

MENTAL HEALTH AND HOUSING RESEARCH: HOUSING NEEDS AND SUSTAINABLE INDEPENDENT LIVING

Robin Peace¹

Susan Kell

Knowledge Management Group
Ministry of Social Development

Abstract

Research to quantify the extent of independent housing need and homelessness and transience among people who experience mental illness, undertaken by the Ministry of Social Development, was commissioned as part of an interdepartmental work programme established by the Ad Hoc Committee on Mental Health in April 2000. Questions of affordability, adequacy and sustainability of housing form the core of the research. A key outcome from the research was the development of a typology focused on the idea of “sustainable housing” for consumers/tangata whai ora. The discussion of the framework provides a backdrop for the presentation of the research findings in which the extent and nature of housing are discussed, the role of support services in the retention of housing summarised, and information about specific groups affected by housing need is put forward. The evidence from the research suggests that there is a need for systematisation of support services for consumers/tangata whai ora and that developing a coordinated inter-agency strategic framework for resource allocation and service provision to this group is a necessary step towards ensuring the sustainability of independent housing.

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INTRODUCTION

This paper summarises research undertaken by the Research Unit of the Ministry of Social Development (MSD) between July 2000 and August 2001. The research responded to a Cabinet directive to quantify the independent housing need, and homelessness and transience of consumers/tangata whai ora.² Although the immediate function of the research was to inform Government and the initial audience for the findings was government officials, the outcomes from the research have relevance for a wider audience.

An extensive review of the literature³ identified several key New Zealand documents:

- the Mental Health Commission (MHC) publications establishing the MHC *Blueprint for Mental Health Services in New Zealand* (1998) and related publications updating progress with service provision;
- the 1998 report, *Housing and Housing Support for People with Mental Illness*, by Paine;
- the MHC's 1999 discussion paper, *Housing and Mental Health: Reducing Housing Difficulties for People with Mental Illness*; and
- Bennion's (2000) report, *Planning Processes for Providing Supported Accommodation for People with Mental Illness*.

The New Zealand research into the experience of mental illness and the effectiveness of services available to consumers/tangata whai ora has taken place in the context of findings that the experience of mental illness and housing difficulties are linked. The widespread acceptance of the link between the two is exemplified by the Mental Health Commission in its 1999 *Discussion Paper*.

Recovery [from mental illness] requires specific housing arrangements that combine support, a quality physical environment and suitable local environment. These arrangements may include:

- coordination of support, clinical services and housing;
- assistance to make "wise housing choices";
- help from time to time in managing the day to day responsibilities of

² During a scoping workshop with consumers of mental health services, a preference was expressed for the term "consumers/tangata whai ora" when referring to people with mental illness. Advice from Te Taura Whiri i te Teo Māori is that "whai ora" means "in search of well-being. This term is used throughout the remainder of this paper.

³ Ministry of Social Development (forthcoming). The literature review included New Zealand and international material from a number of different categories, including technical research reports; books; refereed journal articles; online material from a variety of organisations; New Zealand and other governments' policy and research reports; reports from semi-autonomous government bodies such as the Mental Health Commission; evaluation reports of service delivery models and programmes; and non-government (NGO) lobby publications.

- housekeeping, budgeting and maintaining a house;
- being handy to shops, community facilities, support services and clinical services;
- availability of social support networks (friends and relatives and community);
- meeting needs for living alone or with others;
- empowerment to choose living arrangements; and
- physical comfort, safety and privacy. (Nelson et al. 1998)

The recovery requirements described above were used in conjunction with the Kearns et al. (1991, 1992, 1993) housing stressors, to shape the MSD national survey of 800 mental health service providers paid by the District Health Boards (DHBs). This paper focuses on the findings from this national survey of providers and the group interviews with 190 consumers/tangata whai ora and providers, which together comprised the research fieldwork.

In the following section, we discuss the main challenges presented by the project, the methodological constraints, key concepts and terms, and introduce the conceptual framework for subsequent discussions of sustainability. The next section furthers the discussion and application of the sustainability framework. This is followed by the research findings, and then a concluding section.

MAIN CHALLENGES AND METHODOLOGICAL CONSTRAINTS

A range of challenges had to be met in the research. These included identifying the research population, addressing ethical issues and processes, developing a research strategy, clarifying definitions and terms, and addressing specific methodological constraints.

Identifying the Research Population

The population focus for research on consumers/tangata whai ora depends on whether the research aims to include all people who experience mental illness of any degree, only those who experience “serious, ongoing and disabling” mental illness, or only those who receive mental health services. It is estimated that 20% of the national population has a diagnosable mental illness (including alcohol and drug disorders) at any one time. The Mental Health Commission (1998) reports that around 3% of people have serious, ongoing and disabling mental illness requiring treatment from specialist mental health and alcohol and drug services. Not all of these people are receiving treatment, however, and recent estimates, including one made in the course of this research, suggest that the numbers receiving services are fewer than anticipated (MHC 1998 and MHC 2000 online). We estimate that only about 1.2% of the population are receiving services, and

our research draws on information from and about this group. The research paid particular attention to the circumstances of Māori and Pacific peoples and examined the impact of gender issues on housing and mental health. Current data collection and mental health funding criteria made it particularly hard to identify issues in relation to youth, older people and ex-prisoners, but it is important to note that these groups are also significantly affected by mental health and housing issues.

Addressing Ethical Issues and Processes

Ethical issues are complex because people who experience mental illness are considered to be a vulnerable group, potentially open to exploitation. Although the ethical issues are not discussed in any detail in this paper, particular efforts were made to ensure the safety of research participants. Extensive consultation, not only with consumers/tangata whai ora but also with Māori and Pacific communities, was undertaken during the scoping phase for the research. Ethical approval from the Association of Social Science Research was sought and obtained for the project. Informed consent was obtained for all interviews and for survey participation.

Developing a Research Strategy

The project team settled on a research strategy designed to obtain information from a range of sources, using a mix of quantitative and qualitative methods. Twenty-three consumers/tangata whai ora from around the country took part in a one-day workshop as part of the scoping of the research. The main data collection tools were a national survey of 800 mental health service providers and group interviews with 190 consumers/tangata whai ora undertaken between March and July 2001. This empirical work was preceded by an extensive review of relevant New Zealand and international literature.

There were a number of specific methodological constraints produced by the nature and resourcing of the research and discussed in greater detail in the report (Ministry of Social Development forthcoming). An important issue was that, in order to respond to the Cabinet directive to quantify housing need, it was necessary to undertake empirical work since no currently available statistics were suitable for this purpose. It was not considered feasible to conduct a survey of consumers/tangata whai ora, because of the lack of an appropriate sampling frame, and also because of concerns about privacy. Instead, mental health service providers were asked to furnish estimates of the numbers of their consumers who were having housing difficulties of some sort.⁴

⁴ 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).

It was recognised that this would not be a precise source of data, because some providers would know little about the housing circumstances of the consumers/tangata whai ora using their services. Nevertheless, it was considered that this would permit a rough estimate to be made of the level of housing difficulties they were experiencing.

Clarifying Definitions and Terms

A number of terms and concepts required clarification. This was undertaken systematically throughout the research, and is discussed in more detail in the section below on developing a conceptual framework. The terms around which there is confusion and debate include: clients, consumers, customers, people with mental illness, tangata whai ora; and adequate housing, sustainable housing, unmet housing need, living independently, living independently in the community and supported housing. In order to resolve the issue of definitions for this research, specific interpretations of the concepts were developed on the basis of consultation with mental health service providers, in a series of telephone interviews, and with 23 consumers/tangata whai ora from around the country in a one-day workshop.

An important question in the research revolved around the interpretation of the phrase “independent housing needs”, referred to in the Cabinet directive. Because of the difficulty of developing a direct measure of “housing needs”, it was decided to use the alternative concept “housing difficulties”, which would be more amenable to measurement.

The concept of **housing difficulties** refers to the whole range of housing and related service-access issues that consumers/tangata whai ora face. Important dimensions of housing difficulties are “adequacy”, “suitability”, “affordability”, and the “sustainability” of housing arrangements, defined below.

In our research, **adequacy** refers specifically to the physical condition of a dwelling. Housing can be regarded as adequate when it is of good quality; does not cause discomfort because of a poor state of repair, dampness, dilapidation and pest infestations; and is not overcrowded. However, in the New Zealand Housing Indicators Project (led by Statistics New Zealand) “adequacy” has since become the concept used to encompass the “descriptors”, “dimensions” and “drivers” identified in the model, and is therefore a much broader concept than is indicated here. “Affordability”, “suitability”, “habitability”, “crowding”, “discrimination” and “tenure” are all dimensions of “adequacy” in the Indicators Project. The concept of “habitability” is the closest meaning of “adequacy” as it was used in our project on mental health and housing.

The concept of **suitability** arose early in the research as a term used to distinguish between housing that may be physically adequate (i.e. not damp or cold, etc.) but is not safe or appropriate for a person experiencing mental illness. It is also related to “affordability”, as it is very often lack of income that restricts the capacity of consumers/tangata whai ora to gain access to suitable housing. Suitability refers to the appropriateness of housing for the mental health recovery of consumers/tangata whai ora. Suitable housing needs to be physically adequate and located near sources of support, which may include clinical and other services, as well as family/whānau and friends. Unsuitable housing refers to housing which, though it may be adequate in other respects, is not aligned with an individual’s mental health recovery needs.

The concept of **affordability** was defined in the research as the cost of housing in relation to the income of consumers/tangata whai ora. It is important that assessments of affordability should take into account not only the costs of rent or mortgage, but also the additional costs imposed by illness, including costs of medication, moving house to assist mental health recovery, and costs (such as transport) incurred accessing support services.

The concept of **sustainability** was originally defined for the research to reflect a sufficient supply of available housing to meet long-term demand, that would allow people with mental illness and tangata whai ora to live within their means. As the research progressed, however, it became evident that sustainability was a broader concept than adequacy, suitability or affordability, and needed to be considered in a different way. While it is possible to speak of adequate, suitable and affordable housing, the concept of sustainability is of a different order. It is not an attribute that can be applied to a particular house, but rather encompasses the wider environment of regulations, resources and support services surrounding accommodation arrangements of consumers/tangata whai ora.

The focus on the concept of sustainability thus leads to an analysis of the wider environment of services and regulations. In this context, then, sustainability refers to the network of resources and services consumers/tangata whai ora require in order 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 must be configured to allow consumers to manage independently on a daily and weekly basis, and also to retain their housing arrangements during episodes of acute care, respite care or hospitalisation.

In the empirical research, the concepts of adequacy, suitability, affordability and sustainability were not used directly. Rather, in the survey of providers a list of particular types of housing difficulty, incorporating different aspects of adequacy, affordability, suitability and sustainability, was included in the survey text; and providers were asked a range of questions about consumers/tangata whai ora who were experiencing

difficulties of these types. The types of difficulties were listed as follows:

- substandard physical conditions (that is, where factors such as a poor state of repair, dampness, dilapidation, inadequate sunlight, and/or pest infestations cause discomfort);
- overcrowding;
- lack of privacy;
- lack of choice about housing options;
- lack of personal safety;
- exposure to excessive noise;
- unsuitable location relative to support and/or family/whānau;
- insecurity of housing tenure;
- unaffordability of housing relative to income and medical costs;
- loss of independent accommodation during episodes of acute care or hospitalisation; and
- discrimination in finding and retaining housing.

This list of housing difficulties was derived from previous research by Kearns et al. (1991) and the Mental Health Commission (1999).

Homelessness and transience were also problematic concepts. **Homelessness**, in the context of this research, refers to either being without shelter of any kind, having “no fixed abode” or “sleeping rough”, or living in emergency and temporary housing (which may include night shelters, boarding houses⁵ and hostels). Homeless consumers/tangata whai ora include those remaining in residential institutions simply because there is no suitable alternative housing, and those living in temporary or insecure housing that is unsuitable for long-stay.

Transience refers to the high levels of residential mobility that are coupled with homelessness and/or housing that is so unsatisfactory that consumers/tangata whai ora move from it.

The key concepts are further considered in the section on research findings, below.

RESEARCH FINDINGS

The research findings were derived from a synthesis of the consultative workshop, the review of the literature, the survey of mental health service providers and the group

⁵ Boarding houses are often used as a form of emergency housing and, as emergency housing, need to be regarded as a form of “homeless” accommodation. Better quality boarding houses, however, are also used as a form of permanent accommodation of choice by some consumers/tangata whai ora. Using the concept “boarding house” to signify homeless accommodation needs to be restricted to the context of emergency housing.

interviews with consumers/tangata whai ora and providers. In the following discussion, the provider survey and group interviews, in particular, are used as the basis for reporting on the extent and nature of independent housing need. A more theoretical angle is also introduced in this section on research findings through the presentation of a sustainability framework that evolved from the analysis of the survey results and group interview transcripts. This precedes and underpins a discussion of the role of support services and social services for consumers/tangata whai ora. The final section of the research findings section highlights discussion about specific population groups of consumers/tangata whai ora.

The Extent of Independent Housing Need

The national survey of mental health service providers was designed to permit a rough estimate to be made of the level of independent housing need among consumers/tangata whai ora. The alternative concept of “housing difficulties” was considered to be more amenable to measurement than “housing need”. The 11 areas of housing difficulty have been listed above in the section clarifying definitions and terms.

Providers were first asked to provide estimates of the *number* of their consumers who had one or more housing difficulties; and then to estimate what approximate *proportion* of their consumers were experiencing difficulty in each of the specified areas.

Based on the responses of DHB providers to the first set of questions (on numbers of their consumers), it is estimated⁶ that somewhere in the order of:

- 8,000 consumers/tangata whai ora receiving mental health services (17%) may be experiencing housing difficulties; and
- 2,000 consumers/tangata whai ora receiving mental health services (4%) may be homeless (living without shelter of any kind, having no fixed abode or sleeping rough) or living in temporary and/or emergency accommodation.

In addition to the estimated 2,000 people who are currently homeless/transient, another 8,000 consumers/tangata whai ora were living in circumstances that may involve a heightened risk of future homelessness. It is likely that many of these people will also have been counted among those experiencing housing difficulty.

The responses to the second set of questions (estimating proportions of their consumers), however, led to a higher estimate of the extent of housing difficulties among

⁶ See Ministry of Social Development (forthcoming) for a discussion of how the estimated numbers and proportions of consumers/tangata whai ora were calculated.

consumers/tangata whai ora. These responses indicate that perhaps between a quarter and a third of consumers/tangata whai ora were having problems with affordability of housing, and a similar proportion were having problems with lack of choice.

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

A plausible (and conservative) interpretation of the two sets of estimates is that the estimated numbers represent a minimum estimate of the level of housing difficulty, encompassing those who were in most serious difficulty, because they included cases that were serious enough to be thought of by mental health providers when they were asked to think about consumers/tangata whai ora who were having housing difficulty. Beyond this group of people who were in more serious difficulty, there was a wider group of consumers/tangata whai ora – perhaps up to as many as a half of the population of consumers/tangata whai ora who were receiving services – who were having difficulties with particular aspects of their housing, especially affordability, lack of choice, and discrimination.

Finally, it should also be noted that these estimates covered only the pool of people who were receiving mental health services. In addition, there may be similar numbers of people, with similar mental health conditions but not receiving treatment, who were also experiencing housing difficulties or homeless or transient. The survey did not attempt to elicit any information about this group.

The Nature of Independent Housing Need

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

The principal areas of housing difficulty identified by mental health service providers for all consumers/tangata whai ora regardless of ethnicity, age or gender were:

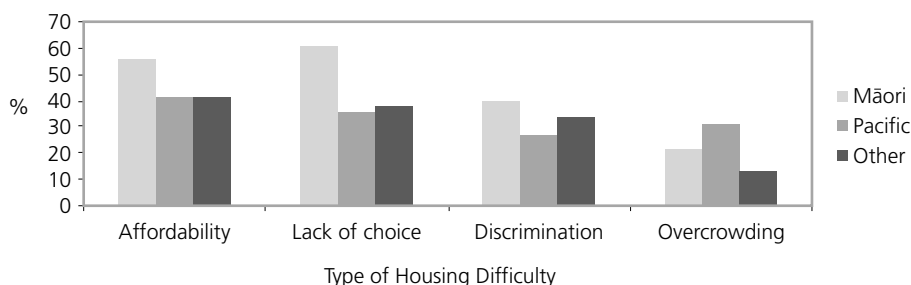
- the unaffordability of housing relative to income and medical costs;
- lack of choice in housing options; and
- discrimination in finding and retaining housing.

The extent to which DHB providers identified these three items as significant housing difficulties for consumers/tangata whai ora is represented in Figure 1. In the national survey, providers were asked to indicate whether “none”, “some”, “about half” or “most” of the consumers/tangata whai ora using their services experienced each of the 11 types of housing difficulties specified in the survey. All the providers indicated that at least “some” of the consumers/tangata whai ora using their services experienced at least one housing difficulty.

Figure 1 illustrates the proportion of providers who indicated that “about half” or “most” of the consumers/tangata whai ora using their services experienced difficulties relating to the “unaffordability of housing relative to income and medical costs”, “lack of choice in housing options”, “discrimination in finding and retaining housing”, and “overcrowding”.

The data suggest that a higher proportion of providers noted housing difficulties in relation to tangata whai ora than other consumers, especially in relation to unaffordability and lack of choice in housing options. More providers noted that “overcrowding” was experienced by Pacific consumers than other consumers.

Figure 1 Experiences of Particular Housing Difficulties by Specific Population Groups



Although it is not possible to estimate how many consumers/tangata whai ora may be affected by each of the items of housing difficulty, the fact that a substantive proportion of providers report them suggests that the problems are widespread.

The analysis of the group interview discussions shows that the issues identified by the service providers in the survey were also reported by consumers/tangata whai ora.

Three groups of issues were identified most consistently and emphatically in the group interview discussions: the unaffordability of suitable housing, problems relating to benefit income and benefit debt (also an affordability issue), and discrimination. These issues can be classified as barriers in the sense that they are beyond the scope of mental health service provision to remedy. These three issues are related more to a lack of material resource and/or regulatory protection than to service resourcing. Each of these factors is reported in more detail below.

The **unaffordability** of housing was noted by almost half of the DHB providers as affecting “about half” or “most” consumers/tangata whai ora. Possibly between a quarter and a third of consumers/tangata whai ora may be experiencing problems relating to the unaffordability of housing. Consumers/tangata whai ora noted that suitable housing was unaffordable in relation to income levels. As a result many had no choice of housing, lived in housing that is substandard, and had to accept housing that did not contribute to their mental health recovery – conditions that often led to the deterioration of their mental health.

The lack of **choice** in housing options was noted as a problem by both providers and consumers. It can be argued that lack of choice derives both from gaps in housing supply and the affordability of suitable housing. There may not be enough physically adequate housing that is suitable for mental health recovery in areas where consumers/tangata whai ora may wish to live or there may not be a wide enough range of options from which consumers/tangata whai ora can choose their housing.

The survey data would suggest that around a quarter to a third of consumers/tangata whai ora may be experiencing problems relating to the lack of choice about housing options. Choice of location (near family or support services, in a safe neighbourhood with options for privacy and quiet) and housing type (suitable for different types of consumers – single persons or couples with children, for example) were matters of significant concern to consumers/tangata whai ora and service providers. Consumers/tangata whai ora expressed the desire to live in ordinary houses in ordinary suburbs like ordinary people.

Choice of housing was also related to adequacy and affordability. Consumers/tangata whai ora with low income (either from benefits or low wage or part-time employment) could not afford suitable houses and were often forced by their financial circumstances to choose houses that were inadequate or substandard.

Many consumers/tangata whai ora in the group interviews reported a lack of basic utilities in the houses they were able to afford, and between a quarter and a third of providers responding to the survey indicated that substandard housing affected “most” consumers/tangata whai ora using their services.

Discrimination was the third most highly ranked housing difficulty that providers noted and was discussed as a significant issue in every group interview. Discrimination was reported as being ongoing, pervasive and at a serious level for consumers/tangata whai ora. Direct discrimination was experienced in the housing market, the labour market, from flatmates, acquaintances, and also from some employees of the government agencies that consumers/tangata whai ora had to interact with. Problems of discrimination were probably more severe for Māori and Pacific consumers/tangata whai ora. While the *Like Minds, Like Mine* programme was acknowledged as being helpful, it represents only a beginning.

Consumers/tangata whai ora noted that media reporting was frequently inappropriate, encouraging negative community attitudes to mental illness and fuelling discrimination.

The “not in my backyard” syndrome was noted, and consumers/tangata whai ora and providers expressed concern about the pressures being put on local councils by residents to have laws and by-laws changed in ways that would facilitate further discrimination against people who experience mental illness. Groups currently lobbying for change to the Resource Management Act were cited as a particularly worrying example. Providers thought that, because of this pressure, group housing, for example, might not be an effective solution for housing people with mental health problems, even on a temporary basis.

Developing a Conceptual Framework – Exploring Sustainability

As this research was geared to a specific policy purpose, there was no particular motivation to develop or use a conceptual or theoretical framework other than a descriptive/empirical approach that would facilitate the “quantification of housing

need". One of the unanticipated outcomes of the research has been a focus on the issue of sustainability in the context of mental health and housing as an attribute of the wider environment rather than of a particular house, and the subsequent development of a "sustainability framework". The evolution of the framework contributed significantly to our re-consideration of the nature of housing need among people who experience mental illness. It also contributed to a much clearer appreciation of the complex and intermeshing factors affecting consumers/tangata whai ora and the need for intersectoral solutions.

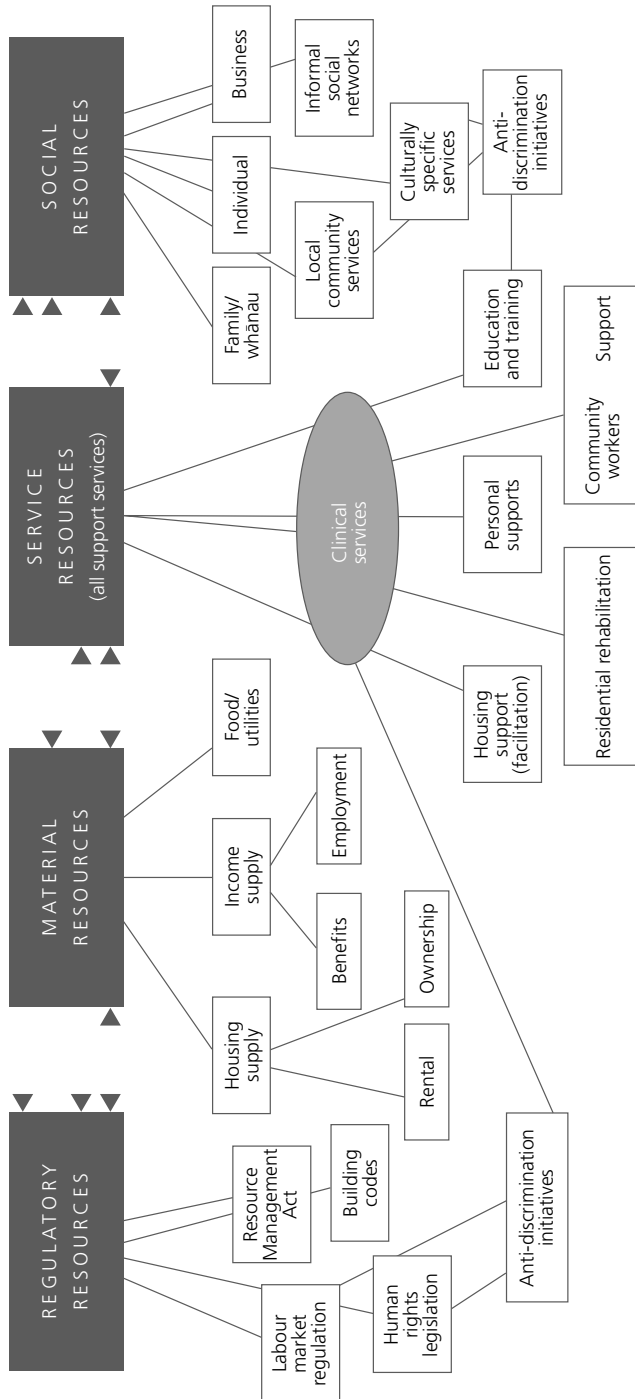
Arguably the concept of sustainability provides a vehicle for considering the cross-portfolio complexity of mental health and housing issues as it reflects the array of supports and resources available to assist consumers/tangata whai ora to maintain independent living in the long term. Any consideration of sustainability, therefore, requires a focus on the arrangements of supports that are available to consumers/tangata whai ora. The sustainability framework categorises an array of supports that are necessary if consumers/tangata whai ora are to sustain independent living (see Figure 2). The research findings suggest that consumer access to each of the following four separate categories of resources is necessary for their independent housing arrangement to be truly sustainable. The categories are:

- a regulatory environment that encompasses the statutory central and local government frameworks that apply to safeguarding human rights, combating discrimination, labour market regulation and land use, building codes and housing standards pursuant to the Resource Management Act 1991;
- a set of material resources, including the stock of adequate, suitable housing to choose from, sufficient income to afford to pay for it, and access to basic necessities, such as food and utilities;
- a set of service resources, including clinical services, housing facilitation services, and personal support services that can be tailored to meet individual need; and
- a set of social resources derived from the community and groups within it, families/whānau and social networks, and local and/or culturally specific networks and activities.

A shortfall in any of these resources will threaten the sustainability of independent living. What must be developed is a clear synthesis of what the necessary resources are; why they are necessary and for whom; who is providing which services; and how the intersectoral policy implications are being managed, if at all.

This framework also underpins the discussion below about the role of support services.

Figure 2 Sustainability Framework – A Typology of Resources Necessary for Consumers/Tangata Whai Ora to Sustain Independent Living



If there is a shortfall in any of these resources, consumers/tangata whai ora are less likely to be able to sustain independent living. Central government agencies, local government agencies, non-government organisations/community groups, family/whanau and individuals may be involved in the initiation and ongoing provision of any of these resources – in many instances it is partnership between agencies, groups and individuals at different levels that successfully sustains resources for consumers.

The Role of Support Services

In the context of the sustainability framework, service resources include both clinical mental health services and a range of other support services for consumers/tangata whai ora. Two types of non-clinical support services were identified in the literature: **housing facilitation** services that offer practical help with setting up a housing arrangement and sustaining occupancy, and **personal support** services that assist with social contacts and networks, development of daily living skills, and employment opportunities.

The information collected in the group interviews indicated that very many consumers/tangata whai ora were unclear about what service resources are available, or which services they were receiving. However, consumers/tangata whai ora perceived that the range of service resources available to them differed significantly depending on whether or not they received their clinical service in an accommodation setting (such as residential rehabilitation and group homes). Those living in independent housing (not associated with the delivery of clinical services) reported less successful access to personal support services that focus on daily living skills. Housing support (facilitation) services, however, appeared to be less accessible to consumers/tangata whai ora who are accommodated in clinical service settings.

Consumers/tangata whai ora reported problems with access to services in particular locations, especially rural areas, that forced a choice between living with or near whānau and accessing support services. Problems were also identified with the provision of service resources designed for specific population groups – Māori, Pacific peoples, rural people, young and older people, women, parents, and people discharged from forensic mental health services.

The data from the national survey of mental health providers also indicated that the provision of service resources for consumers/tangata whai ora could not guarantee that the full range of services was available to all. There is currently no unifying administrative framework of support service provision to guide the funding, location and scope of the many services that are available from a number of different government agencies as well as a wide variety of community-based groups and non-government organisations, and from family/whānau.

Three groups of issues regarding the provision of support services arose most prominently in the group interviews and were identified as service gaps that affected the sustainability of independent living:

- access to information;
- the transition between clinical care and independent living; and
- the need for long-term services.

There was considerable difficulty with **accessing information** from government agencies about what kind of assistance was available, and entitlements and eligibility, particularly about what was available to meet rent or mortgage payments while a person was in hospital. Access to other information about whether the new social allocation model recently implemented by Housing New Zealand Corporation would prioritise their own housing needs was also a problem. Consumers/tangata whai ora had a lot of difficulty working out how these administrative systems applied to their own circumstances. For consumers/tangata whai ora living in rural areas, the sheer difficulty and expense of making repeated visits to town while unwell to see government officials one at a time brought a strong call for more coordination and the establishment of small but comprehensive government service centres in rural areas.

Disruption to mental health recovery could occur if the **transition** was not smooth between accommodation provided with clinical services in the health sector, and the move to independent housing. Each accommodation had its own set of support services, none of which focused on the transition itself. In particular, consumers/tangata whai ora who lived in supported accommodation could not easily access the practical housing support services they needed to find and set up a new flat. Conversely, a move into clinical service accommodation could result in the loss of an independent housing arrangement as well as personal possessions. Of the 303 providers who offered housing-related services, 97% indicated that they offered one or more liaison/advocacy type services for consumers, whereas less than half of providers (48%) indicated they offered practical help. Practical help was often identified in the group interviews as a current service gap.

Practical support and advocacy on a **long-term basis** was needed to sustain independent living. Such ongoing support would help to avert crises, which might begin as problems with housing, but could quickly turn into deteriorating mental health. Personal support was needed to build up networks of social contacts to alleviate loneliness, to increase confidence and skill levels, and to participate in employment. Absence of such services undermined the sustainability of independent housing. More coordination was needed among all support services to ensure the availability at all times of a comprehensive range of services tailored to the specific needs of the individual consumers/tangata whai ora, and their whānau and families, including more emergency housing.

Social Resources

Although the research was not designed to explore the specific contribution of social resources to sustainable independent housing for consumers/tangata whai ora, it was evident from the group interviews that family/whānau played a significant role in supporting the material and service needs of family members who experienced mental

illness. In particular, Māori and Pacific families responded to different cultural imperatives in terms of family-based care. There is some evidence that a higher proportion of Māori and Pacific consumers/tangata whai ora than other consumers received their primary support from family/whānau. The resulting effect, particularly the economic impact on these families/whānau, deserves further attention.

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

The social development model outlined in the recent government statement *Pathways to Opportunity* (New Zealand Government 2001) states that joint action between central government and the voluntary sector, along with local government and with business, will generate positive results. The mental health sector already provides some examples of successful local partnerships. Further initiatives focusing on housing difficulties could be encouraged at the local level.

Independent Housing Need Within Specific Population Groups of Consumers/Tangata Whai Ora

The research was designed to identify particular housing difficulties of specific population groups. A number of groups of consumers/tangata whai ora were identified in the group interviews as being in particularly serious housing need. Interview participants suggested that these groups might require specific (targeted) intervention. The list of specific groups identified and discussed in this research includes:

- tangata whai ora (Māori consumers); and
- Pacific consumers.

It also includes consumers/tangata whai ora who are:

- single and male;
- recently discharged from forensic mental health services;
- living in rural areas;
- homeless or transient;
- custodial and non-custodial parents;
- older people; and
- younger people – especially young, male consumers.

The group interviews with consumers/tangata whai ora and mental health service providers elicited information about all of these groups. The largest amount of

information was reported in relation to Māori, Pacific peoples and rural dwellers, although other groups, such as older people, young people, ex-prisoners, women, and parents of dependent children, are also known to experience specific housing problems. There is a need for more detailed research about each of these particular high-need categories. Although the overall numbers of consumers/tangata whai ora in any one category may not be high, identifying specific opportunities or interventions could prove to be an effective approach.

Māori

Many providers (77% of the providers who responded to the survey) estimated that they were providing services to one or more tangata whai ora who were experiencing one or more housing-related difficulties in the March 2001 quarter.

Almost half of the providers (49%) indicated that Māori were most seriously affected by housing difficulties (compared with 7% who indicated Pacific people were most seriously affected and 32% who indicated all others were most seriously affected).⁷

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

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

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

Tangata whai ora and Māori providers alike expressed concern that the importance of whānau is not recognised by mainstream mental health services. Unfair advantage could therefore be taken of whānau whose contribution was not recognised, and who

⁷ A number of providers (11%) indicated that more than one group was most seriously affected. A number of providers either did not respond to the question or responded with "don't know". (See also, footnote 8).

were not recompensed for the resources and care they provided. In contrast, the whanaungatanga (kinship) model used by Kaupapa Māori mental health services supported the whole whānau, not just the tangata whai ora.

Pacific Peoples

Over half of the providers (57%) indicated that one or more Pacific consumers were experiencing one or more housing-related difficulties in the March 2001 quarter. Seven per cent of providers indicated that, of the three broad ethnic groups, Pacific consumers were most seriously affected by housing difficulties.⁸

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

- Different needs among different ethnic groups of Pacific peoples were not always recognised in service provision.
- Stigma, discrimination and racism were widely experienced and related both to the mental illness and the status of consumers as Pacific people.
- Support was currently lacking for most Pacific consumers who continued to live with their families – unfair advantage could be taken of the family whose contribution was not recognised, and who were not recompensed for the resources and care they provided.
- Pacific peoples generally have larger families and overcrowding was a significant problem.
- Strong cultural values of respect and honour could be given precedence over the needs of consumers.
- Cultural expectations that financial support be provided to family, both in the Pacific and in New Zealand places an economic burden on Pacific consumers, who are mostly beneficiaries. This narrows housing choice because it reduces available income.
- Some Pacific consumers are homeless – some choose to be homeless to avoid cultural commitments of financial support to family.

⁸ There are some additional caveats in relation to the survey data about Pacific consumers. Undercounting may have been caused by the fact that there are relatively few specialist mental health providers for Pacific consumers, and we know that at least two of the larger providers did not respond to our survey. Where Pacific consumers access services available to all consumers/tangata whai ora, their ethnic identity may be overlooked or unreported. There are smaller numbers of Pacific consumers in the population overall, and they tend to be concentrated in particular geographic locations. There was a relatively low return rate from DHBs in Counties Manukau, Waitemata and Waikato, where there are known to be higher concentrations of Pacific people in the general population, and where it would be reasonable to assume there are higher concentrations of Pacific consumers.

Rural

Group participants noted that there were specific issues for consumers/tangata whai ora who lived rurally, related to isolation and distance from mental health and housing services. Services generally were very limited in rural communities. Assumptions by clinicians, service providers and policy makers, that consumers/tangata whai ora “should not live” in areas where support is limited, were highly problematic because support from family/whānau was also critical to mental health recovery.

Rural consumers/tangata whai ora who had to move from rural to urban centres to access hospital services, residential facilities or supported accommodation faced particular difficulties, either establishing new housing and support networks, or on return to their communities.

Alcohol and Drug Users

Returning to communities could be particularly difficult for consumers/tangata whai ora with alcohol and drug problems, who often needed to distance themselves from their previous community. This required them to re-establish housing and community/social supports. Coming out of rehabilitation into independent housing, however, was extremely difficult for consumers/tangata whai ora with alcohol and drug addictions, who could face double discrimination. The chances of relapse and/or loss of housing arrangements were high, without ongoing home-based support.

Homeless and Transient

Consumers/tangata whai ora who were reported to be most at risk of homelessness and/or transience (rapid residential mobility) were those people:

- coming out of prison and those receiving forensic mental health services;
- with dual diagnosis (mental illness and alcohol and drug problems);
- with a past history of institutionalisation; and
- who were neither linked into good social and community supports, nor receiving mental health services.

CONCLUSION

Housing difficulties, homelessness and transience are significant problems among people with mental illness. Information collected in the present study indicates that, among consumers/tangata whai ora who were receiving mental health services from DHBs, the number who are experiencing housing difficulties could be of the order of 8,000 (17%), while the number who are literally homeless or living in temporary or emergency accommodation could be of the order of 2,000 (4%). Eight thousand (17%)

are estimated to be living in circumstances which may involve a heightened risk of homelessness, such as boarding houses, hostels, hotels, motels, bed and breakfast houses and caravan parks, and many of these people are likely to have been included among the group of people who were experiencing housing difficulties.

Perhaps between a quarter and a third of consumers/tangata whai ora were having problems with affordability of housing, and a similar proportion were having problems with lack of choice about housing options, while a further 10% to 20% may be having problems associated with discrimination, insecurity of tenure, unsuitable location of housing relative to support and/or family/whānau, and loss of accommodation during acute illness or hospitalisation. Overcrowding appears to be an area of difficulty that particularly affects a high proportion of Pacific consumers.

These rough estimates are based on the size and circumstances of the group of people receiving services from DHBs. It is known, however, that many people with ongoing and disabling mental illness serious enough to warrant specialist treatment are not accessing mental health services. Estimates from the Mental Health Commission indicate that perhaps only half do so. This means that to include people with similar conditions but not receiving services might double these estimated numbers.

More important than these crude estimates of the size of the problems are the findings about the nature of the housing difficulties faced by consumers/tangata whai ora. The principal areas of difficulty identified by service providers were:

- the unaffordability of housing;
- lack of choice in housing options; and
- discrimination.

Three main structural barriers to independent housing were identified in the group interview discussions:

- Suitable housing was unaffordable in relation to income levels.
- Benefit debt and time restrictions on Special Needs Grants provided by Work and Income New Zealand seriously affected access to the level of income needed to set up and sustain independent housing.
- Widespread discrimination existed.

Participants identified a wide range of other factors that they saw as making housing unsuitable and unsustainable for consumers/tangata whai ora.

Affordability of housing was a significant area of difficulty for consumers/tangata whai ora, as reflected in both consumer and provider views. Many consumers/tangata whai ora existed on low incomes and the effects of poverty and poor-quality housing were exacerbated by the experience of mental illness. This could lead to a negative cycle that might eventually result in re-hospitalisation. Debt to Work and Income New Zealand

was also widespread among consumers/tangata whai ora and placed a further squeeze on their financial circumstances, both through the requirement to repay and through restricting access to further assistance in the form of Special Needs Grants.

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

Consideration of the sustainability of housing arrangements raises broader issues about the range of support services that can assist consumers/tangata whai ora to maintain an independent housing arrangement. The main findings from the group interviews about the role of support services in maintaining sustainable independent housing arrangements have been the identification of service gaps, and recognition of the need for a comprehensive administrative framework for the provision of support services. Apart from frequently reported problems of existing services being inappropriate for some population groups, and/or unavailable in some parts of the country, more fundamental service provision issues included:

- problems with access to basic information from government agencies;
- lack of services that focused on supporting the transition from clinical services to independent living and, in particular, offered advocacy and practical help; and
- insufficient recognition of the long-term nature of the needs of many consumers/tangata whai ora for support services.

The evidence from the research suggests that there is a need for systematisation of support services for consumers/tangata whai ora. Developing a coordinated inter-agency strategic framework for resource allocation and service provision to this group is a necessary step towards ensuring the sustainability of independent housing, by ensuring comprehensive service provision to all those who need it, and ongoing identification of service gaps.

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

REFERENCES

- Bennion, T. (2000) *Planning Processes for Providing Supported Accommodation for People with Mental Illness: A Survey of Council District Plans and Discussion Paper*, Mental Health Commission Occasional Publications No. 3, October, Mental Health Commission, Wellington.
- Kearns, R.A., C.J. Smith and M.W. Abbott (1991) *Exploring the Relationships Between Housing Problems and Mental Health Issues in Two New Zealand Cities*, final report submitted to the Foundation for Research, Science and Technology, Wellington.
- Kearns, R.A., C.J. Smith and M.W. Abbott (1992) "The stress of incipient homelessness" *Housing Studies*, 7:280-298.
- Kearns, R.A., C.J. Smith and M.W. Abbott (1993) "Housing stressors and persons with serious mental health problems" *Health and Social Care*, 1:263-275.
- Mental Health Commission (1998) *Blueprint for Mental Health Services in New Zealand: How Things Need To Be*, Mental Health Commission, Wellington.
- Mental Health Commission (1999) *Housing and Mental Health: Reducing Housing Difficulties for People with Mental Illness*, discussion paper, Mental Health Commission, Wellington.
- Mental Health Commission Online (2000)
- Ministry of Social Development (forthcoming) *Mental Health and Housing Research Report*, Wellington.
- Nelson, G., B. Hall and R. Walsh-Bowers (1998) "The Relationship between housing characteristics, emotional well-being and the personal empowerment of psychiatric consumer/survivors" *Community Mental Health Journal*, 34(1), February.
- New Zealand Government (2001) *Pathways to Opportunity Nga Ara Whai Oranga: From Social Welfare to Social Development*, Government Statement, New Zealand Government, Wellington.
- Paine, T. (1998) *Housing and Housing Support in New Zealand for People with Mental Illness*, paper prepared for the Mental Health Commission, Mental Health Commission, Wellington.
- University of Otago (2000) *A Regional Survey of Mental Health Clinicians' Perceptions of How Well the Needs of Users of Mental Health Services with High Support Needs Are Met*, final report, Department of Psychological Medicine, Wellington School of Medicine, Wellington.