example, 'Residential Long-term Services' were reported by 101 providers while 'Residential Alcohol and Drug Services' by only 25 providers.

Other specialist services such as Eating Disorder Service/Inpatient (15), Pacific Island Mental Health Services (16) and Mother and Baby/Inpatient Services (16) are offered by fewer providers.

Table 3 shows the number of providers that offered mental health services by the type of service provided. The results are ranked from most to least frequently reported.[38] The far right column indicates the percentage of respondents who indicated they provided these services.

Table 3: Type of mental health service provision ranked by most frequently reported service

Mental health service descriptor	**N°**	**%[39]**
Activity-Based Rehabilitation Service/Day Activity and Living Skills	235	46
Community Mental Health Service	180	35
Family/Whānau Support Service	154	30
Liaison/Consultation Service	126	25
Crisis Intervention	125	24
Respite Services/all types	120	23
Residential Rehabilitation/all levels	113	22
Home-Based Support Services	107	21
Kaupapa Māori Service	104	20
Community Alcohol and Drug Service	101	20
Residential Long-Term Service	101	20
Needs Assessment and Service Co-ordination	98	19
Dual-Diagnosis Service	95	19
Early Intervention for Young People	90	18
Work Rehabilitation/Employment and Education Support Service	80	16
Clinical Rehabilitation Service/ Community	75	15
Consumer-Run Support Service	75	15
Clinical Rehabilitation Service/Inpatient	63	12
Acute Inpatient Service	62	12
Nga Oranga o Te Reo/Kaupapa Māori Community Support Workers Service	41	8
Day Hospital Programme/Community	39	8
Eating Disorder Service/Outpatient	35	7
Intensive Care Service/Inpatient	33	6
Mirimiri and Rongoa	33	6
Mobile Intensive Treatment	31	6
Maternal Mental Health Service	28	5
Residential Alcohol and Drug Service	25	5
Mother and Baby/Inpatient	16	3
Pacific Island Mental Health Service	16	3
Eating Disorder Service/ Inpatient	15	3

It is possible that less frequently provided services may be centred in particular geographic locations. Consumers/tangata whai ora in an area that does not offer the service would therefore have to travel to access the service they need. There was some evidence for this.

[38] Providers were given the option to specify other services that were not listed in the common schedule. Of the providers on the dataset, 69 listed additional services. A further 15 services were listed by providers who were not eligible for dataset entry, but did provide mental health services.

[39] NB: Percentages will not add to 100 per cent because providers could report on more than one service.

- Although there appear to be at least 16 Pacific Island Mental Health Services, these were reported in only eight DHB areas. Pacific consumers in other DHB areas may not therefore have access to appropriate services.
- Mother and Baby/Inpatient services were reported in 11 of the 21 DHB areas, suggesting that consumers/tangata whai ora giving birth may not have access to specialist mental health service support in the area where they live.
- Specialist Residential Alcohol and Drug Service were reported by 14 of the 21 DHB areas and were particularly concentrated in Canterbury DHB (which includes Hanmer).

Although it is now commonplace for many New Zealanders to have to consider travel to access specialist medical services, the impact of this on people who experience mental illness may be threefold. First, their financial resources are often already stretched and travel is expensive. The cost of travel must also be factored into the generally low levels of discretionary income that many consumers/tangata whai ora have – given that many consumers/tangata whai ora are benefit recipients or in low- wage, part-time employment. Money spent on travel has to be set against money available for accommodation. Second, the support of family/whānau and known caregivers is often an important part of maintaining wellbeing and recovering from mental illness, and distance creates barriers between the consumers/tangata whai ora and their support systems. Third, the potential loss of housing and possessions during an acute episode or a period of residential care may be exacerbated by the consumer/tangata whai opa being at some physical distance from their house and chattels.

Accommodation services

Many providers reported that they offered more direct accommodation-related services to consumers/tangata whai ora in addition to the mental health services listed above. A large proportion of providers (93 per cent) reported the need for more accommodation services to help consumers/tangata whai ora access and retain independent housing.

Of the 513 providers in the dataset, 59 per cent reported that they also provided accommodation support services. This suggests that accommodation support is a relatively important service that is provided by slightly more than half of all the mental health service providers. Furthermore, 121 providers (41 per cent) identified that they offer housing-related services that are not part of their contractual funding.

Table 4 categorises the accommodation-related services into two groups, *Liaison/advocacy* and *Practical help* and reports the numbers of providers who offered each service.

Of those providers who offered services, 97 per cent indicated that they offered one or more of the liaison/advocacy services for consumers tangata whai ora whereas less than half of providers (48 per cent) indicated they offered practical help. Practical help was often identified in the group interviews as a current service gap (see *Part 4 - Group Interviews*).

Apart from identifying that all 14 of the listed services were provided to some extent, 39 providers listed a range of other services that they provided. These were also weighted in favour of liaison/advocacy services, with 17 providers listing variations such as: "Support in accessing the community", "Support the consumer till they're settled in", "Support in preparation for living in the community", "Community re-integration", "Ongoing support after exit from residential services", "Clinical support", "Contact on a regular basis", "Referral to appropriate others to implement support", "Referral to other agencies", "Brokerage access to other services", "Referral to appropriate service", "Support interviews to get housing in HNZ house", "Advocacy/support", "Landlord liaison (start-up only)", "Case managed weekly visit (as landlord)", "Social worker advice and assistance with accommodation difficulties/access to appropriate accommodation support providers", "Social work support" and "Forensic social workers provide some accommodation support".

Table 4: Types of accommodation-related services and numbers of mental health service providers offering each service

Liaison/advocacy	**N°**	**%**	**Practical help**	**N°**	**%**
Assistance to find a place to live	**258**	**50**	Fire safety equipment (provision and maintenance e.g. smoke alarms	**69**	**13**
Assistance with establishing support networks	**260**	**51**	Furniture pool	**43**	**8**
Budget advice	**204**	**40**	Laundry service	**29**	**6**
Help with accessing benefits	**263**	**51**	Lawn mowing and gardening	**55**	**11**
Help with power and phone connections	**188**	**37**	Rubbish removal	**43**	**8**
Help with accessing DWI re-establishment grant	**156**	**30**	Shifting household goods	**104**	**20**
Landlord liaison	**160**	**31**	Spring cleaning	**52**	**10**

Six providers offered practical support, listing such things as:

- a returns bin for sharps [a receptacle for used needles];
- clothing;
- provision of temporary accommodation;
- activities of daily living;
- repairs to homes; and
- assistance to develop home management skills.

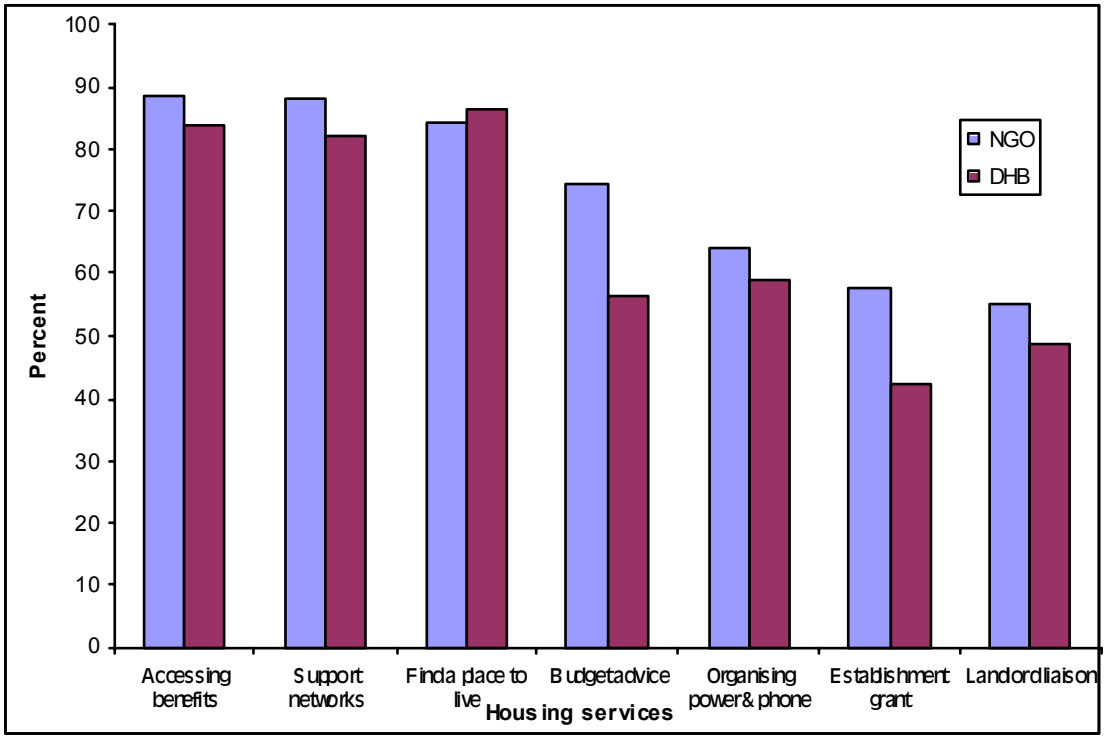
An additional four providers indicated that they offered transport services of some kind - these could also be counted as direct practical help. One provider listed "Education re mental illness" and one "Support to clients with children".

The provision of accommodation services highlights a gap that is confirmed by consumers/tangata whai ora (see *Part 4 - Group Interviews*). For many consumers/tangata whai ora, there is a useful range of services provided either by the mental health services or by supplementary accommodation-related services. The gap seems to exist in the provision of more practically oriented services to help consumers/tangata whai ora cope with very day-to-day concerns.

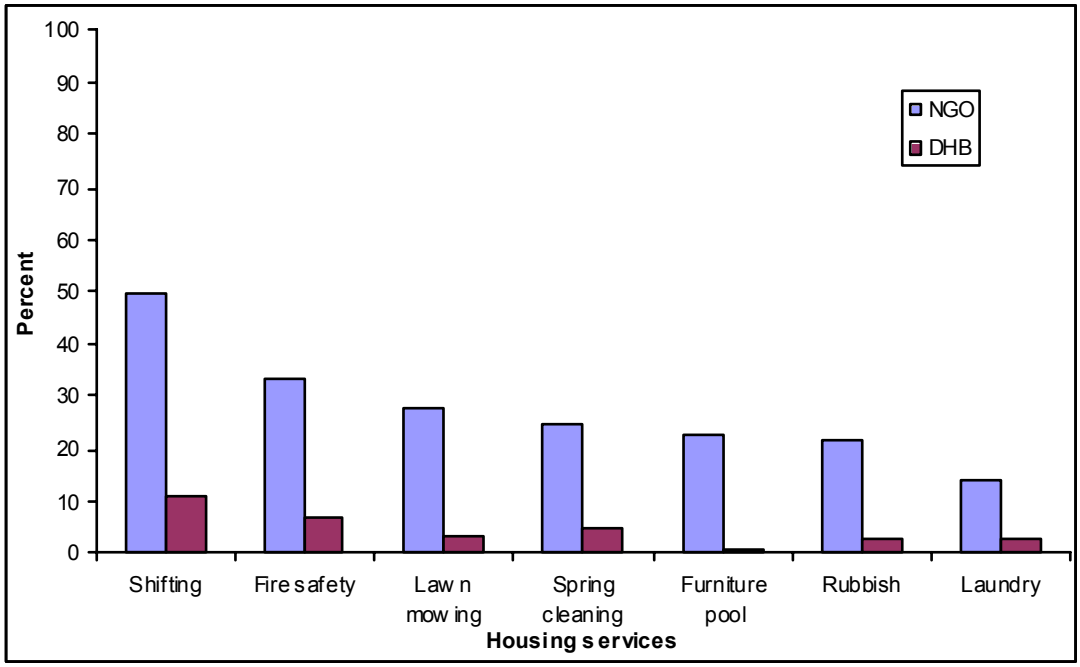
Rubbish removal may seem like the ordinary responsibility of a householder. If you do not own a car, however, if other people add to your rubbish uninvited, and if using a small or non- existent discretionary income to purchase council rubbish sacks or to pay for tip fees is not a priority, then disposing of rubbish becomes a significant issue. Many consumers/tangata whai ora report being distressed by accumulating rubbish, and it is reasonable to assume that it would also become a problem for landlords.

Graphs 8 and 9 demonstrate that many of the liaison/advocacy services are provided both by DHB and NGO services. The practical help services, however, are predominantly provided by NGO services. It is possible that DHBs have limited the extent of service delivery in areas that cannot easily be rationalised as 'mental health service' delivery.

Graph 8: Accommodation-related services in the category 'liaison and advocacy'



Graph 9: Accommodation-related services in the category 'practical help'



The accommodation services provided by groups funded through health allocations are developed on a case-by-case base.

Provider confidence in survey answers

Some assessment of the accuracy of the providers' estimates[40] of the numbers of consumers/tangata whai ora they provided services to, the numbers of consumers/tangata whai ora with housing difficulties, and the proportions of consumers/tangata whai ora experiencing different types of housing difficulties was made. Providers were asked to rate whether they felt **highly confident** (i.e. their responses were based on personal knowledge and/or official records); **reasonably confident** (i.e. their responses were based on some personal knowledge and/or some records); or **not confident** (i.e. their responses were based on limited personal knowledge) about the accuracy of the information they provided.

Generally, the mental health service providers were not highly confident of their ability to provide accurate housing-related data. This is borne out in the providers' confidence ratings that are outlined below.

- In relation to reporting total numbers of consumers/tangata whai ora experiencing housing difficulty,[41] 20 per cent[42] of providers did not respond to the question, and of those who did:
    - 36 per cent of providers felt 'highly confident' (i.e. their responses were based on personal knowledge and/or official records);

[40] A workshop held during the scoping phase of the research (see *Part 2 – Expert Voices*) elicited comments from consumers/tangata whai ora that very few providers would have a good grasp of the consumer/tangata whai ora experience of housing difficulties.
[41] Question 24 in the survey, collecting information on Questions 21-Q23.
[42] All percentages in this report have been rounded to the nearest whole number. Some calculations will not add to 100 per cent.

- 47 per cent were 'reasonably confident' (i.e. their responses were based on some personal knowledge and/or some records); and
- 17 per cent were not confident (i.e. their responses were based on limited personal knowledge).

In relation to the questions[43] on types of housing difficulties, fewer providers were confident in their knowledge of the housing experiences of consumers/tangata whai ora, and 25 per cent of providers did not respond to the question. Of those who did respond:

- 26 per cent said they were highly confident;
- 58 per cent were reasonably confident; and
- 17 per cent were not confident.

In relation to the questions on homelessness,[44] 43 per cent of providers did not respond to the question, and of those who did:

- 35 per cent said they were highly confident;
- 50 per cent were reasonably confident; and
- 15 per cent were not confident.

In relation to the questions on types of accommodation occupied by consumers/tangata whai ora,[45] 42 per cent of providers did not respond to the question, and of those who did:

- 32 per cent said they were highly confident;
- 45 per cent were reasonably confident; and
- 23 per cent were not confident.

These findings perhaps reinforce consumers'/tangata whai ora concerns that providers have little real knowledge of consumers'/tangata whai ora housing circumstances. The indication that providers have relatively little confident knowledge of the housing circumstances of consumers/tangata whai ora is an important finding. It suggests that quantification of housing difficulty at a national scale would require the collection of consumers'/tangata whai ora perceptions of their own housing difficulties.[46] [47]

The low level of provider confidence in the accuracy of their responses also reflects the absence of mandatory reporting of housing status in relation to mental wellbeing. If the contention that housing status is one of the compounding factors that impacts on mental health is taken seriously, then there

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[43] Question 31 in the survey collecting information on Questions 28-Q30.
[44] Question 38 in the survey collecting information on Questions 32-Q37.
[45] Question 40 in the survey collecting information on Q39.
[46] A similar approach of surveying providers to gain information about the circumstances of consumers/tangata whai ora has nevertheless been used in recent research: see the comments on a 1997 Health Funding Authority study conducted by North Health and a 1999 study by the University of Otago, in University of Otago (2000).
[47] It may also be possible that, because the survey was quite long, providers tired as they worked through the questions, and towards the end of the survey, they responded less often and less carefully to the questions.

may be a case for more systematic data collection, by people with appropriate skills, about housing status and housing need.

7. Summary

Numbers experiencing difficulty

The NZHIS is able to provide increasingly reliable data about the number of consumers/tangata whai ora accessing mental health services who have a diagnosed mental illness. Currently it would appear that just over 1 per cent of the population are receiving mental health services. It is possible that the MSD survey captured housing information in relation to 48 per cent of this population. The NZHIS data provides a useful benchmark for our research. The NZHIS data collection fails to capture information about those people who experience mental illness who are not receiving services. Under-reporting of housing issues for consumers/tangata whai ora who are not receiving services may be particularly pertinent to Māori and Pacific peoples. There is some suggestion from the group interview data that there are Māori and Pacific consumers who are not being clinically diagnosed under the western psychiatric health paradigm, are not receiving 'conventional' mental health services and are more invisible than non-Māori/non-Pacific peoples in terms of their housing need generated by mental illness.

The stand-alone numbers collected through the MSD survey, and these numbers when benchmarked against NZHIS figures, indicate that housing difficulty for consumers/tangata whai ora may be more widespread than previously believed. Māori and males are disproportionately affected.

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 per cent of 46,200) consumers/tangata whai ora may be experiencing housing difficulties; and
    - 2,000 (4 per cent 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 per cent of 46,200)[48] 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 and are subject to considerable uncertainty; and
- there may in addition be similarly-sized groups of people with similar conditions but not receiving treatment who are also experiencing housing difficulties, or are homeless or transient.

Information about the group of consumers/tangata whai ora who are not currently receiving services is a necessary part of any more final or comprehensive estimates of housing need for consumers/tangata whai ora.

Kinds of difficulties experienced

The survey indicates that the affordability of housing relative to income and medical costs, and the lack of choice about housing options are the two factors that affect the highest proportion of consumers/tangata whai ora. Between **some** and **most** of all consumers/tangata whai ora living independently in the community were affected. Discrimination in finding and retaining housing also affected a very high proportion of consumers/tangata whai ora.

The average scale scores used to analyse data collected in the survey highlight the issues perceived by providers to create greatest difficulty for consumers/tangata whai ora. These are:

- unaffordability
- lack of choice in housing options;
- discrimination;
- unsuitable location relative to support services or family/whānau; and
- for Pacific consumers/tangata whai ora, overcrowding.

Other issues, such as loss of housing during acute illness or hospitalisation, insecurity of tenure, lack of privacy, lack of personal safety, and substandard physical conditions were all difficulties that providers reported being experienced by some or about half of all the consumers/tangata whai ora with whom they dealt.

There is a perceived regional variation in the experience of different kinds of housing difficulty, but further research would be needed to confirm this in any useful detail.

Although providers were not highly confident in their knowledge of the kinds of accommodation in which consumers/tangata whai ora live, they confirmed that

[48] Note that this 17 per cent is different from the 31 per cent cited on page 20 as not living in either privately owned houses or in rental accommodation 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.

disproportionate numbers (compared with the general population) lived in rental accommodation. Rental accommodation, apart from often providing an insecure tenancy, can expose consumers/tangata whai ora to discrimination, lack of privacy, substandard physical conditions, exposure to excessive noise, and to the potential loss of their accommodation during periods of illness.

Accommodation service provision

There appears to be a wide range of accommodation-related services offered by mental health service providers to consumers/tangata whai ora around the country. What the survey does not show is the extent to which consumers/tangata whai ora use the services provided or just get by, not accessing services that may be available in their local areas. A different survey instrument, one that collected information directly from consumers/tangata whai ora, would be needed to assess this.

There seems to be a service gap in terms of 'practical help' for consumers/tangata whai ora that is being partly met by NGO services, that may not be wellfunded (or funded at all) for this work. A lack of coherent funding arrangements may have implications for the continuity of the service, as well as being stressful for organisations and their clients if services are disrupted because of lack of resources.

Confident information

Mental health service providers have little confident knowledge of the housing difficulties of consumers/tangata whai ora. They are not required to collect housing-related data, and even though many providers work closely with consumers they do not have recourse to any records of their housing circumstances. Providers are also not confident about the extent of homelessness and transience amongst the consumer/tangata whai ora population.

More accurate knowledge about the extent of housing difficulty for consumers/tangata whai ora living independently in the community would require some kind of informed, mandatory reporting on housing issues, or at least some detailed research that targets consumers/tangata whai ora rather than health service providers.

8. Conclusion

The MSD national survey of providers asked service providers to access administrative data about the consumers/tangata whai ora to whom they provided services, and the kinds of services their organisations provided. The process of collating the data from administrative records seemed to be easy for some respondents but not for others.

There are a number of areas where further research could confirm or dispute the findings from this research. A number of specific research avenues have been identified here, including research that is aimed at assessing the experience of:

- people who experience mental illness but are not consumers/tangata whai ora (i.e. who are not currently in receipt of services) in order to develop informed comment on their housing circumstances; especially Māori and Pacific consumers who are not being clinically diagnosed under the western psychiatric health paradigm, are not receiving

'conventional' mental health services and are thus invisible to the mental health system in terms of their housing need generated by mental illness;

- both younger and older consumers/tangata whai ora who fall outside some of the existing parameters of mental health service delivery;
- overcrowding for Pacific consumers/tangata whai ora;
- particular kinds of housing difficulty, the reasons for them, and the degree of regional variation across the country;
- how the contracting environment of the past few years has shaped the configuration and scope of service delivery;
- expectation and cultural preference in relation to housing for consumers/tangata whai ora, and in particular how this impacts on notions of housing 'choice'; and
- regional differentiation in relation to different kinds of housing difficulty and homelessness and transience amongst consumers/tangata whai ora.

The main results from the survey have been integrated into the summary report in this series (see Part 1 this series). A number of factors that the survey alludes to, however, are not highlighted in the summary report because the data are not considered to be robust enough to support more detailed analysis. A further research suggestion, therefore, would be to re-examine some of the relationships indicated in these findings. In particular, the following areas of research would help develop a more complete picture of the housing needs of consumers/tangata whai ora living independently in the community:

- an examination of the relationship between clinical and non clinical services and the extent to which a mix of services provides the best support for consumers/tangata whai ora living independently in the community;
- the significance of housing 'choice' for maintenance of wellbeing;
- the extent to which the inter-relationship of housing difficulties compounds the experience of housing difficulties and which housing difficulties are most intractable;
- the relationship between homelessness/transience, the experience of mental illness and difficulties experienced in the conventional housing markets; and
- the relationship between poverty and poor housing for people who experience mental illness.

The survey results, coupled with the findings from the group interviews and recent reports, form part of an overall picture. This picture confirms that although poor housing is already known to have negative implications for mental health recovery, serious housing problems for consumers/tangata whai ora persist – housing problems that are connected with their experiences of mental illness.

The survey results also contributed to the development of the sustainability framework as outlined in *Part 1 – A Summary of the Research*, *and Part 3 – A Literature Review.*

Appendix 1 – The survey

A Survey of Mental Health Service Providers

2001

Background information

The Ministry of Social Policy is collecting information about the current housing needs of people who experience mental illness (consumers/tangata whai ora) to help inform housing policy. One way this information is being collected is through a national postal survey of all mental health service providers (both HHS and NGO) throughout Aotearoa/New Zealand. The survey collects information on the type of service provision, issues of housing difficulty, and the role of support services in the retention of housing for consumers/tangata whai ora during the month of March[49] 2001.

The phrase 'consumers/tangata whai ora' is used to refer to people who experience mental illness and who are clients, customers and patients of mental health and/or alcohol and drug services.

> ***For the purposes of this survey we are interested in collecting information about consumers/tangata whai ora who live independently in the community.*** *If your service provides inpatient, residential or supported accommodation only, we would appreciate your response to Questions 1–12 and any additional comments (Question 41). You will have particular knowledge about people who move between inpatient, residential or supported accommodation and independent housing.*
>
> *The survey is conducted in accordance with the ethical requirements of the Association of Social Science Researchers.* ***Any information you provide is confidential and neither you nor your service will be identified in any way in the final reporting process. Information provided will not be used for any auditing or monitoring purposes. The surveys will be seen only by researchers working on the analysis of responses, and all surveys will be destroyed following analysis.*** *We have given each survey an identification number (top right of page). The number is not linked to your response and will not be used in any way that leads to a breach of confidentiality.*

The survey has been designed to be as brief as possible and should take less than 30 minutes[50] to complete.

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[49] March is the last month of the Jan-March three-month reporting phase for service providers to report to the Ministry of Health / District Health Boards (DHB) (formerly the Health Funding Authority (HFA)).

[50] Note that this time not an accurate estimation – most providers said it took them at least an hour while those who reported having difficulty accessing data suggested 2-3 hours was more accurate.

If you would like a copy of the results of this survey once a report has been written, please provide your service contact details on this page. To ensure confidentiality, this page is separate from the survey and you may wish to use a second sealed envelope when you return the survey to help ensure your confidentiality.

We will be following up all the surveys sent out. If you do not wish to participate in the pilot survey please return it in the self addressed envelope.

Thank you for your time.

For a copy of the results of this survey please return the cut-off slip below. This information will not be linked to your survey return.

✂……

Name of service:……..

Address:……

……

……

……

……

A Survey of Mental Health Service Providers (HHS & NGO)

on

independent housing needs and homelessness/transience of people who experience mental illness (consumers/tangata whai ora)

Key definitions as used in this survey

Consumers/tangata whai ora refers to people whose experience of mental illness disrupts the course of their lives and requires support and treatment from specialist mental health and/ or alcohol and drug services.[51] This term is used rather than clients, customers, patients or service users.

Tangata whai ora, as a phrase on its own in this survey, refers to Māori people who experience serious, ongoing and disabling mental illness requiring treatment from specialist mental health and/ or alcohol and drug services.[52]

Living independently in the community refers to the situation of consumers/tangata whai ora who are living in accommodation that is not residential/supported accommodation. Consumers/tangata whai ora living independently in the community may still be in receipt of clinical and social services on a regular basis and may receive financial support for their accommodation. Homeless and transient consumers/tangata whai ora are considered to be living independently.

Residential and supported accommodation refers to the Residential Support Services currently funded by the Ministry of Health / District Health Boards (DHB) (formerly the Health Funding Authority (HFA)). These services provide accommodation coupled with support services and are funded through levels one to four. Drug and Alcohol Residential Treatment and Drug and Alcohol Supported Living Services are also included under this definition for this survey.

Housing difficulties refer to the whole range of housing and related service access issues that consumers/tangata whai ora face. Housing difficulties include factors related to adequate, affordable, suitable and sustainable housing. Specific dimensions of housing difficulties are itemised within the survey. This term is used rather than serious housing need or unmet housing need.

The focus of this survey is on consumers/tangata whai ora who live independently in the community.

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[51] In the Mental Health Commission Blueprint this is described as a 'serious, ongoing and disabling mental illness' (*Blueprint for Mental Health Services in New Zealand*, Mental Health Commission 1998 p7).

[52] In some contexts 'tangata whai ora' is used to refer to all people who experience mental illness. We have had different advice on this and have chosen to use the composite term consumers/tangata whai ora except when referring solely to Māori.

Filter questions

The following questions have been asked and answered in the initial telephone contact. Please complete them again on this form. Thank you.

1. Does your organisation provide services to consumers/tangata whai ora:

- whose experience of mental illness disrupts the course of their lives and requires support and treatment from specialist mental health and/ or alcohol and drug services and
- who **live independently in the community**?

1 ☐ **Yes**

2 ☐ **No**

2. Does your organisation provide services to consumers/tangata whai ora:

- who live in **inpatient, residential or supported accommodation**?

NOTE: Organisations that provide services only to consumers/tangata whai ora who live in inpatient, residential or supported accommodation please answer questions 1-12.

1 ☐ **Yes → please continue**

2 ☐ **No → if you have answered NO to BOTH question 1 and question 2 please stop here and return the survey in the self-addressed envelope**

Thank you

3. Has your organisation been operating for more than three months?

1 ☐ **Yes → please continue**

2 ☐ **No → please stop here and return the survey in the self-addressed envelope**

Thank you

4. What type of service provider is your organisation? **(Please tick one box only)**

1 ☐ **Non-Government Organisation (NGO)**

2 ☐ **DHB (formerly Hospital and Health Service HHS)**

Provider location

5. What is the **main** District Health Board (DHB) locality your organisation provides services in? **(Please tick <u>one</u> <u>box</u> <u>only</u>)**
(The areas in brackets are local authorities included in each DHB locality.)

1 ☐ **Northland DHB**
(Far North, Whangarei, Kaipara)

2 ☐ **Waitemata DHB**
(Rodney, North Shore City, Waitakere City)

3 ☐ **Auckland DHB**
(Auckland City)

4 ☐ **Counties Manukau DHB**
(Manukau City, Papakura)

5 ☐ **Waikato DHB**
(Franklin, Waikato, Hamilton City, Matamata/Piako, Waipa, Otorohanga, South Waikato, Waitomo, Thames, Coromandel)

6 ☐ **Bay of Plenty DHB**
(Tauranga, Whakatane, Kawerau, Opotiki, Western Bay of Plenty)

7 ☐ **Lakes DHB**
(Rotorua, Taupo)

8 ☐ **Tairawhiti DHB**
(Gisborne)

9 ☐ **Hawkes Bay DHB**
- (Wairoa, Napier City, Hastings, Central Hawkes Bay)

10 ☐ **Taranaki DHB**
- (New Plymouth, Stratford, South Taranaki)

11 ☐ **Wanganui DHB**
(Wanganui)

12 ☐ **MidCentral DHB**
- (Ruapehu, Rangitikei, Manawatu, Palmerston North City, Horowhenua, Tararua)

13 ☐ **Wairarapa DHB**
- (Masterton, Carterton, South Wairarapa)

14 ☐ **Capital & Coast Health DHB**
- (Kapiti Coast, Porirua City, Wellington City)

15 ☐ **Hutt DHB**
- (Upper Hutt City, Lower Hutt City)

16 ☐ **Nelson Marlborough DHB**
- (Nelson City, Tasman, Marlborough)
-

17 ☐ **West Coast DHB**
Buller, Grey, Westland

18 ☐ **Canterbury DHB**
- (Kaikoura, Hurunui, Waimakariri, Christchurch City, Banks Peninsula, Selwyn, Ashburton)

19 ☐ **South Canterbury DHB**
- (Mackenzie, Timaru, Waimate)

20 ☐ **Otago DHB**
- (Waitaki, Dunedin City, Queenstown-Lakes, Central Otago, Clutha)

21 ☐ **Southland DHB**
- (Southland, Gore, Invercargill City)

If you do not know the main DHB locality your organisation provides services in, what town/city is your organisation located in?

……..……

6. Does your organisation provide services to rural areas/rural centres (population under 1000)?

1 ☐ **Yes** 2 ☐ **No**

Types of mental health service provided by <u>your service/team</u>

7. Are your services provided as part of a larger organisation (e.g. are you a team/service within a hospital or large NGO)?

1 ☐ **Yes**

2 ☐ **No**

8. What types of service(s) does your organisation provide for consumers/tangata whai ora? **(Please tick as many boxes as required). Please note: If your service/team is part of a large organisation please specify only <u>the services that your team provides</u>.**

☐ ***Activity-based Rehabilitation Service/ Day Activity and Living Skills***

☐ ***Acute Inpatient Service***

☐ ***Community Alcohol and Drug Service***

☐ ***Clinical Rehabilitation Service/ Community***

☐ ***Clinical Rehabilitation Service/ Inpatient***

☐ ***Community Mental Health Service***

☐ ***Consumer-run Support Service***

☐ ***Crisis Intervention***

☐ ***Day Hospital Programme/ Community***

☐ ***Dual-Diagnosis Service***

☐ ***Early Intervention for Young People***

☐ ***Eating Disorder Service/ Inpatient***

☐ ***Eating Disorder Service/ Outpatient***

☐ ***Family/ Whānau Support Service***

☐ **Home-based Support Services**

☐ ***Intensive Care Service/ Inpatient***

☐ ***Kaupapa Māori Service***

☐ ***Liaison/ Consultation Service***

☐ ***Maternal Mental Health Service***

☐ ***Mirimiri and Rongoa***

☐ ***Mother and Baby/ Inpatient***

☐ ***Mobile Intensive Treatment***

☐ ***Needs Assessment and Service Co-ordination***

☐ ***Nga Oranga o Te Rea / Kaupapa Māori Community Support Workers Service***

☐ ***Pacific Island Mental Health Service***

☐ ***Residential Alcohol and Drug Service***

☐ ***Residential Long-term Service***

☐ ***Residential Rehabilitation/ all levels***

☐ ***Respite Services/ all types***

☐ ***Work Rehabilitation/ Employment and Education Support Service***

☐ **Other (please specify)**

……..……..

Accommodation support services

9. Does your organisation provide accommodation support services to help consumers/tangata whai ora access and retain independent housing?

1 ☐ *Yes → please go to question 10*

2 ☐ *No → please go to question 12*

10. What types of accommodation support services does your organisation provide? **(Please tick as many boxes as required)**

- ☐ *Assistance to find a place to live*
- ☐ *Assistance with establishing support networks*
- ☐ *Budget advice*
- ☐ *Fire safety equipment (provision and/or maintenance e.g. smoke alarms)*
- ☐ *Furniture pool*
- ☐ *Help with accessing benefits*
- ☐ *Help with organising power and phone connections*
- ☐ **Help with accessing DWI re-establishment grant**
- ☐ **Landlord liaison**
- ☐ **Laundry service**
- ☐ **Lawn mowing and gardening**
- ☐ **Rubbish removal**
- ☐ *Shifting household goods*
- ☐ *Spring cleaning*
- ☐ *Other (please specify)*

.....

11. *Are all these accommodation support services that your organisation provides part of a contract with the HFA / DHB / Ministry of Health?*

1 ☐ *Yes* 2 ☐ *No*

12. *In your view, is there a need for more accommodation support services to help consumers/tangata whai ora access and retain independent housing?*

1 ☐ *Yes* 2 ☐ *No*

NOTE: If your organisation provides INPATIENT, RESIDENTIAL SERVICES or SUPPORTED ACCOMMODATION ONLY please STOP here and return the survey in the self-addressed envelope. Thank you for your participation.

Numbers of consumers/tangata whai ora

DEFINITION

This part of the survey collects information ONLY about consumers/tangata whai ora who:

- received services from your organisation in March 2001; and
- lived independently in the community for all or any part of March 2001; and
- whose experience of mental illness disrupts the course of their lives and requires support and treatment from specialist mental health and/ or alcohol and drug services.

In answering this part, please base your responses on total numbers of separate individuals rather than numbers of contacts (i.e. do not count the same person twice). PLEASE CHECK THAT THE TOTALS FOR EACH SECTION (A, B, C) ARE THE SAME.

SECTION A

13. Using the definition above what is the **total number of**: ▪ **Tangata whai ora (Māori consumers)**?	
14. Using the definition above what is the **total number of**: ▪ **Pacific consumers**?	
15. Using the definition above what is the **total number of**: ▪ **Other consumers (i.e. those who are not Māori or Pacific people)**?	

SECTION B

16. Using the definition above what is the **total number of**: ▪ **Male consumers/tangata whai ora**?	
17. Using the definition above what is the **total number of**: ▪ **Female consumers/tangata whai ora**?	

SECTION C

18. Using the definition above what is the **total number of**: ▪ **Consumers/tangata whai ora aged 0 – 19 years**?	
19. Using the definition above what is the **total number of**: ▪ **Consumers/tangata whai ora aged 20 - 64 years**?	
20. Using the definition above what is the **total number of**: ▪ **Consumers/tangata whai ora aged 65 years and over**?	

Housing difficulties

DEFINITION

This part of the survey collects information ONLY about consumers/tangata whai ora who:

- received services from your organisation in March 2001; and
- lived independently in the community for all or any part of March 2001; and
- whose experience of mental illness disrupts the course of their lives and requires support and treatment from specialist mental health and/ or alcohol and drug services.

Housing difficulties for consumers/tangata whai ora are those housing conditions that hinder mental health recovery and maintenance of wellbeing and include **any or all** of the following:

- Substandard physical conditions - that is where factors such as a poor state of repair, dampness, dilapidation, inadequate sunlight, and/or pest infestations cause discomfort
- 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
- Overcrowding
- Insecurity of housing tenure
- Unaffordability of housing relative to income and medical costs
- Loss of independent accommodation during episodes of acute care or hospitalisation
- Discrimination in finding and retaining housing.

In answering this part, please base your responses on total numbers of separate individuals rather than numbers of contacts (i.e. do not count the same person twice).

21. Using the definitions above, what is your best estimate **of the** total number of**:**

- Tangata whai ora (Māori consumers) **who had one or more housing difficulties?**

22. Using the definitions above, what is your best estimate **of the** total number of**:**

- **Pacific consumers** who had one or more housing difficulties?

23. Using the definitions above, what is your best estimate **of the** total number of**:**

- **Other consumers (i.e. those who are not Māori or Pacific people)** who had one or more housing difficulties?

24. How confident are you about the accuracy of the information you have provided in **questions 21-23** of this survey? **(Please tick <u>one</u> <u>box</u> <u>only</u>)**

- 1 ☐ **Highly confident** (responses based on detailed personal knowledge and/or official records)
- 2 ☐ **Reasonably confident** (responses based on some personal knowledge and/or some records)
- 3 ☐ **Not confident** (responses based on limited personal knowledge)

25. In your view, what group of consumers/tangata whai ora is most seriously affected by housing difficulties **(Please tick <u>one</u> <u>box</u> <u>only</u>)**

- 1 ☐ **Tangata whai ora** (Māori consumers)
- 2 ☐ **Pacific consumers**
- 3 ☐ **Other consumers (i.e. those who are not Māori or Pacific people)**

26. What sex, in your view, is most seriously affected by housing difficulties? **(Please tick <u>one</u> <u>box</u> <u>only</u>)**

1 ☐ **Male** 2 ☐ **Female**

27. What age group, in your view, is most seriously affected by housing difficulties? **(Please tick <u>one</u> <u>box</u> <u>only</u>)**

1 ☐ **0 – 19 years** 2 ☐ **20 - 64 years** 3 ☐ **65 years and over**

28. Using the definitions provided, in your view, what proportion of **tangata whai ora (Māori consumers)** experienced the following housing difficulties? **(Please tick <u>one</u> <u>box</u> <u>only</u> on each housing difficulty scale)**

Substandard physical conditions
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Lack of privacy
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Lack of choice about housing options
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Lack of personal safety
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Exposure to excessive noise
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Unsuitable location relative to support and/or family/whānau
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Overcrowding
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Insecurity of housing tenure
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Unaffordability of housing relative to income and medical costs
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Loss of accommodation during acute illness or hospitalisation
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Discrimination in finding and retaining housing
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

29. Using the definitions provided, in your view, what proportion of **Pacific consumers** experienced the following housing difficulties? **(Please tick <u>one</u> <u>box</u> <u>only</u> on each housing difficulty scale)**

Substandard physical conditions
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Lack of privacy
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Lack of choice about housing options
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Lack of personal safety
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Exposure to excessive noise
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Unsuitable location relative to support and/or family/whānau
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Overcrowding
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Insecurity of housing tenure
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Unaffordability of housing relative to income and medical costs
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Loss of accommodation during acute illness or hospitalisation
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Discrimination in finding and retaining housing
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

30. Using the definitions provided, in your view, what proportion of **other consumers (i.e. those who are not Māori or Pacific)** experienced the following housing difficulties? **(Please tick one box only on each housing difficulty scale)**

Substandard physical conditions
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Lack of privacy
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Lack of choice about housing options
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Lack of personal safety
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Exposure to excessive noise
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Unsuitable location relative to support and/or family/whānau
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Overcrowding
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Insecurity of housing tenure
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Unaffordability of housing relative to income and medical costs
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Loss of accommodation during acute illness or hospitalisation
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

Discrimination in finding and retaining housing
1 ☐ None 2 ☐ Some 3 ☐ About Half 4 ☐ Most 9 ☐ Don't know

31. You may have answered '**Don't Know**' in some of the housing difficulty scales for **questions 28-30**. We are interested in how reliable the information is for the **other** responses.

For those housing difficulties that you **did** have knowledge about, how confident are you of the accuracy of the information you have provided? **(Please tick one box only)**

1 ☐ **Highly confident**
(responses based on detailed personal knowledge and/or official records)

2 ☐ **Reasonably confident**
(responses based on some personal knowledge and/or some records)

3 ☐ **Not confident**
(responses based on limited personal knowledge)

Homelessness/transience

DEFINITION

This part of the survey collects information ONLY about consumers/tangata whai ora who:

- received services from your organisation in March 2001; and
- lived independently in the community for all or any part of March 2001; and
- whose experience of mental illness disrupts the course of their lives and requires support and treatment from specialist mental health and/ or alcohol and drug services.

Homelessness/transience refers to **either** being without shelter of any kind, that is, having 'no fixed abode' or 'sleeping rough', **or** living in emergency and temporary accommodation (which may include night shelters, boarding houses and hostels). Homeless consumers/tangata whai ora include those remaining in residential institutions simply because there is no suitable alternative accommodation, and those living in temporary or insecure accommodation that is unsuitable for long-stay.

In answering this part, please base your responses on total numbers of separate individuals rather than numbers of contacts (i.e. do not count the same person twice). PLEASE CHECK THAT THE COMBINED TOTAL FOR SECTION D (this page) PLUS the TOTAL FOR SECTION E (page 15) IS THE SAME AS TOTAL A (page 6).

SECTION D

32. Using the definitions above, what is your best estimate **of the** total number of**:**

- Tangata whai ora (Māori consumers) **who were homeless/transient?**

33. Using the definitions above, what is your best estimate **of the** total number of**:**

- Pacific consumers **who were homeless/transient?**

34. Using the definitions above, what is your best estimate **of the** total number of**:**

- **Other consumers (i.e. those who are not Māori or Pacific people) who were homeless/transient?**

35. For what group of consumers/tangata whai ora, in your view, was homelessness/transience most serious? **(Please tick one box only)**

1 ☐ **Tangata whai ora (Māori consumers)**

2 ☐ **Pacific consumers**

3 ☐ **Other consumers (i.e. those who are not Māori or Pacific people)**

36. For what sex, in your view, was homelessness/transience most serious? **(Please tick one box only)**

1 ☐ **Male** 2 ☐ **Female**

37. What age group, in your view, is most seriously affected by housing difficulties? **(Please tick one box only)**

1 ☐ **0 – 19 years** 2 ☐ **20 - 64 years** 3 ☐ **65 years and over**

38. How confident are you about the accuracy of the information you have provided in **questions 32-37** of this survey? **(Please tick one box only)**

1 ☐ **Highly confident**
(responses based on detailed personal knowledge and/or official records)

2 ☐ **Reasonably confident**
(responses based on some personal knowledge and/or some records)

3 ☐ **Not confident**
(responses based on limited personal knowledge)

Types of accommodation

DEFINITION
This part of the survey collects information ONLY about consumers/tangata whai ora who:

- Received services from your organisation in March 2001; and
- Lived independently in the community for all or any part of March 2001; and
- whose experience of mental illness disrupts the course of their lives and requires support and treatment from specialist mental health and/ or alcohol and drug services.

SECTION E

39. *Using the definitions of homelessness and transience provided on page 13, what is your **best estimate** of the **total number of** consumers/tangata whai ora, who were **not** homeless/transient, and who lived **for all or most of March 2001 in**:*

- ☐ **Boarding houses or hostels long-term**
- ☐ **Council rental accommodation**
- ☐ **Hotels, motels, caravan parks or B&Bs long-term**
- ☐ **Housing New Zealand rental accommodation**
- ☐ **Private rental accommodation**
- ☐ ***Privately owned home***
- ☐ ***Respite care***
- ☐ ***Arrangements with Family/whānau, friends or carers long-term and not of their choice***

40. How confident are you about the accuracy of the information you have provided in **question 39** of this survey? **(Please tick one box only)**

1 ☐ **Highly confident**
(responses based on detailed personal knowledge and/or official records)

2 ☐ **Reasonably confident**
(responses based on some personal knowledge and/or some records)

3 ☐ **Not confident**
(responses based on limited personal knowledge)

41. Is there anything else you would like to add? **(Please specify)** 1 ☐

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Thank you for your time

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