Mental Health and Independent Housing Needs
Part 3
Affordable, Suitable, Sustainable Housing
A Literature Review

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Ministry of Social Development

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Mental Health and Independent Housing Needs Research: Part 3
Affordable, Suitable, Sustainable Housing: – A Literature Review

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Mental health and housing needs – outline of the project

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

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

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

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

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

The other four parts include:

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

As Part 3 of the series, this report surveys the international and New Zealand literature relating to mental health and housing issues. It includes an account of the development of the sustainability framework, as well as providing information about service provision in New Zealand for people experiencing mental illness who live independently.

[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

Sustainable independent housing for consumers/tangata whai ora[2]

This literature review forms part of a research project designed to quantify the housing needs and the extent of homelessness and transience of people living independently in the community (i.e. not in hospital or residential care settings) who experience mental illness. The review was completed as part of research undertaken by the Ministry of Social Development during 2000-2001 (see p.i for details of the project). One of the clear outcomes from the research was a recognition that a number of factors intersect with the capacity of individuals and communities to develop and achieve sustainable, independent housing for consumers/tangata whai ora. Any efforts to increase this capacity requires a cross-sectoral, multi-faceted approach.

The MSD researchers therefore developed a sustainability framework (see Part 1, the summary report) to highlight the intersecting demands and issues. This literature review has been structured to foreground the issues identified in the framework. After a general introduction and a focus on the international literature on housing and mental health, it focuses on what has been identified in the New Zealand literature with respect to the regulatory environment that underpins the housing aspirations of consumers/tangata whai ora, and the material, service and social resources currently available to mental health service providers and consumers/tangata whai ora.

The typology was developed out of the research rather than prior to the research commencing. Some aspects of the typology are therefore treated more fully than others are, in the following discussion. In a sense, the gaps that are now visible contribute to an argument for more detailed cross-portfolio research that pays particular attention to the inter-linkages that the typology highlights.

Researching mental health and housing in New Zealand

There is a dynamic interaction between mental health problems and housing difficulties, reflected in two broad fields of inquiry in existing literature. The first is concerned with a wider perspective either of housing or of health issues, and while each approach is likely to include a section that links the two, the interaction of housing and mental health issues does not form the bulk of such studies.

The other main approach encountered is found in studies that focus on just one aspect of an issue, such as the literature on homelessness that does not necessarily explore the connections between homelessness and other housing difficulties, or the connection between homelessness and mental health. Where people with mental health problems are mentioned in the context of such

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[2] During the one day workshop with consumers of mental health services that was a key part of the scoping for this research (see *Expert Voices. Part 2 of the mental health and independent housing need research – a consultation report*), a preference was expressed for the term "consumers/tangata whai ora" when referring to people with mental illness. The preference was indicated by Māori, Pacific and Pākehā consumers and was seen to be a less pejorative term than other labels such as 'clients', 'people with mental illness' or 'mentally unwell' people. Advice from Te Taura Whiri i te Reo Māori is that 'whai ora' means "in search of wellbeing". This term is used throughout the five reports in the MSD series on mental health and independent housing need.

studies, they are usually identified as the population group with the most intractable housing problems.

'Transience' or the high degree of residential mobility from place to place, house to house, is rarely mentioned in the overseas literature as a separate issue, although some studies explore the dynamic where fluctuating mental illness problems can lead to fluctuations in housing stability. Rapid mobility in housing arrangements as such is not widely identified as a problem *per se*; rather, it happens as part of the wider dynamic of people with mental health problems negotiating accommodation arrangements that may be for a shorter or longer term, according to what is available and affordable. Illness or poverty can undermine such arrangements.

In New Zealand, almost no empirical data is available that includes both housing and mental health issues, either in the research evidence, or in official statistics and administrative data. Only a small amount of literature presents or discusses findings for New Zealand from the joint perspective of housing and mental health. A variety of other data are available, however.

The Ministry of Health (1994) estimated that around 20 percent of New Zealanders have a diagnosable mental illness, including drug and alcohol disorders. In any one month, approximately 3 percent of adult New Zealanders and approximately 5 percent of children and young people have severe mental health disorders requiring clinical mental health services. The other 17 percent have less severe illnesses and problems which either do not need specialist mental health services, or are not diagnosed as needing specialist clinical support. The then National Housing Commission (1988) estimated that 17,500 households (i.e. one or more persons who usually reside together and share facilities) had serious housing need, but this estimated as unrelated to mental health issues.

An important observation made in one of the major New Zealand research studies that will be discussed in more detail in this review of the literature (University of Otago, 2000) was that far fewer numbers of consumers were identified than would have been expected according to the Ministry of Health's estimate of 3 percent of the adult population having a severe mental disorder, with 0.6 percent having high support needs. The number of consumers identified by the research reached only 57 percent of the number (i.e. 4930 consumers) that the 3 percent estimate of the central region's population would predict. The report includes discussion of the possible causes for such a large difference, including definitional differences, the possibility that numbers of consumers with high needs are not being recognised, and cultural barriers to service provision and access making Māori and Pacific consumers/tangata whai ora less visible.

The New Zealand literature reviewed identifies the small number of New Zealand primary research reports that concern the housing needs of people who experience mental illness: the largest studies being conducted by Kearns, Smith and Abbott (1991) and associated articles[3]; Robinson (1996a) and (1996b);

[3] Articles directly associated with the Kearns, Smith and Abbott research report published in 1991 include: Kearns, 1995; Kearns and Smith, 1994; Kearns, Smith and Abbott, 1992; 1993; 1; Milne and Kearns, 2000; Murphy and Kearns, 1994; Smith, Kearns and Abbott, 1992a; 1992b; Smith et. al., 1993; 1994.

University of Otago (2000). While these bodies of research findings and their related publications are most valuable, they do not, of course, mesh together to provide a complete basis for discussion in the New Zealand context. This is understandable as the relevant research studies in this country have been funded and conducted completely independently from each other, focusing on different research objectives using different research methodologies. The various studies have focused on different geographical locations, been conducted at different times during the last decade and reflect differences in the social policy environment. Other primary research studies relating to New Zealand are on a smaller scale (e.g. Framework Trust, 1993; Waldegrave and Stuart, 1996b and 1996c; Buttle, 1999; O'Brien and Haan, 2000).

Very little of the New Zealand material available that is specifically about mental health and housing is *also* focused on the specific experiences of Māori, Pacific peoples, women, older people, younger people, or people released from prison. For example, it is known that Māori experience comparatively high rates of mental illness compared with the rest of the population and also that Māori experience high rates of housing difficulty (Waldegrave and Stuart, 1996a; 1996b; 1996c; MHC, 1999c; Gray, 2001). What is not known is how many of these people are the same – i.e. present in both statistics. In a previous report, Waldegrave and Sawrey (1994) found that in Lower Hutt, proportionate to their numbers in the population, Māori were two and a half times and Pacific peoples four times more likely to be in serious housing need and require better housing.

By 1996 Waldegrave and Stuart's literature review (1996a: 24) asserted

> It is clear … that whatever aspect of housing adequacy one is interested in, be it housing need, or 'homelessness', or housing choice, and whatever means are used to study it, Māori are consistently identified as among those who are at a disadvantage.

Furthermore, the companion publication explains:

> … it is very clear, from the results reported here, that Māori are not faring well under the housing reforms. The picture of Māori housing, emerging from the three respondent groups in this study, is one of high levels of overcrowding, high levels of financial shortage with households unable to afford essentials after paying housing costs, and, as a consequence, perceptions by householders that they have little choice of housing options … Overcrowding is a mark of poverty and carries with it all the associated consequences. These involve physical sicknesses, including respiratory problems and chronic illnesses, mental health sicknesses, including neurotic stress and chronic depression (Waldegrave and Stuart, 1996b: 35-36).

There is evidence that the separate spheres of mental health and housing each have great power to influence outcomes for the other, although the systematic detail of the interaction is not understood. Housing as a basic need is acknowledged in reports regarding Māori mental health (e.g. Dyall, 1999) and has its place in treatment models for Māori mental illness (Durie, 1985; 1997), but the focus of these studies is on developing health interventions within an appropriate paradigm for Māori and does not include, for example, the impact

of the dynamics of the housing market on the availability of housing to meet tangata whai ora needs. What is known, however, is that services for Māori and Pacific peoples must be delivered within a culturally appropriate framework. A Kaupapa Māori framework is needed for the effective delivery of services to Māori. Crawley et al. (1995) also emphasise that adequately resourced home-based care is culturally appropriate for Pacific peoples.

There is a lack of accurate national data on the mental health status of Pacific peoples. Pacific peoples have higher rates of admission to acute psychiatric services and higher rates of readmission than Māori or Pākehā/European (Crawley, et al., 1995; Bridgman, 1996). Crawley et al. advise that Pacific peoples are less likely to use mainstream mental health and social service agencies, which may reflect the lack of cultural fit within those services for Pacific peoples as well as their higher rates of acute admission and readmission to psychiatric services. Studies which gather data from service providers including that reported on this MSP report may fail to provide a clear or accurate picture of the nature and prevalence of either mental illness or housing problems for Pacific peoples who do not access conventional health and housing services. The evidence about housing issues for Pacific peoples is also serious (Milne and Kearns, 2000): problems with affordability in the housing market, overcrowding, and the levels of discrimination experienced in the private rental market all interface with the lower use of mental health services by Pacific people.

The housing difficulties and independent housing needs of older people is also a seriously under-researched area, particularly in view of the forecast increase in numbers of people aged over 65 years in the next few decades. Melding (1997) reports that it is common for older patients to have mental illnesses as well as physical illness, but that mental illness needs may be overlooked in favour of the physical illnesses. This can happen despite the fact that the adverse effects of anxiety and depression (functional disorders, rather than organic disorders such as dementia) can be effectively treated.

Methodology

This literature review was designed to complement and inform the research work conducted in response to the direction of an ad hoc Cabinet Committee on mental health established by the New Zealand Government in 2000. Specifically, research was required to quantify the existence of housing need among consumers/tangata whai ora in New Zealand, and to estimate the extent of homelessness and transience amongst the consumers/tangata whai ora population.

The extensive review of the literature that was undertaken included New Zealand and overseas material from a number of different categories: 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.

The challenge was to locate material directly related to the housing needs of people who experience mental illness living independently in the community,

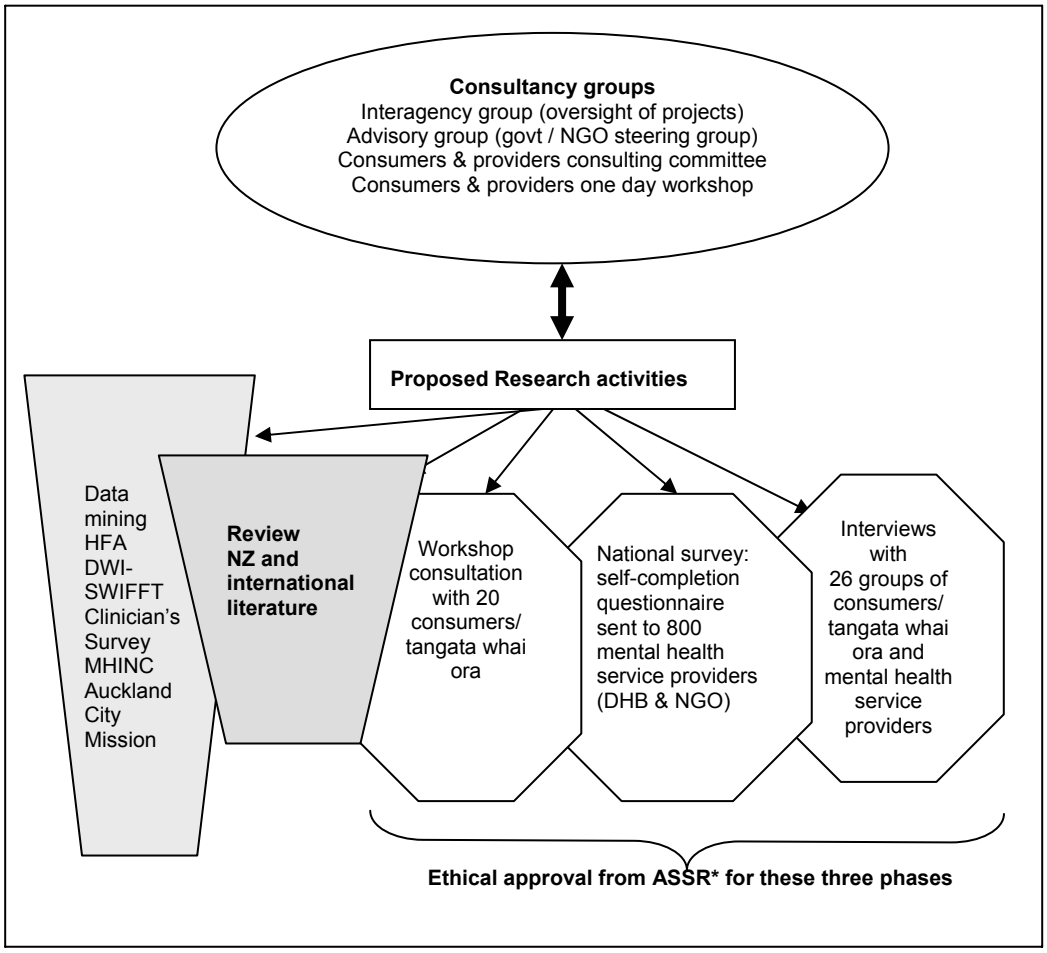
rather than the mental health needs of people who had been diagnosed with a mental illness, and were being supported clinically and otherwise within institutional contexts such as hospitals and residential care facilities.

The MSD Information Centre conducted key word searches for the initial cut and references that appeared in publications that were relevant were also followed up. There is an increasing amount of mental health information on the internet and a number of documents were sourced directly.

The relationship between the literature review and other aspects of the research is demonstrated in Diagram 1. The review, which began before the fieldwork sections, was used initially for scoping the overall project, and as a source for general concepts and definitions. As the fieldwork commenced the literature review continued, and material that came to light through discussions with service providers was also added to the analysis.

It was originally thought that answers to the research questions would be available within existing data, but as the paucity of data became clearer, statistical findings that were relevant were incorporated into the literature review.

Diagram 1: *Interlinked components of the research methodology* (Source: MSD).



*ASSR refers to the Association of Social Science Researchers in New Zealand. (see Parts 2, 4 and 5 for fuller discussion of the ethical commitments of this research).

Structure of this report

Part 1 of this literature review examines the international literature, focusing on the double linkage between mental health and housing where each factor has causality in relation to the other. Concepts of the 'adequacy' and 'suitability' of housing are raised in relation to the mental health consequences of unsatisfactory housing. A discussion of the housing consequences of mental illness, however, introduces the concepts of 'affordability' and 'sustainability' and examines an array of factors that limit the capacity of consumers/tangata whai ora to access and hold on to good quality housing. The international literature on homelessness is also discussed.

Part 2 introduces the sustainability framework that was developed from the combination of the research findings and the literature. Much of the New Zealand literature discussed in Part 3 has been retrospectively organised to reflect the focal points of the framework.

Part 3, by identifying the challenges of achieving housing sustainability in the consumers/tangata whai ora community, provides a new perspective on New Zealand studies of mental health and housing. After a brief overview of the key New Zealand studies, this part explores the literature on the regulatory, material, service and social support provision in and for the consumers/tangata whai ora community.

Part 4 focuses on service provision, identifying and discussing the role of resources and the activities of support services in sustaining independent living for consumers/tangata whai ora.

The conclusion to this review then highlights the need for the conceptual integration of key housing and mental health policies and services, and points to gaps in the current research agenda in New Zealand.

Appendix 1 provides details of a range of current support services for consumers/tangata whai ora in New Zealand.

2. The international literature

The double linkage between housing and mental health

The assumption that mental health and housing issues are linked is widely accepted in the overseas literature. A good summary of the issues is provided by Glover (1999), who refers to a number of official reports (e.g. Ritchie, 1994; Royal College of Psychiatrists, 1996) that observed a connection between failures in housing provision and subsequent deterioration in the patient's mental condition. Furthermore, adequate housing plays a major role in community care and rehabilitation and is often the key to independent living (Cunningham and Spenser, 1996). Glover stresses the significance of housing in the overall integration into society of people who experience mental illness.

> If the patient is not provided with appropriate housing, there is a greater risk of the patient becoming lost to the caring system … Consequently, the provision of housing is not a peripheral need and has to be given equal emphasis with medical assistance (Glover, 1999:235).

A further source of authority from the United Kingdom (Farrar, Young and Malin, 1996) is in the advice provided by the United Kingdom Department of Health to local authorities, to guide the commissioning of mental health services. A close link between mental health and housing is also documented in recent United States research (Evans et al., 2000) noting that while the hypothesis that housing quality affects mental health is difficult to evaluate scientifically, different studies demonstrate that physical housing quality predicts mental health status.

Two principal messages emerged from our analysis of the literature on the relationship between housing and mental health. The first is that *unsatisfactory housing can lead to the development of mental health problems* for some people (as well as physical problems for even more people), or can be a factor in deteriorating mental health for people already experiencing mental health problems. The second message from the literature is that *having a serious mental illness is very likely indeed to result in the experience of unsatisfactory housing conditions*, because of the effects of compounding disadvantage flowing from the experience of mental illness. It is very likely that this process of accumulating disadvantage is a substantial cause of homelessness. It arises from an adverse mix of:

- discrimination;
- poverty/lack of income;
- fragmentary or no employment;
- disrupted education;
- failure of the housing market to supply low cost single-occupancy housing of an adequate physical standard;
- difficult access to services to deal with any of these problems;
- detachment from mental health clinical services;
- alcohol/substance abuse.

The derivation from the literature of these two interlinked messages is consistent with the results of research by Nelson, Hall and Walsh-Bowers (1998), who attempted to achieve some insight beyond the associational link between mental health and housing. In their findings, there was evidence that having a better standard of housing appeared to reduce the adverse effects of poor housing on mental illness, while a good social environment increased the positive effect that housing circumstances had on mental health problems. The authors used regression analysis to test hypotheses to explore which housing characteristics could predict which adaptations. They found that the physical aspects of the house and the characteristics of the social environment produced different outcomes for consumers: good physical housing reduced mental health problems, while good social environment increased mental well-being.

Adequacy and suitability – the mental health consequences of unsatisfactory housing

A number of publications focus on the general health consequences of unsatisfactory housing, with often more attention given to physical than to the mental health problems that arise from living in cold, damp, crowded, high-rise

or otherwise problematic or substandard housing conditions. Although most imply that the existence of physical illness is likely to indicate the existence of mental illness as well, some include a more detailed consideration of the effects of poor housing on mental health (for example, Blackman et al., 1989; Burridge and Ormandy, 1993; Smith, 1989; Gordon and Pantazis, 1997; Evans et al., 2000). Fewer studies of housing have mental health problems as their prime focus.

The Nelson, Hall and Walsh-Bowers' (1998) study mentioned above found that housing concerns generally, and lack of privacy in particular are directly related to residents' experiences of negative affect. Other housing conditions cited as problematic for mental health include crowding, living in high-rise flats (Freeman, 1993), as well as the isolation effects, for some people, of low-density living (Smith, 1989; Gabe and Williams, 1993). The Smith study concludes by pointing out that although there is no clear evidence that better housing improves mental health, there is evidence that poor housing worsens it.

Interviews with consumers/tangata whai ora in New Zealand (see Report 4 this series) provide testimony about the extent to which 'adequate' and 'suitable' housing are perceived by consumers/tangata whai ora to be critical to their mental health recovery.

Further evidence from New Zealand confirming the negative effects on mental health that can be caused by unsuitable housing is found in the review of the New Zealand literature in Part 3 of this report.

Affordability and sustainability – the housing consequences of mental illness

As well as the physical quality of housing, the sustainability of housing circumstances also has a major effect on mental health outcomes. A major United States study by Tanzman (1993) that reviewed 26 sufficiently comparable studies of consumer preferences for housing highlighted Carling's finding that lack of stable affordable housing for people with psychiatric disabilities undermines the effectiveness of rehabilitation and other mental health services and contributes to the problem of inappropriate institutionalisation (Carling, 1990; see also US Surgeon-General, 2001). Tanzman's review emphasised that most consumers strongly prefer independent living situations, but with a range of supports available to them wherever they live. This separation of accommodation from mental health service provision presents a challenge for service providers. Suitable housing situations must ensure that material needs are met, while also ensuring a wide range of support is available at the level of response the consumer needs at the time.

Socio-economic factors

The United States Surgeon General's Report (US Surgeon-General, 2001) identifies ongoing poverty as a major difficulty for people who experience mental illness. "Although the reasons are not understood, poverty is a risk factor for some mental disorders, as well as a predictor of poor long-term outcome among people already diagnosed." The underlying causes of the poverty are the post-diagnosis shift to reliance on income support, and the high level of unemployment (in the United States, up to 90 percent, for people with serious and persistent mental disorders). The report clearly locates housing as part of

this mesh of inter-related problems facing people with serious mental illness. After presenting evidence on the value of consumer and family self-help programmes, consumer-operated programmes and consumer advocacy, as well as the need for services that are client-focused, the report points out that despite what is known about how to treat mental illness and how to run effective programmes, serious housing problems persist because most individuals with mental illness are poor.

> Facing multiple life stressors, all severe, with a minimum of resources, people with severe mental illnesses often need a variety of supportive services. Paramount among these are housing, employment and income assistance, and health benefits … Housing ranks as a priority concern of individuals with mental illness. Locating affordable, decent, safe housing is often difficult, and out of financial reach. Stigma and discrimination also restrict consumer access to housing (US Surgeon-General, 2001).

The effects of discrimination

One of the main drivers of stigma and discrimination is the strength of the public perception, often perpetuated by sensationalist reporting in the news media,[4] that people who experience mental illness might pose a threat to safety in the community. Goldfinger et al. (1996) in the United States developed a model to achieve a reliable safety assessment technique for people with serious mental illness, finding that independent living would be a safe option for some 68 percent of the people in the study. An important finding was the extent of inter-relatedness of some of the factors, alerting the researchers to look for constellations of factors, rather than single factors that might predispose a person to be considered unsafe. The authors point out that public confidence in adequate safety assessment is necessary for levels of discrimination to reduce. A central message of the classic study of community attitudes to mental health care (Dear and Taylor, 1982) is encapsulated in the title, *Not on Our Street*. This study makes it very clear that the success or otherwise of the host role of the local community is a fundamental determining factor of the outcomes of community housing for people with mental illness. Furthermore, rejection by the local community of people with mental illness will undermine any therapeutic effects of living in a 'normal' community.

People who are homeless are also strongly affected by discriminatory attitudes that have a connection with worries about public safety. Pleace (2000) provides an insightful framework that explains the discordance between public and professional opinions about mental illness and homelessness. According to this framework, public opinion is maintained and even enhanced by sensationalist reporting in the news media (i.e. the old consensus), whereas the professional view (the new consensus) has developed through clinical and academic study as

[4] See Mental Health Commission (2000). This publication is based on A systematic survey of 805 newspaper clippings published in 1997 and 1998 and entailed a "a simple text analysis of what is published in newspapers, in a snapshot of time, about mental illness, mental health services, and people who have experienced mental illness". The stated aim of the publication is to "analyse and describe how the newsprint media (re)presents people with mental illness to their readers, to identify blind spots and shining lights in this (re)presentation, to identify ways to improve the presentation of people with mental illness".

well as through the direct experiences of service providers, and is shared by government policymakers, clinicians and service providers alike. The old consensus matches homelessness with deviance, is informed by the perspective that homelessness and rough sleeping in particular is a result of weak moral fibre and fecklessness, and owes much to the continuation of popular opinion from the time of the English Poor Law.

In sharp contrast, the new consensus view is that people who sleep rough are predisposed to becoming homeless because they have characteristics that make them especially vulnerable to changes in housing supply, labour markets, and other structural factors. Since structural problems such as the declining supply of affordable housing and the hyper-casualisation of the labour market cannot be fixed quickly or easily, the best course of action is to equip homeless people with the skills they need to reintegrate into society. A further point emphasised by Pleace is that viewing rough sleepers as vulnerable people who need care and protection is no more use to them than viewing them as losers. What they actually need are services that are responsive to individual circumstances, and not a non-directional service that is aimed at the 'typical' homeless person.

Income and employment problems

In Britain, Henderson, Thornicroft and Glover's (1998) study that aimed to define populations at high risk of mental disorder found that

> the association between socio-economic status and mental disorder is best documented for schizophrenia. Past reviews of both true prevalence and of treated incidence have shown that low socio-economic status confers a relative risk of 2-3 [times] greater than the general population (Henderson, Thornicroft and Glover, 1998:105).

These authors strongly recommend strategies to prevent impoverishment and provide employment, to counter the mental illness trends associated with poverty. Gordon and Pantazis' (1997) study of poverty in the United Kingdom also reports a connection between poverty, mental health and housing, in which the rate of self-reported mental health problems was far higher among people experiencing low incomes, unemployment, and lack of money, than among other people. There was also a clear link with housing tenure as well as with the physical condition of the house, with owner-occupiers far less likely to report mental health problems than people in council housing.

> The material … suggests that that there is a very real relationship between the experience of poverty and deprivation and the risk of poor mental health … Being 'poor', then, is likely to significantly affect mental health. The solution to this appalling additional burden on the poor is not, however, a dose of psychiatry. The greatest risk factor is poverty and the solution to this problem comes from policies which are directed towards the eradication of poverty in the 1990s (Gordon and Pantazis, 1997:176).

The difficulty of budgeting on a low income, or on what is left after care providers have deducted their proportion, is remarked upon in the US Surgeon-General's report (US Surgeon-General, 2001). A further issue is the problematic interface with income support systems caused by fluctuating levels of illness,

where the difficulty of re-starting income support can be a barrier to relinquishing it, even to take up employment.

Although the effects of discrimination, interrupted education, active symptoms, and the experience of low-paying menial jobs all make it very difficult indeed for people who experience mental illness to find and retain employment, its benefits are also cited by the US Surgeon-General.[5]

> In a randomized trial of consumers assigned to paid versus unpaid work, paid employment was found to reduce symptoms of schizophrenia (Bell et al., 1996). Moreover, employer accommodations for those with psychiatric difficulties appear to be inexpensive. The most frequently requested accommodations focus on orientation and training of supervisors, provision of onsite support, and adaptive work schedules. Such accommodations rarely result in significant cost to the employer (Mancuso, 1990; Fabian, Waterworth, and Ripka, 1993).

Homelessness also is intertwined with the material disadvantages of lack of income and/or employment, and for some people may be the most obvious expression of their mental illness. According to May (2000), homelessness is often characterised by a pattern of repeated episodes, rather than one long spell. This study found that the housing careers of the respondents had been dominated by the use of poor quality and often insecure, private, rented bedsits and flats while almost all had simultaneously been long-term or permanently unemployed. After acknowledging the new orthodoxy that homelessness can be understood as the result of structural disadvantage, May observes: "… it is possible that we have failed to recognise the full significance of unemployment in the homeless dynamic." Starr (1998) also looks at the interaction of housing, income levels and labour markets in the United States, finding it complex.

> The causes of homelessness involve changes in labor and housing markets, mental health policy, and social behaviour. Since the 1970s, housing costs have risen more rapidly than the incomes of the least skilled workers … The decline in marriage rates has exposed more poor people to the risk of homelessness when they are unable to meet the costs of housing individually (Starr, 1998:1762).

The consequences of compromised education

The US Surgeon-General's report (US Surgeon-General, 2001) draws attention to the educational disruption that occurs when people experience the onset of mental illness symptoms during their school-age years. The usual transition of the young person from the education system to the workforce with the required skills to earn income is then in jeopardy, and often does not take place. Supported education programmes are then required to assist consumers with their education, for example, the Consumers and Alliances United for Supported Education, a consumer-operated program in Quincy, Massachusetts, that operates a wide range of services to encourage individuals with psychiatric

[5] The US Surgeon-General cites evidence from Bell, Lysaker and Milstein, 1996; Mancuso 1990; and Fabian, Waterworth and Ripka, 1993.

disabilities to enter or re-enter college or technical school programs. Services include academic and career counselling, assistance with finding financial aid, study skills, stress control, tutoring/coaching, and assistance with crisis while hospitalised.

The effects of serious mental illness

As well as exploring the connections between being in poor housing and access to mental health services, the literature includes material regarding the physical and mental health issues of homeless people, and their access, or lack of it, to health services. These publications provide insight into the predicament that awaits people who are at risk of becoming homeless because of housing difficulties resulting from declining mental health, as well as the issues that face people who are already homeless. The Royal College of Physicians' study (Connelly and Crown, 1994) into the connections between homelessness and mental health reveals that the prevalence of mental health problems among homeless people is high. Their summary finds:

- Serious mental illness is more common among single homeless people than in the general population;
- Schizophrenia is the most frequently observed serious disorder;
- Less serious disorders are also common amongst single homeless people;
- Factors associated with schizophrenia, combined with social and economic difficulties, increase the chance of a housing crisis which precipitates homelessness;
- Housing crises occur when there is inadequate integration of housing provision with social and health care as part of community care programmes. Housing policies must be reviewed and integrated with community care policies.

The physicians' study discusses two prominent, but alternative views regarding the association between homelessness and schizophrenia: either first, that the high prevalence of schizophrenia among single homeless people must be due to the closure of mental health institutions, or second, that the stress of being homeless must be a factor in triggering schizophrenia. The rejoinder to the first is that most mentally ill, single, homeless people have been temporary mental health patients in the past and have not lost their places as long-term patients in mental health institutions. Evidence does not support the second view either – there are very few reports of onset while homeless, but it is common to find people with schizophrenia becoming homeless.

> Although adverse life events, such as homelessness, double the risk of developing schizophrenia over the subsequent six months, this does not nearly account for the fact that this disorder is fifty to a hundred times more common in single homeless people than in the general population. It is therefore not likely that the stress of homelessness explains the association with schizophrenia (Connelly and Crown, 1994:83).

The study then provides a very plausible explanatory model that identifies features of schizophrenia that contribute to homelessness; contributing social factors; factors that predispose and then precipitate a housing crisis; and then the factors prevent the crisis from being resolved. The result of this chain of events is that the individual is maintained in a homeless state. In the New Zealand context, Robinson (1996a: p.6) comments that the problems of homelessness may lie just as much with landlords as with consumers/tangata whai ora. Robinson suggests that temporary homelessness is not so much an absence of housing, as an inability of housing managers to absorb expressions of psychotic behaviour that may include aggression to staff and residents and/or damage to property.

Being homeless is clearly connected with both physical and mental health problems, but as noted previously, it would be simplistic to attribute the extent of the problem to the after-effects of de-institutionalisation. Franklin observes that:

> very few homeless people are rendered homeless immediately on discharge from psychiatric hospitals, which suggests that the problem is related more to issues of care in the community, in terms of both support and housing (Franklin 1999:193).

A survey of self-reported health problems among homeless people was generated by the implementation of the London Homeless Mentally Ill Initiative (a policy response to visible homelessness carried out in the United Kingdom in the early 1990s). On the basis of its results, Bines (1994) suggests that the mental health of homeless people is not well served by the mental health services. Some 40 percent of the homeless people surveyed reported mental health problems such as anxiety, depression and 'nerves'. A quarter of these people had been in a psychiatric hospital at some time in their lives, although two-thirds were not receiving treatment at the time of the survey. This incidence of mental illness was found to be eight times more prevalent among people in hostels and bed and breakfast accommodation and 11 times more prevalent among rough sleepers than that of the general population.

In a further publication, Bines (1997) discusses the difficulties of comparing the mental health of homeless people with that of the general population. Such a comparison is possible for the United Kingdom, however, as the first wave of the British Household Panel Study, a general population survey, was also conducted in 1991 and inquired about self-reported mental health problems using the same definition.

> Mental health problems were much higher among single homeless people; this was reported by 28 percent of people in hostels and B&Bs, 36 percent of day-centre users and 40 percent of soup-run users, compared to 5 percent of the general population (Bines, 1997:138).

Less than a third of single homeless people with mental health problems were receiving treatment. A much higher than expected proportion of single homeless people with mental health problems also reported heavy drinking. Bines also reports that many of the reasons people gave for leaving home were associated with stressful events such as relationship breakdown, which can be interpreted

as situation where push factors are operating, as observed in New Zealand by Kearns, Smith and Abbott (1991). Fisk et al. (2000) observed in the United States that family relationships were a contributory source of mental health problems that then produced housing repercussions. The development of delusional beliefs plus expulsion from the household, manipulative behaviour within households, negative family styles of interaction and lack of family problem resolution can all undermine the stability of housing arrangements. This study makes the case for interdisciplinary services that are alert to pertinent signals of family problems, and are able to help resolve family conflict before severe disruption resulting in homelessness occurs.

In the United States, Banyard and Graham-Berman (1998) observed differences in the effects of stress on depression and coping strategies, in housed and homeless mothers. While in both groups it was found that depression was associated with avoidant coping strategies such as smoking and drinking, higher levels of these avoidant coping strategies were found among homeless mothers. The authors recommended a longitudinal study to find whether the observed levels of depression are a cause or an effect of homelessness.

The role of alcohol and drug abuse and dependency is not discussed widely as a separate issue in the literature surveyed. However, the extent of alcohol and drug use is remarked upon by authors from all countries as an accompanying problem for people with mental health problems (for example, Robinson, 1996b; Bines, 1997; US Surgeon-General, 2001). There is little suggestion in the literature surveyed that consumption of alcohol and other substances leads to mental illness and thence to housing problems. Rather, most authors suggest that people under the stress of mental illness and/or housing problems turn to alcohol and drugs (albeit unsuccessfully) to alleviate their stress levels. The necessary expenditure can lead to poverty, and the criminality of some behaviours can lead to imprisonment, both of which then become the more obvious face of the problems for consumers/tangata whai ora. The role that alcohol and drug use plays in the public perception of homeless people as deviant losers is significant.

Access to health services

Franklin (1999) reports that people with mental health problems often find it difficult to keep accommodation, do not understand the housing system, and are frequently not accessing any support services at all. Both psychotic and depressive illnesses are common, often resulting in repeated visits to hospital accident and emergency departments, yet fewer than a third of those with a history of psychotic illness have any contact with a psychiatrist or other mental health worker (Franklin, 1999: 94).

The United Kingdom literature identifies a number of barriers to the availability of treatment for mental health problems to homeless people. Among the most prominent are the effects of strict control of the catchment zones for access to general practitioners and psychiatrists within the National Health Service. Homeless people who move out of the catchment for their previous GP find they cannot be accepted into the catchment of another doctor. According to one study,

> The relationship between the extent to which becoming homeless causes health status to deteriorate and the extent to which people

> may become homeless because they have poor health status is not properly understood … homelessness does not represent a cause of poor health, but an increased risk to health … The main impact, the unique impact, of homelessness on health in the United Kingdom, is that it restricts or even prevents access to health services (Burrows, Pleace and Quilgars, 1997: 152-3).

Health selectivity in the housing market

A topic that is explored by several authors (Kearns, Smith and Abbott, 1993; Easterlow, Smith and Mallinson, 2000; Robinson, 1998;) is how health status is used as a mechanism to help identify support needs, and then used again to ration housing. The housing outcomes (that are produced in the market, outside the health system) then negatively reflect the seriousness of the health problems, rather than the extent of the person's need. Referred to as the health selectivity of housing, this dynamic is characterised by rationing systems which result in decreasingly satisfactory levels of housing assistance according to increasingly serious levels of illness. Thus, owner-occupation, as a stable form of housing for people who experience mental illness is the least likely option that people with very serious levels of illness will be assisted to achieve. Easterlow, Smith and Mallinson (2000) report that their exploration of the assumption that people who are more seriously mentally ill deserve increased help, reveals instead the opposite effect.

> If, by unpicking this assumption we find that we have developed a housing system that not only makes people sick, but which also works to direct and confine people with health problems and disabilities to the least healthy and most disabling segments of the residential environment, then the pretence of social justice loses its last vestige of legitimacy. Something drastic needs to be done (Easterlow, Smith and Mallinson, 2000:383).

Access to owner-occupation is negotiated via a commercial process based on people's ability to pay. People who experience mental illness are very likely to have compromised incomes (e.g. benefit level) as well as compromised earning histories resulting from illness-related unemployment and absences. The effects of the lack of credit-worthiness are exacerbated by the reliance of the housing finance market on mortgage protection insurance. People without jobs, or on below-average incomes are thus excluded from a form of housing that could produce good health outcomes. Housing tenure depends on the ability to maintain a mortgage, and is thus a reflection of the macroeconomic climate. The Easterlow, Smith and Mallinson study reports that mortgage arrears, resulting either from health problems that led to redundancies or from accidents, were the main cause of respondents' loss of their housing via repossession, and observes that in periods of low inflation and rising interest rates all marginal home owners are at risk.

Mortgage holidays are marketed as being helpful, but inevitably lead to increased costs overall. Even rescue packages that can turn a mortgage contract into a tenancy have their problems, as regular payments are still required.

The cost of housing

In a study that is focused on housing affordability as a major cause of homelessness, Starr (1998) observes that although the homeless population has increased greatly since the 1960s, housing standards have not declined – indeed, housing standards have improved in that time. The low-grade, crowded dwellings that once provided homes to the very poor can no longer be built under current housing codes. According to Starr, the solution can be considered in a very straightforward way.

> If people with very low incomes are to afford homes, either their incomes must be higher or housing must be cheaper. Increases in the minimum wage and higher wage subsidies, such as earned-income tax credits, help raise more of the poor to self-sufficiency. Increased subsidies for low-income housing or reduced regulation can make housing cheaper or cheap housing more available. The remedy does not have to be a single magic bullet (Starr, 1998:1762).

A study by Dickey et al. (1997) evaluated the costs of two kinds of housing arrangements: Evolving Consumer Households (i.e. group home arrangements), and Independent Living Apartments. This study found:

> … that treatment and case management costs did not vary by housing type, but housing costs were significantly higher for those assigned to Evolving Consumer Households. Regardless of original housing assignment, treatment costs were lower for clients who remained where they were originally placed. The authors conclude that providing support for clients that increases housing stability reduces their need for treatment and that independent living arrangements may be a more cost-effective policy choice (Dickey et al., 1997:Abstract).

The detailed comparison of the relative costs to the residents of the two types of housing produced a startling result: "Of the total costs, housing represented about 44 percent for those assigned to apartments and 76 percent for those assigned to ECHs, a difference accounted for largely by ECH staffing costs" (Dickey et al., 1997:300).

Price signals in the housing market: housing availability

The lack of affordable, available housing is implicated in residential mobility (Kearns and Smith, 1994b) and the subsequent or intermittent predicament of homelessness. A different perspective of the problems of housing difficulty and homelessness is offered by Quigley and Raphael (2000), whose study of the role of the housing market suggests different strategies to deal with housing availability issues. In contrast with Starr (1998) who notes the phasing out of older very low-grade housing, these authors find in the United States that housing of 'demolition quality' is still an option at the bottom end of the housing market. In a climate where this is the only affordable housing choice available, a decision in favour of homelessness can be more easily understood.

> [R]ather straightforward conditions in US housing markets – not complex social pathologies, drug usage, or deficiencies in mental health treatments – are largely responsible for variations in rates

> of homelessness. We find that rather modest changes in housing markets, in vacancy rates and rents, for example, have substantial effects upon the incidence of homelessness. We conclude that public policies to make housing markets freer to respond to housing demand, especially for low quality services, could yield a large payoff in reducing homelessness (Quigley and Raphael, 2000:3-4).

These authors looked into the dynamics of the housing market and particularly at the reality of the housing choices that face people on very low incomes, observing that "Homelessness … results from decision-making under extreme income constraints and not from a preference for the 'homeless lifestyle'" (Quigley and Raphael, 2000:8).

In the United Kingdom, Hutson and Clapham (1999) have highlighted the consequences of mortgage repossessions brought about by restructured housing policy that placed increased risk on individuals to bear the consequences of unavoidable misfortune. Loss of one's home for whatever reason poses a serious threat to the housing stability of people who experience mental illness.

On this basis, it is reasonable to expect that an interventionist approach to housing policy would significantly assist the proportion of homeless people who are also affected by mental illness, since their capacity to participate in an adverse housing market can be severely limited by the combination of ongoing low income levels, high levels of discrimination, and by the adverse effects of their illness.

The housing consequences of mental illness: homelessness and transience

What happens, if the individual consumer/tangata whai ora, for whatever reason, cannot sustain their access to adequate, suitable, affordable housing? Homelessness and transience (or high residential mobility) can be understood as the end point of the cycle of compounding disadvantage in which some people can become trapped. The predicament of homelessness has a negative public face in the United Kingdom and United States of rough sleeping and deviant vagrancy accompanied by substance abuse (Pleace, 2000). Despite this, the literature provides a picture of homelessness as an extreme response to housing difficulties, often (but not always) compounded by mental illness: what is clear is that housing difficulties and homelessness lie on the same continuum. The experience of homelessness can therefore be located at the extreme end of the scale of housing inadequacy, already known to be associated with poor mental health. According to Neale (1997), a useful starting assumption is that:

> homelessness is a highly ambiguous and intangible phenomenon, which lies at one end of a spectrum of housing need/experience. It is integral to the housing system and inseparable from other aspects of housing need. Theories of homelessness and policies to tackle homelessness cannot, therefore, be separated from other aspects of 'housing' and housing need (Neale 1997:48).

Much of the extensive literature on homelessness surveyed for this project focuses on the huge increase in the homeless population in the last 25 years in

the United States following the de-institutionalisation of the 1970s and the crack epidemic of the 1980s. This literature includes O'Flaherty, 1996; Wong and Piliavin, 1997; Banyard and Graham-Bermann, 1998; Wright, et al, 1998; Zima et al, 1999; and Quigley and Raphael, 2000. Another body of relevant literature concerns a similar situation in the United Kingdom following similar trends to those in the United States but including housing market failure, with different impacts due to the legal categories of statutory and non-statutory homelessness reflecting different levels of the state's willingness to help. This second group of studies includes Timms and Fry, 1989; Fisher and Collins, 1993; Connelly and Crown, 1994; Daly, 1996; Burrows, Pleace and Quilgars, 1997; Hutson and Clapham, 1999.

A considerable body of literature focuses on homelessness *per se*, with only marginal mention of the effects of mental illness, but some studies do provide a very clear picture of homelessness as a last-resort response to multi-dimensional adversity beyond the control of the individual. Daly's advice (1996:113) on the connection between homelessness and mental illness in the United Kingdom is that "Though numbers are elusive, it is generally accepted that about one in three homeless people has serious and chronic forms of mental illness." In the United States, however, Daly estimates that "one in four homeless people … have been in hospital at least once. This is more than five times the rate for the general population" (Daly, 1996:114).

The literature includes a considerable debate on the fundamental causes of homelessness. Particular focus is placed on whether the homelessness problem can be attributed to the closure of psychiatric institutions (e.g. Howie the Harp, 1987; Timms, 1993; Franklin, 1999; Quigley and Raphael, 2000). The debate also includes the dynamics of the subsequent 're-institutionalisation' of people with mental health problems into the prison system (Quigley and Raphael, 2000). Among the homeless population in the United Kingdom, sleeping rough is a characteristic of younger, white males and some white females. However, less visible is the unknown but probably large amount of 'incipient' homelessness experienced by females generally, and by males and females of ethnic minorities. This latter issue is explored extensively by Fischer and Collins (1994), Smith and Gilford (1998), Smith, Gilford and O'Sullivan (1998)), and Franklin (1999).

Timms' (1993) view from the United Kingdom is that the increase in concern about homelessness in recent times is due to the increased visibility of homeless people, many of whom appear distressed or disturbed. When put together with a parallel (but not necessarily correct) concern about the fate of de-institutionalised people, the logic leads to the view that vulnerable people are being decanted out of hospitals into an ill-prepared community, and then on to the streets. The underlying assumptions, according to Timms, are that:

> … the phenomenon of the homeless mentally ill is new, that psychiatric bed closures have happened only recently, and that discharges from long-stay beds are unplanned. I hope to demonstrate that these assumptions are false. The real situation is more messy, less related to closure of psychiatric beds and more to do with the way psychiatry is practised in the post-institutional era (Timms, 1993:94).

Harvey (1999) finds in Westminster that one in eight of former residents of mental hospitals is now homeless. Moreover, "it is equally clear that for the majority of homeless people, problems of stress, substance abuse (principally alcohol) and mental illness followed rather than preceded homelessness" (Harvey, 1999: p.61).

Thorns (1986) conceptualises homelessness as a continuum. A further perspective on the cause of homelessness in the United Kingdom is provided by Hutson and Clapham (1999), who strongly assert that homelessness is created by public policy, but is nevertheless experienced as a private trouble. The attention of the news media to the most visible effects has produced the widespread but minimalist public view that sleeping rough equals homelessness. Hutson and Clapham link homelessness with a set of interacting adverse circumstances. It is clear that homelessness is caused by exclusion – exclusion from the labour market and welfare, exclusion from the housing market and exclusion from the family. Recession and economic restructuring underlie the current trends on homelessness. The exclusion of under-25s from full social security benefits triggered youth homelessness after 1988. Homelessness among young single people can therefore be understood to result directly from their exclusion from council housing (Hutson and Clapham, 1999:7).

Smith and Gilford (1998) suggest that there may be much larger numbers of people, and certainly larger numbers of women and families, among those whose homelessness is hidden from view because they are staying with friends and relatives, than among the visibly homeless. This issue is also explored by Wright et al (1998), who analyse the factors associated with 'doubled-up' housing, and identify it as a common precursor of homelessness, especially where it occurs in young adulthood. The effects on children of living in sheltered accommodation for the homeless is reported on by Zima et al. (1999), who raise considerable concern about the exposure of children to severe psychosocial stressors, and how that exposure relates to mental health outcomes. They found that high residential instability and acute homelessness were related to child depressive symptoms, suggesting that homeless families should be conceptualised as two generations at risk of mental health problems.

The difficulties of actually locating homeless people to count the numbers of people involved, and then of avoiding double counting are discussed in detail by Dail, Shelley and Fitzgerald (2000), who developed a systematic approach to dealing with these methodological issues. The media response to homelessness, or rather, the public response to the visibility of homelessness, is discussed by Liddiard (1999).

Initiatives aimed at improving housing circumstances

International research has shown unsuitable housing can exacerbate mental illness and hinder recovery. Independent long-term housing (i.e. ordinary housing, where a person feels at home) is consistently reported in the literature as producing better outcomes for people with mental illness than long-term group housing or cluster housing specially constructed or purchased for consumers of mental health services. First, such clustered housing attracts attention to the presence of mental health consumers in the community, and can fuel discrimination and hostility by other people in the locality, even if it is out of proportion with the real level of risk. Second, there is the risk that staffed

housing arrangements, however well intentioned, will reproduce the institutional atmosphere that the accommodation arrangement seeks to replace. Clustered housing is not necessarily the answer, as it is argued that the creation of specialised residential programs with on-site staff reduces the chances of people with mental illness living in a normal environment.

Carling analysed a database of over 4,000 journal articles and book chapters published in the previous 15 years, finding that support services for consumers should include:

- working with individuals to formulate their housing and support goals;
- financial assistance in acquiring long-term stable housing;
- help in searching for an apartment and moving;
- assistance in managing money and participating in leisure activities;
- assistance with medication;
- ongoing monitoring of needs;
- crisis support;
- peer support.

A major American study by Tanzman (1993) reviewed 26 sufficiently comparable studies of consumer preferences for housing. The review emphasised that most consumers strongly prefer independent living situations, but with a range of supports available to them wherever they live. It identified clearly that most people with mental illness have a strong preference for ordinary living situations such as long-term or permanent rented or owned apartments or houses, where they can feel at home with friends or relatives of their choice, rather than living with other consumers (except temporarily) or with support staff. Suitable housing situations must ensure that material needs are met, while also ensuring a wide range of support is available at the level of response the consumer needs at the time.

Keck's (1990) trial in Toledo, Ohio, which provided people with serious mental illness with sufficient support services to sustain their own real choice of housing, found that about three quarters were able to maintain independent living in rented apartments, and that their use of psychiatric services declined dramatically. However, ongoing support services were critical to the success of the trial. An effective response system to deal with crises, many of which originated with loneliness and inactivity, prevented many residents from losing their apartments. Interestingly, the view is expressed by Blanch, Carling and Ridgway (1988) that the widespread belief among mental health service providers in the United States that their clients are too disabled to succeed with independent living constitutes one of the greatest barriers to its achievement.

A real choice of housing is also important. Srebnik et al. (1995) found that housing service providers could often exercise a high degree of influence over housing choice. These authors conducted an experimental, empirical study,

finding that over two-thirds of consumers only had one housing option presented to them. Over one-third perceived little or no choice in their housing and felt their choice was highly or completely influenced by other people. This study found that having more choice was positively related to housing satisfaction and stability, and therefore with recovery. This study also identified that the level of benefit income in the United States was too low for consumers to meet the costs of adequate housing or have any capacity to exercise choice.

A different kind of support that provides financial back-up in times of crisis is provided in Toronto, where the Canadian Mortgage and Housing Corporation (CMHC, 2001) operated a rent bank pilot. This scheme provided emergency financial support to meet rental payments for mental health consumers who were in hospital, or to those whose illness meant they could not manage rent payments. This service helped many people to achieve housing security by avoiding eviction from private rental accommodation because of failure to maintain rent payments. One of its features was the recognition that rent loans might, in exceptional circumstances, need to be forgiven. The pilot evaluation recommended that the City of Toronto proceed to establish a rent bank.

Salend and Giek (1988) report that good outcomes for consumers can be achieved by providing landlords with information, especially about what services are available to support the consumer, and with reliable contact details in case of a crisis. Crisis management is important. Sustained, even if intermittent contact between mental health services and clients is frequently reported in the literature as a means of avoiding crises. In the United Kingdom, lack of access to mental health services, especially at times of crisis is often linked to homelessness.

In the United States, a randomised clinical trial was conducted by Susser et al. (1997) to study a strategy to prevent homelessness among individuals with severe mental illness, by providing a bridge between institutional and community care. The aim was to test the assumption that homelessness among people with mental illness can be attributed, in part, to discontinuity in mental health services. The study identified a critical time for interventions, over the nine months following discharge from the institution, where some of the respondents in the study received enhanced levels of service. The duration of the beneficial effect of the enhanced service was found to persist beyond the time of the intervention, and was still present 18 months later.

The need for policy integration

Even seemingly unrelated income support policies can cause consequential effects on housing experiences. Smith and Gilford (1998) point out the connection between the introduction in 1990 of the London Rough Sleepers Initiative (a policy to address the rapidly rising numbers, particularly of young people, sleeping rough in London) and the withdrawal of income support from young people aged 16-17 years, only two years earlier.

> In essence the RSI was a policy ‘targeted’ at those young people who had failed to survive within their own families after the withdrawal of state benefits or no longer had the income to support themselves (however poorly) outside a family home. Young people in the latter position included young people

> leaving care (often with no care plan), young people fleeing violence and other young people whose family was now disrupted and they were no longer welcome in the family home of the new partnership (mother/mother's new partner, father/father's new partner) (Smith and Gilford, 1998:71).

Much of the literature affirms the importance of service integration as a way of avoiding boundary issues and gaps in service for people with particular combinations of need, but without advising how this can actually be achieved. Nor is there much commentary on the fundamental role of government policies and programmes in generating and perpetuating the service boundaries.

> There has … in recent years arisen an atmosphere of increasing public and political scepticism towards the actions of professionals charged with delivering public services. At the start of the 20th century there appears to have been a general assumption that doctors, police officers, teachers and other professionals were the experts, whose judgement was to be trusted, and who were therefore left relatively unchallenged to carry out their duties. By the end of the century this culture of public trust had been severely diluted, as an increasingly educated, informed and questioning public sought reassurance that its taxes were being well-spent (Davies, Nutley, and Smith, 2000: p.1).

The more forward-looking advice perhaps is that a much greater level of service flexibility and responsiveness is required so that the needs of the individual can be addressed coherently and effectively in a way that makes sense to them, by their service provider of choice. To achieve this would necessitate far more flexibility and boundary crossing within the currently segregated pools of state funding, however.

One advocate of this view considers that if social services were to be conceptualised all over again, the structures and processes might not be focused on health or housing at all.

> The focus of social care is … difficult to summarise succinctly. Generally speaking it is concerned with individually manifested problems with a social dimension amenable to social intervention. However, history and bureaucratic happenstance isolate some areas – such as education, transport, housing and many aspects of healthcare – that might, were we to start afresh, properly be seen as social care (Macdonald, 2000:118).

Macdonald discusses the bureaucratic arrangements for social care, and also of the volatility inherent in the way that social problems are conceived within the political ideology of the day. Boundary issues, efficiency and co-ordination of services get a lot of attention since they relate to what money is being spent on, rather than the problems and issues that necessitate the expenditure. This view observes the world of support services reflecting the rather contradictory characteristics of the wider social policy framework.

The need for service integration

Effective integration among organisations committed to providing seamless services is supported by much of the literature as something that is self-evident. The World Health Organization supports a concept of integration that includes the community itself, not just the service providers, and aims to

> ... provide a comprehensive local service aimed at enhancing the autonomy and independence of the individual with a network of professional services and properly trained staff employed where the patient or resident lives (cited in Ranson, 1991).

The US Surgeon-General's report (US Surgeon-General, 2001), however, warns that reliance on service integration alone cannot necessarily produce results, and that other material support is still required. The report discusses the evaluation of a programme developed by the Robert Wood Johnson Foundation and HUD to promote the concept of local mental health authorities as the agencies responsible for integrating all services for people with chronic mental illness, including housing opportunities. The integration actions included reduced fragmentation of services, expanded case management, greater continuity of care and reduction in family burden, and improved client outcomes in social functioning and quality of life. The evaluation, however, found that the improvements for clients could not necessarily be attributed to the service integration actions, and that for some clients, their improvement was due to the benefits of special combined housing and support services.

This finding led to the speculation that the essential factors for service success were the availability of rental subsidies and supports, or more intensive and higher quality case management – such as those offered in assertive community treatment. A new study building on these findings is now being evaluated, and the preliminary findings support the value of assertive community treatment to obtain better clinical and social outcomes. These findings also support the association of better system integration with higher rates of moving people with severe mental illness from homelessness into independent housing (Rosenheck et al., 1998), but it is not yet known whether the improvements in system integration observed over time are associated with improvements in consumers' social and clinical outcomes.

3. A sustainability framework

Developing the framework

What became evident in the interviews and in the written responses on returned survey questionnaires, was that although a great deal of work was being done by a wide array of mental health service providers in New Zealand, there was a lack of unity of overall purpose in those services. Furthermore, there was no conceptual basis for thinking about how to bring such integration about. Much of the literature also was presented within narrow categories, with very few publications acknowledging their relationship to the big picture. Many mental health service providers indicated their awareness of the complex nature of the problems faced by consumers/tangata whai ora, but lacked a framework through which to articulate those concerns. The development of the sustainability framework during the course of this research was an attempt to respond to the need for an integrated typology of the resources, supports and support services

seen to be necessary for increasing the capacity of consumers/tangata whai ora to sustain independent housing.

As the international research literature indicates, the concept of 'support services' can be wide-ranging. Consumers/tangata whai ora require a considerable variety of resources, supports and support services if they are to live independently in the community. Both the literature review findings and the research evidence from this research study support the view that as well as the importance of integrated policies, support service delivery tailored to meet the full range of needs of the individual is also a vital element in sustaining independent housing.

The concept of 'sustainability' was originally defined so that the research could reflect a sufficient supply of available housing to meet long-term demand, which would therefore allow consumers/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. Although sustainability is sometimes discussed in the same context as adequacy and affordability as concepts pertaining to housing, the research suggests that the term sustainability is more useful if it is applied to consumer/tangata whai ora capacity to sustain independent living in the long term.

In New Zealand at present, there is no explicit conceptual administrative framework that can demonstrate how the responsibility for ensuring the provision of support services for consumers/tangata whai ora is divided among different agencies. One of the major outputs from this research project therefore has been the development of a concept to illustrate not only the role of support services and the current range of services, but also to provide a systematic framework in which the concept of resourcing in relation to individual needs can be articulated.

This sustainability framework (see Diagrams 2 and 3) was derived from an analysis of the literature, the results elsewhere in this project of the National Survey of Providers and the group interviews, and from available information about state provision at the time of the research in 2001.

The framework

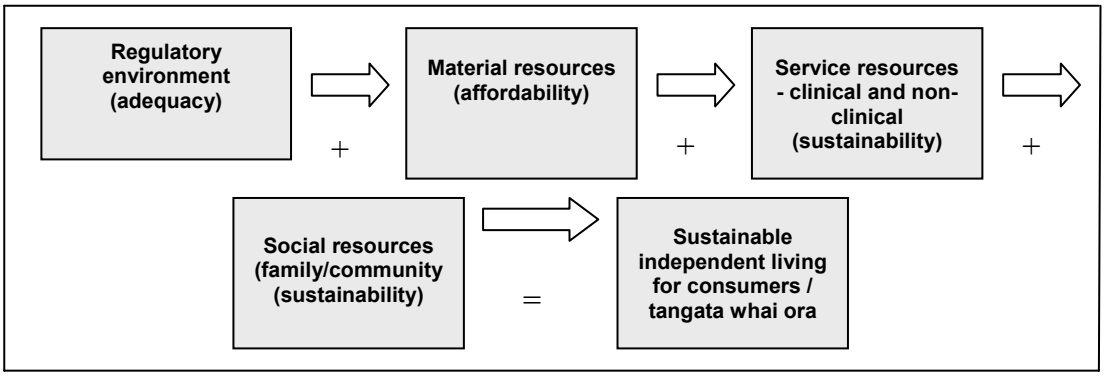
The framework shows that clinical resources are only part of the picture and that the provision of support services across a wide spectrum is needed if sustainable independent housing is to be a reality for consumers/tangata whai ora. Sustainability therefore is not so much an attribute of a particular housing unit, but is rather concerned with the array of supports and resources that are available to assist consumers/tangata whai ora to maintain independent living in the long term. Any consideration of sustainability therefore requires a focus on the arrangements of supports that are available to consumers/tangata whai ora.

Sustaining independent living requires considerably more resources and help than simply having a house.

The framework makes the distinction between regulatory, material, service and social resources.

In broad form also, the framework represents the relationship among the concepts of housing adequacy, affordability and sustainability:

Diagram 2. *Key resources and sustainable independent living*



The **regulatory environment** encompasses the systems that oversee the provision of material and service resources to ensure efficiency, order, safety and fairness. These systems include the regulation of the physical environment via the Resource Management Act 1991, and the Building Code and associated fire safety requirements and procedures. The regulatory environment also includes the Human Rights Act 1993, and its associated obligations to prevent discrimination in the provision of services, and in the housing and labour markets. The scope, power and degree of actual observance of the obligations imposed by this regulatory environment underpins much of the success or otherwise of the desire of consumers/tangata whai ora to sustain independent living.

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

- Housing supply relates to the location, quantity and quality (physical adequacy) of housing stock. The critical aspect of housing supply for consumers/tangata whai ora is the existence of housing stock in their local area that is adequate, affordable and suitable. Such housing may be provided by central government housing services (Housing New Zealand Corporation) local government (local authority housing), by the private market (rental, mortgage, or ownership), by NGOs (boarding houses, night shelters etc), or by family/whanau.
- Income supply includes the provision of the economic means whereby consumers/tangata whai ora can afford housing arrangements – these are largely benefit-related services including supplementary benefits such as accommodation support but may also include some of the regulatory aspects of the employment market such as the minimum wage. The provision of benefits is the responsibility of Work and Income

but the regulation of employment is more widely the responsibility of the Department of Labour and, at a local level, by local authorities.

- Food and utility supply is partly guaranteed under income supply – if a person's income is adequate their access to food and utilities is less likely to be compromised – but it also includes emergency foodbanks and community facilities such as soup kitchens on the one hand, and rating regimes for utilities on the other. In New Zealand, most of these elements either are or were provided by central government or subject to central government regulation. One of the unexpected outcomes from the group interviews was that consumers/tangata whai ora highlighted the additional burden created by rateable water.

Service resources cover those elements that are often described as 'support services': clinical support services, housing support services (or housing facilitation services), and personal support services.

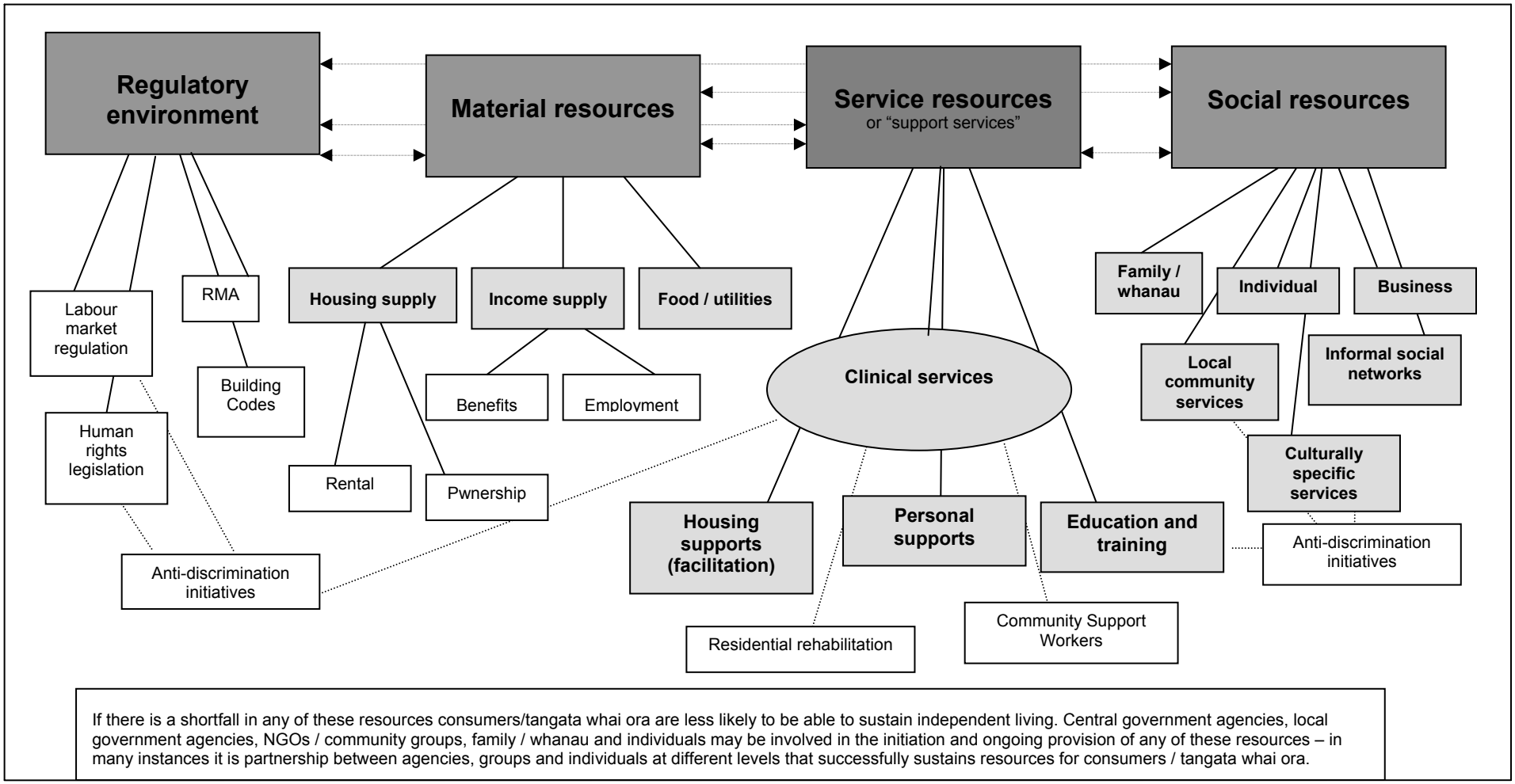
- Clinical services provide psychiatric support for consumers – ensuring that they have access to medication, specialist clinical services, and hospitalisation or other therapeutic residential accommodation funded by clinical services. This support is recognised by western medical and legal fraternities as part of what defines a person's mental illness – the support is put in place in response to diagnostic criteria. Clinical services, and the diagnostic criteria in particular, are not always regarded as culturally appropriate and there is some contestation of the status of clinical services in New Zealand – especially from Māori and Pacific communities. The Ministry of Health funds most of the clinical support services in New Zealand.
- Housing supports (facilitation services) includes the provision of practical help to assist consumers/tangata whai ora maintain their accommodation – such things as house and garden maintenance, furniture removal, laundry services, maintenance of fire safety equipment, rubbish removal and spring cleaning. There is also a range of liaison and advocacy services that can enable consumers/tangata whai ora to find and retain suitable, affordable, independent housing – such things as budget advice, help with utility connections, and landlord liaison.
- Personal support services refers predominantly to aspects of education and training that facilitate independent living, including the re-education of consumers/tangata whai ora about daily living skills. Personal support services also include counselling, self-development training and assistance to develop and maintain social contacts. Personal support services include many of the roles undertaken by community support workers.
- Anti-discrimination initiatives are designed more for the support of the 'general public' than for direct support for

consumers/tangata whai ora. They include a wide range of opportunities for combating the levels of stigma and discrimination experienced by consumers/tangata whai ora, including provision of anti-discrimination programmes aimed at landlords, the news media and the general public; and more vigorous enforcement of current anti-discrimination legislation.

Social resources refers to the range of less visible and often less formally organised supports that are also essential if consumers/tangata whai ora are to lead viable independent lives. These resources range from the capacities of the individual and their family/ whānau to participate in informal social networks, and locally and culturally specific services and activities that consumers/tangata whai ora can be connected with.

Diagram 3 demonstrates in detail the complex web of interacting resources and supports that must be woven together for sustainable, independent living to result for the individual consumer/tangata whai ora.

Diagram 3: *The sustainability framework: a typology of resources necessary for consumers/tangata whai ora to sustain independent living.*



4. The New Zealand literature

Application of the sustainability framework in the New Zealand context can provide the opportunity to consider provision of the full range of resources, supports and services needed by the individual consumer/tangata whai ora in order to sustain independent housing arrangements, thereby contributing to improved mental health outcomes. The following review of New Zealand research results and other literature is therefore structured to reflect the conceptual divisions within the sustainability framework.

The link between mental health and housing: New Zealand research evidence

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 the assumption that the experience of mental illness and housing difficulties are linked, although documenting the exact details of the linkage has not necessarily been the prime focus. The widespread acceptance of the linkage is exemplified by the Mental Health Commission in its discussion paper on housing (1999c):

> … recovery [from mental illness] requires specific housing arrangements that combine support, a quality physical environment and suitable local environment. These arrangements may include:
>
> - co-ordination 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 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;
> - physical comfort, safety and privacy[6].

Primary New Zealand research

As well as a number of smaller-scale studies on specific topics, three substantive research studies have been conducted in New Zealand in the last decade to explore different aspects of the link between housing and mental health issues (including Kearns, Smith and Abbott, 1991 (see also other papers associated with this study) and Robinson, 1996a and 1996b). The most recent

[6] Derived from Nelson, Hall and Walsh-Bowers, 1998).

New Zealand survey was commissioned by the Health Funding Authority, and was conducted during 1999 by the University of Otago's Department of Psychological Medicine at its Wellington Clinical School (University of Otago, 2000).

These three large studies of mental health and housing issues that form the core of the New Zealand research to date all have different perspectives and methodologies. Despite these studies, there are groups of people, such as Māori, Pacific peoples and older people, about whom very little is known in terms of the interaction between their mental health and housing needs. Furthermore, very little is known about how the circumstances of people who experience mental illness who have housing difficulties differ from the circumstances of people who also have housing difficulties, but do not experience mental illness. An additional factor is the role of drug and alcohol abuse: as a cause and as a symptom of mental illness, and also as a cause of poverty that undermines housing arrangements.

The three primary research studies conducted in New Zealand can be considered in terms of their focus on different aspects of the sustainability framework. The results of the Kearns, Smith and Abbott (1991) research provide New Zealand evidence of the link between housing and mental health, particularly the finding that poor quality housing can have mental illness consequences. These are issues of housing adequacy and suitability, and are discussed below under *Regulatory Environment Issues*. The Robinson studies (1996a and 1996b) both illustrated the necessity of a comprehensive range of services to sustain independent living in the community, and are discussed under *Support Service Provision* below. The University of Otago study focused on a particular aspect of support service provision, i.e. clinical services, finding that the most important service gaps identified in the study related not to clinical services, but to other aspects of support service need.

The current administrative framework for service funding and provision is such that many of the issues identified as needing attention are beyond the power or authority of clinical service providers to address. In general, all of these studies yielded information about problems whose solutions relate to responsibilities elsewhere in the current administrative system of support and service provision. It is reasonable to propose that these collected findings point to the absence of integrated goals for government-funded services and other interventions in the lives of consumers/tangata whai ora.

Other New Zealand research

As well as the major primary research studies, a number of New Zealand reports take their findings into account along with relevant research from overseas to discuss mental health and housing concerns in New Zealand, either as the primary field of discussion or as a related issue: (Sheerin and Gale, 1985; Crawshaw, 1991; Public Health Association, 1992; Abbott and Kemp, 1993; Framework Trust, 1993; Waldegrave and Sawrey, 1994; Crawley et al., 1995; Bridgman, 1996; Saville-Smith, McClellan, and McKay, 1996; Waldegrave and Stuart, 1996a, 1996b and 1996c; Ellis and Collings, 1997; Jamieson, 1998; Melding and Osman, 1998; National Health Committee, 1998 ;Dept. of Corrections, 1999; Murphy, 1999; NZCOSS, 1999; Yisrael, 1999); Cairncross, 2000; Howden-Chapman and Tobias, 2000; Lynch, 2000; National Health

Committee, 2000; O'Brien and Haan, 2000; Cooper, 2001; and Ministry of Health, 2001a .Gray, 2001; In particular, the substantial publications edited by Ellis and Collings (1997) *Mental Health in New Zealand from a Public Health Perspective*, and Howden-Chapman and Tobias (2000) S*ocial Inequalities in Health: New Zealand 1999* both provide a wide range of contextual material to inform any investigation of mental health issues, especially in New Zealand.

The publications of the Mental Health Commission (MHC), however, provide the core framework of the most recently published literature available in New Zealand that specifically explores the link between mental health problems and housing. Apart from the MHC publications establishing the MHC *Blueprint for Mental Health Services in New Zealand* (1998b) and related publications updating progress with service provision, three recent publications are particularly valuable in informing this topic: Paine's 1998 report *Housing and Housing Support for People who experience mental illness*, the Mental Health Commission's discussion paper, *Housing and Mental Health: Reducing housing difficulties for people who experience mental illness* (MHC, 1999c), and Bennion's (2000) report on the significance of planning processes for supported accommodation.

The absence of sustainability: homelessness and transience in New Zealand

The New Zealand literature discusses three levels of homelessness: sleeping rough, temporarily homeless and incipient homelessness. The overseas research establishes that rather than being an outcome of de-institutionalisation, homelessness can be understood to be an extreme outcome of serious housing difficulties. People with serious mental health problems, who tend to have the most intractable housing problems, often experience homelessness. Serious mental illness such as schizophrenia often precedes homelessness but is not usually caused by it. Alcohol and substance abuse are often associated with attempts by homeless people to relieve stress, which can then lead to long-term addiction. Overseas studies of homelessness detail how it develops in response to local combinations of difficulty in accessing adequate housing and mental health services. New Zealand research on homelessness by Buttle (1999) and O'Brien and Haan (2000) has provided information on the numbers of homeless people (e.g. Buttle reports 819 in Auckland, Wellington and Christchurch in 1999). The New Zealand research also explores the circumstances of homeless people (i.e. poverty, discrimination, and lack of access to services).

Kearns, Smith and Abbott (1993) report New Zealand evidence that there is a connection between mental health and homelessness, citing Smith (1986). O'Brien and Haan (2000) nevertheless assert strongly that in New Zealand, the categories of 'homeless' and 'mentally ill' only partly overlap, despite the public perception based on the visibly homeless. Timms' (1993) view from the United Kingdom is that the increase in concern about homelessness in recent times is due to the increased visibility of homeless people, many of whom appear distressed or disturbed. When put together with a parallel (but not necessarily correct) concern about the fate of de-institutionalised people, the logic leads to the view that vulnerable people are being decanted out of hospitals into an ill-prepared community, and then on to the streets.

One of the related studies from the New Zealand research by Kearns, Smith and Abbott (1991) concerns residential mobility, which is akin to the concept of transience. In 1994b, Kearns and Smith listed a number of factors that influence residential mobility. Marginalised groups are likely to be more vulnerable to experiencing the effects of such trends:

- constantly changing patterns of economic opportunities;
- changing demographic trends;
- state restructuring activities;
- ideological shifts;
- the changing character of the urban housing market.

(Kearns and Smith, 1994b: 115).

This Kearns and Smith study also cites other sources to confirm that:

> [t]here is some evidence that severely constrained groups such as the mentally ill, tend to be significantly more mobile than the population as a whole, presumably because the sort of housing they can afford is seriously inadequate for their needs, especially following a period of institutionalisation [Taylor et al., 1989]. It is relatively easy to envision a scenario in which, in the absence of sufficient resources and sufficient housing options, such individuals become permanently mobile, and, ultimately, homeless (Aviram, 1990).

Further analysis and discussion of the Kearns, Smith and Abbott (1991) research data noted that the 'housing need' and the 'psychiatric' groups of the research sample were more mobile than the control group. In addition, significantly higher exposure to stressful aspects of housing were demonstrated for the marginalised groups, than for the control group. The research found that the major reasons for moving house were push factors, particularly the stresses associated with cost and overcrowding. Although these stresses meant that many people wanted to move, the people most likely to move house were the younger respondents. For the people in the 'psychiatric' sample, household size and housing stress were also significant correlates: "The results demonstrated that for the two marginalized populations, moving appears to be a means to alleviate the stress of inadequate housing" (1991:125). The authors note that a marked improvement in mental health was found among those who had been re-housed by the state. Even though moving is a stressful experience in itself, the positive effects of obtaining more satisfactory housing outweighed the negative effects of the move.

The more recent New Zealand literature on homelessness features Buttle's (1999) study, Cooper's (2001) thesis on homelessness in central Auckland that points to a range of structural forces impplicated in the predicament of homelessness, and the Auckland City Mission study carried out by O'Brien and Haan (2000). This latter study asserts that although homelessness has been explored within overseas research, there is not necessarily a high level of comparability in the needs of homeless people between countries overseas and in New Zealand. Overseas models of service provision will not necessarily be

applicable in New Zealand. Furthermore, it is spurious to assume there is a causal connection between homelessness and mental ill-health.

> It is more productive and useful to see the homeless as a group with particular social, physical and emotional needs, and to understand that mental health services are but one part of the total range of services needed by this group (O'Brien and Haan, 2000:6).

Three levels of homelessness are identified from the literature, including sleeping rough, which is linked with the public perception of homelessness; temporary homelessness, mostly of single people in boarding houses, shelters and other temporary accommodation; and incipient homelessness where people, often female-headed families with children, are at risk of becoming homeless or are already living in doubled-up, crowded households.[7]

O'Brien and Haan (2000) collected data from a range of Auckland services for homeless people, finding that in the first week of August 2000, the combined efforts of the Methodist Mission, the Night Shelter, the Take a Break service and the Auckland City Mission produced a total of 1475 occasions on which services were provided over the course of the week, or (approximately) 210 each day. The authors note that the Methodist Mission reported an increase from 23,025 meals provided in 1998 to 32,757 meals in the year to June 2000, an increase of 42.2 percent; and that similar increases are reported by Auckland City Mission.

The interviews with homeless people revealed that despite the health needs identified, the use of health services was limited, often due to cost. The low use of health services was identified as a cause for concern, given the level of physical and mental health issues identified, and the sometimes extensive use of alcohol as a way to deal with stress. The findings of this study highlight the diversity among the group of homeless people, the range of physical and mental health issues for them, and the significance of the agencies they are connected to for providing a place for the people to be safe in, and for social contact.

The aim of Buttle's research (1999) for Housing New Zealand (HNZ) was to ascertain the numbers of homeless people in Auckland, Wellington and Christchurch, in order to formulate the development of sustainable solutions for their needs. In the study, homeless people were categorised in two groups:

- living in the open or in public areas, or accessing shelters (Group A);
- Women's Refuge residents, asylum seekers and refugees, rape crisis victims [sic];
- families living in overcrowded dwellings (Group B).

[7] For a fuller discussion of incipient homelessness in the New Zealand context, see Kearns, Smith and Abbott, 1992.

The study did not attempt to quantify the numbers of homeless people in Group B (described elsewhere as 'incipient homeless'), but advised that people can easily move from Group B to Group A when their circumstances change.[8]

Buttle estimated on the basis of available data from service providers such as bed rates and meals served at shelters,[9] that within the five categories in Group A, the homeless numbered in 819 in total (see Table 1).

Table 1: Numbers of homeless people in Auckland, Wellington and Christchurch (source Buttle, 1999)

Category of persons in Group A	**Numbers**
Street people	250
Poverty related homeless	160
Mental health consumers	*229*
Drug and alcohol abusers	*100*
Youth	90
Total	**819**

In the five Group A categories, 329 experienced mental health or drug and alcohol related issues.

Buttle formulated strategies to deal with the problem of homelessness:

- including a range of agencies to make sure that different aspects of this complex problem can be addressed;
- accepting that sustainable housing is important as a therapeutic factor, along with medical care and social support services;
- developing partnerships between Housing New Zealand, possibly Community Housing Ltd, and the service organisations[10] which demonstrate commitment and effectiveness, understanding that homelessness is an acute and a long-term problem that will necessitate expenditure on programmes to achieve improvement.

The work in the United Kingdom of Smith and Gilford (1998) discussed earlier certainly suggests that there may be larger numbers of people, and certainly larger numbers of women and families, in Group B than in Group A (the visibly homeless).

Few comments appear in the literature on homelessness and transience in relation to Pacific consumers/tangata whai ora although it is perhaps likely that

[8] The national survey undertaken by MSD as part of this research – see Quantifying independent housing needs: Part 5: a survey of service providers for mental health and independent housing need research, confirms that many people who experience mental illness are homeless or in situations of incipient homelessness – i.e. they are living long-term in caravans, motels/hotels, bed and breakfast establishments, boarding houses or hostels, or are living long term with families/whanau, not necessarily of their choice.
[9] Buttle advised caution regarding the numbers, as the categories may overlap.
[10] Organisations recommended for such partnerships included The Community of Refuge Trust, Auckland; The Auckland Methodist Central Mission; The Sisters of Compassion, Wellington; The Christchurch City Council; and Comcare, Christchurch.

Pacific peoples and Māori , to some extent, will be experiencing the less visible homelessness (temporary and incipient) observed in the United Kingdom among people of ethnic minorities. One study of residential mobility and health in two low-income urban communities (Milne, 1999) suggests a particularly strong relationship between low income, housing stressors and health in Māori and Pacific communities. There is some evidence that overcrowding in households is a persistent aspect of the lives of consumers/tangata whai ora that may contribute to homelessness.

Sustainability of independent housing in the New Zealand context

Regulatory environment issues

Housing adequacy and suitability

Administrative oversight of the physical adequacy of housing for all New Zealanders, not only those who experience mental illness, is an element of the Government's regulatory framework in New Zealand, implemented via the provisions of the Resource Management Act 1991 and the obligations of the Building Code. The impact of housing quality on both physical and mental health is therefore a central issue for those agencies of government responsible for its effective influence.

Housing must be suitable for the mental health needs of the consumer/tangata whai ora, as well as physically adequate. The New Zealand research by Kearns, Smith and Abbott (1991) discussed in detail below established that the condition of the dwelling is a strong predictor of well-being. Robinson (1996a and 1996b) found that levels of stress and tension, and access to support were both key elements in the ability of consumers/tangata whai ora to live independently in the community. In addition, levels of residential mobility are high, and are often associated with the need to get away from conflict with flatmates.

These, and several smaller research studies have found evidence of the negative effects on mental health of housing that is physically inadequate, as well as the negative effects of other aspects of unsatisfactory housing such as crowding, noise, stress, tension and conflict. Access to services is imperative for consumers/tangata whai ora to deal with these problems satisfactorily. Housing that is physically inadequate (i.e. cold, damp, noisy, high-rise, dilapidated etc.) is associated with both physical and mental health problems. These findings add to the overseas research evidence that 'suitability' reflects satisfaction of consumers/tangata whai ora needs for physically adequate housing plus easy access to effective support services that can assist with a wide variety of difficulties.

The New Zealand research published in 1991 by Kearns, Smith and Abbott reported on the results of a longitudinal survey to explore the relationship between mental health and housing in Auckland and Christchurch in two populations totalling 582 respondents. The respondents included people with established psychiatric disorders as well as people experiencing serious housing problems. Within this division, samples were drawn from four groups: applicants to the then Housing Corporation New Zealand (HCNZ), people from 'problem neighbourhoods', recent recipients of mental health treatment, and a comparative random sample of people. The data was then used to generate measures of 'housing stress', which was integrated with other information on

HCNZ points, and dwelling and neighbourhood satisfaction. Correlates and predictors were then identified. The results for the psychiatric group showed that while more Christchurch respondents reported housing problems than those in Auckland did, their problems were less serious. In Auckland, the main housing concerns were the cost of housing and coldness/dampness (even though on average, Christchurch is colder in absolute terms). Longitudinal analysis revealed that the housing stress scale[11] for condition of dwelling was a strong predictor of well-being.

This major New Zealand study found that the mental well-being of people with psychiatric disorders is correlated with the quality of their housing,[12] giving New Zealand evidence to the assertion that poor physical quality of housing can have mental health consequences as well as the more widely reported physical health concerns. Moreover, improved housing conditions including stable tenure can lessen the impacts of mental illness. This body of research demonstrated that re-housing people with psychiatric disorders in state-subsidised housing (producing better living conditions for the people concerned) can lead to reduction in stress levels. These results indicate the reduction in negative affect predicted by the findings of Nelson, Hall and Walsh-Bowers (1998, discussed above).

Kearns, Smith and Abbott (1993:269) discuss the difficulty of establishing what housing adequacy actually means, although "… it has been relatively easy for writers in the mental health literature to identify a normative set of housing standards for people experiencing ongoing mental health problems." These authors cite Sheerin and Gale's (1985) finding that some former psychiatric patients have experienced such lowered expectations that they can sustain themselves in what most other citizens would dismiss as totally unacceptable conditions. This Kearns, Smith and Abbott article goes on to discuss why a disturbingly high proportion of their respondents could not cite any strategy to cope with their housing problems, warning that this lack cannot be interpreted as a matter of individual inadequacy. Rather, limitations on housing options and lack of knowledge and information are more likely scenarios.

This analysis indicated that among the two-city sample (i.e. from Auckland and Christchurch), socio-economic factors were significant determinants of housing stressors among people with mental health problems. Grimly consistent with observations from other Western countries, those people with mental health problems who are most dependent on social welfare benefits appear to be living in the worst dwellings, measured in terms of the physical conditions of their housing. This is ironic in light of the original goals of the welfare state. The occupation of poor quality housing can only add to their stigmatisation and predisposition to distress (Kearns, Smith and Abbott, 1993:274).

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[11] The housing stress scale developed by Kearns, Smith and Abbott (1991) is the basis for the housing difficulty scales used in the MSD national survey of providers, that is reported on as part of the National Survey of Providers.

[12] See also the discussion of these findings in Howden-Chapman and Wilson, 2000; Waldegrave and Sawrey, 1994; Robinson, 1996a and 1996b; Waldegrave and Stuart, 1996a; Paine, 1998.

Resource Management Act issues

The link between mental illness and the public's perception of safety is discussed in the New Zealand context by Bennion (2000: p.19), who points out that while the perceived risk is out of proportion with reality, fear in the community must be nevertheless addressed. The use in New Zealand of the Resource Management Act 1991 by private interests wishing to limit the location of sites for community-based service delivery (e.g. group homes) is a factor that may seriously hinder the development of service provision, thus providing a means of perpetuating institutionalised expressions of discrimination. Of the approximately 65,000 people in New Zealand who use mental illness services, only 3000 live in supported accommodation (Bennion, 2000). Furthermore, people with mental health problems who live in a group home setting are 'at home'. The resource management legislation and processes are thus being used by one group of people who are at home, to limit other people's opportunity to be 'at home'. Bennion points to research showing that the public perception of declining amenity value of neighbourhood properties near community service locations is not borne out in reality.

The operation of the Building Code

Another issue that has been identified as a matter for urgent attention is the current state of the building safety requirements for group housing, which in Paine's (1998) view are so confused as to hinder establishment. In particular, the cost of installing sprinkler systems can stymie community initiatives to establish housing for consumers/tangata whai ora with housing needs. Fire safety compliance requirements, including inappropriate levels of safety equipment and signage even in houses of ordinary structure, can re-create an institutional atmosphere. These issues are discussed in detail by Paine (1998), who urges the authorities to improve the situation.

Labour market regulation

The Vocational Services strategy, *Pathways to Inclusion*, announced by the Government in September 2001, is aimed at increasing the labour market participation of people with disabilities. The category of psychiatric disability is not straightforward, as the notion of long-term permanent conditions is inherent in the concept of disability. Whether or not consumers/tangata whai ora who experience episodic illness punctuated by spells of wellness can benefit from this opportunity has not been explored within the context of this review.

Human rights issues

In order to combat discrimination against consumers/tangata whai ora, the *Like Minds, Like Mine* programme is currently funded to project positive understanding of the predicament of mental illness, and is discussed below. Such initiatives are taken in a climate where the amount of media attention that ensues when a consumer or tangata whai ora is involved in criminal behaviour or physical violence is out of all proportion with the level of risk to the public. Articles in popular magazines such as *What becomes of the broken-hearted?* published in *Metro* (McNaught, 2001) serve to emphasise the current difficulties in New Zealand in providing enough clinical support. These legitimate concerns, however, serve also to heighten public perceptions of the risk associated with the existence in society of people with mental health problems.

Far less information is available that discusses initiatives or even opportunities to safeguard the rights of consumers/tangata whai ora.

The Ministry of Health's very visible initiative to counter stigma and discrimination associated with mental illness (Ministry of Health, 2001d) is part of a national plan to span several years. Supported by valuable and comprehensive publications of the Mental Health Commission in the late 1990s, the *Like Minds, Like Mine* project aims to change opinions and behaviours in all aspects of society, and thereby to the lives of people who experience mental illness. The project aims to achieve six strategic objectives, to:

- develop infrastructure and networks;
- empower people with experience of mental illness and increase their involvement in the project;
- work with the mental health sector to change attitudes and behaviour through education and policy development;
- change attitudes and behaviour in government agencies having frequent contact with people with experience of mental illness through policy development and education;
- change public attitudes and behaviour through media, public relations and community education activities;
- address stigma and discrimination in Māori and Pacific communities through community education.

Material resources Issues

Housing affordability: a function of price and income

To achieve and maintain independent living, any individual must have the material means to afford its price. For consumers/tangata whai ora especially, a supply of available, affordable housing is needed to make possible the selection of housing that is located in an area reasonable close to support services (clinical, housing facilitation and other support) as well as being close to family, friends and existing social networks.

For the very many (but not all) consumers/tangata whai ora who are beneficiaries, their supply of income is fixed by the level of their benefit income, plus whatever additional sources of income support they are eligible for. For a number of years immediately before the fieldwork for this research, however, the price of housing, including that provided by the state, was fixed by the market. The existing measure to ensure housing affordability, the Accommodation Supplement, did not necessarily suffice, as most research studies document the extremely low incomes of consumers/tangata whai ora along with serious housing affordability problems.

However, the scope of the Accommodation Supplement is limited to direct housing costs, and does not cover any of the costs that can be associated with having to choose housing that costs less because it is located on cheaper land in remote areas at the edge of cities. There can be considerable costs associated with the transport required to get to work, or to visit family or friends. Compensation for these costs is not available within housing assistance, and yet they result from the location of affordable housing. Morrison (1995) reports on

a range of issues that result from the exclusivity of the scope and operation of the Accommodation Supplement.

Murphy (1999) provides a valuable critique of the operation of the Accommodation Supplement over time, pointing out that although the Accommodation Supplement replaced other forms of housing subsidisation previously available to low income earners (e.g. subsidised mortgages), it did offered little assistance to low income non-beneficiaries. Thus, unless consumers/tangata whai ora were beneficiaries, the the Accommodation Supplement would not have provided assistance of any great significance. For those with episodic illness punctuated by spells of decreased symptoms (and therefore lack of apparent sickness), beneficiary status is difficult to negotiate and maintain.

A further issue is the decline in the availability of inner city low-income housing that has followed the trend for urban renewal and gentrification in run-down areas close to the city. Gollop (1995) provides a history of town planning that identifies urban renewal as a government-structured intervention into the property market with the appearance of meeting social goals. She also documents local government focus on town planning as a regulatory process, rather than one aimed at the production of housing. Responsibility for the social goals of low-cost housing was left to the government, and still is: recent events in Auckland are evidence of the local government authorities' current wish to sell their rental housing for low-income people.

Horton's somewhat polemical article (1995) sets out all too clearly the deterioration in conditions for low income people in the housing market following the housing reforms in New Zealand in the1990s, and predicts an increase in homelessness. Murphy and Kearns, in a 1994 study of the consequences of the housing reforms, draw attention to the mismatch in house size between the current state rental housing stock and the needs of people wishing to rent. While low-income families are forced to economise on space, leading to overcrowding, people who need single accommodation cannot get it, as there are not enough small units.

Furthermore, those people who need to live alone and can only get a larger unit find that the level of their housing assistance (the Accommodation Supplement) is tied to their single occupancy and not the size of the house (which, being bigger, will cost more in rent). On a single person's benefit income, single occupancy of larger units in these circumstances is almost certainly unaffordable. A two-bedroom unit, where the single occupant can have non-resident caregivers or other people to stay to assist them from time to time, is out of the question. Murphy and Kearns advised that although it had been estimated that about one-third of state house tenants needed single accommodation, only one tenth of Housing New Zealand rental properties were one-bedroom dwellings (Waldegrave, Sawrey and Martin, 1991). In the United Kingdom, Hutson and Clapham (1999) have highlighted the consequences of mortgage repossessions brought about by restructured housing policy that placed increased risk on individuals to bear the consequences of unavoidable misfortune. Loss of one's home for whatever reason poses a serious threat to the housing stability of people who experience mental illness.

A comprehensive analysis of the social and economic factors associated with mental illness that includes appraisal of the overseas and New Zealand research, is provided by Ellis and Collings (1997). This study reviewed the literature on changes in social service provision since 1984, finding increasing poverty, unemployment and disempowerment since this time. Their report also associates increasing levels of stress and poverty in the Māori population with the decline in mental health among Māori. Waldegrave and Stuart (1996a) support this view in their review of the literature on housing disadvantage and Māori since 1980, identifying that Māori are consistently identified among those at most disadvantage, more likely to be in housing difficulty and living in substandard conditions. A further report by the same authors (Waldegrave and Stuart, 1996b: 36) clearly link poor housing with poverty and its consequences: "These involve physical sicknesses, including respiratory problems and chronic illnesses, mental health sicknesses, including neurotic stress and chronic depression."

The active inclusion of people who experience mental illness within the scope of EEO programmes (or similar) may therefore generate beneficial results. The *NZ Disability Strategy: Making a World of Difference. Whakanui Oranga* (Ministry of Health, 2001f) notes the need to educate employers about the skills of disabled people within an environment of increased understanding of the rights of disabled people.

Health selectivity in the New Zealand housing market

Robinson (1998) explored the extent to which housing provision is implicated in the health profile of homeless people in New Zealand. This study observes that there is little research into the health selectivity of housing, because of the assumption that selectivity will operate in favour of people with health problems. In the United Kingdom, local authority housing managers rely on general practitioners for medical advice regarding people needing housing, but doctors have no proper guidelines to assess housing problems, and no basis for assigning priority. Furthermore, the housing professionals have no training in interpreting medical advice.

This potential lack of skill may be an important factor to consider in view of the Mental Health Commission's stated opinion (MHC, 1999c) that housing assessment should be included with clinical assessment of the needs of people who experience mental illness. The Robinson (1998) study found that many people with mental health problems simply did not have enough information to know what assistance they could apply for, and many were unaware that medical grounds for housing assistance existed. When asked about their medical details by council workers, such people were often too suspicious to divulge details, conditioned by experiences of stigma and discrimination to fear a negative response. Thus the 'help' from the gate-keeping council worker to fill out a housing application form can operate as a covert rationing measure. Importantly, Robinson's study found that a common thread running through respondents' experiences was that they did not want to become and do not want to remain homeless (Robinson, 1998:29).

Service resources issues

Support service needs

Two publications prepared for the then Ministry of Housing reported on studies undertaken in Auckland (Robinson, 1996a) and Wellington (Robinson, 1996b). This research focused primarily on issues of suitability, and aimed to provide information to enable policy makers to distinguish between the physical facilities of the house, and the experience of living there. The objective of these studies was to gain an insight into the consumers' experiences of housing, including discrimination, episodes of homelessness and the impact of gatekeepers and support workers. In-depth interviews with many open-ended questions explored a range of topics, with 97 interviews in Wellington and 112 interviews in Auckland. The strength of the qualitative research design was that it could provide first hand information on the range of experiences of the respondents, as had been recommended at the end of the Kearns, Smith and Abott (1991) research discussed above, although these studies were not apparently undertaken as a direct result of that recommendation.

Robinson's (1996b) Wellington study identified two key elements in the ability of consumers/tangata whai ora to live satisfactorily in the community: stress and tension, and access to support. Relations with others living in the same accommodation was a major factor: some people would move to avoid conflict, and some who could not avoid it became homeless or transient as a result – either way the existence of conflict had negative results on individuals.

The focus of the Auckland study (Robinson 1996a) was to explore what housing options work, as well as those that do not work. The answers to these questions were less clearly defined: all of the different types of housing appeared to work for some consumers, for some of the time. The main issue is how to balance the need for ongoing support with the desire for independence. Similarly to the findings in Wellington, the report of the Auckland study suggests that the administrative concept of levels of need requires review to make it more responsive to the circumstances of individuals in a way that separates the need for clinical services from the need for appropriate housing. In Auckland, problems with housing were more likely to relate to relationships with other residents or staff, than with the house itself and consumers wanted assistance to manage their situation, rather than be managed themselves.

Kearns, Smith and Abbott (1991) also observed residential mobility being used by their respondents as a short-term measure to deal with housing problems. They concluded that these people probably moved house as a result of push factors that caused them to leave their housing arrangements (such as poor physical condition of the house; behaviour of flatmates because of their mental illness or their drug or alcohol abuse), rather than pull factors that motivated them to move to a new housing arrangement that was better in some way.

The Ministry of Health (2001a) is currently conducting a review of non-clinical services among the range of services it is responsible for (as distinct from clinical services). This approach implicitly acknowledges the breadth of scope over which services are required by the individual consumers/tangata whai ora, as non-clinical services are included within the range of clinical service providers. The investigation has limited application to this review, however, as it is focused on the service needs of people who are living in residential settings

in order to receive their clinical care, rather than the needs of people living independently, who were the focus of the MSD research.

Clinical support service issues

The University of Otago (2000) survey assessed the needs of 2807 people with severe mental illness in the then Central HFA region, through the perceptions of the clinicians treating them. The methodology used was similar to that of a previous HFA survey carried out in 1997 by North Health, but data collection was restricted to that from key workers alone. It aimed to include all high needs mental health consumers receiving services from HHS in the Central Region, and those from a small number of specified NGO providers. The collection of data from clinicians only was justified by the researchers on the basis of previous research experience in Auckland, in which there were problems recruiting sufficient numbers of consumers to achieve the sample. In that research it was subsequently found that there were only limited differences in the perceptions of clinicians and consumers. The survey design included reliability assessments to ensure the accuracy of the data collected, and the results indicated a high level of reliability. Results of the rates of consumer needs were published by need type, and by district health board area.

The scope of the survey included consumers/tangata whai ora receiving residential care provided via the HFA-funded health sector. It is not completely possible to achieve a clear split in the findings among the consumers receiving accommodation via the health sector, and those making their own arrangements, which is the focus of this current project. However, the survey reports that 55 percent of the group spent the entire three months prior to the survey either in their own home or in rental accommodation. It is also reported that some 298 consumers spent the whole 13 weeks with a family/carer, and 167 spent some of the time with a family/carer. It is not possible to determine from the report whether any of these people are included in the 55 percent above, who were living in their own home or rental accommodation – i.e. whether the consumer stayed at their independent accommodation, and the family/carer came to live with them. What is clear is that 45 percent of consumers did not maintain independent living during the 13-week period studied, spending time in hospital, respite care, and levels III and IV residential accommodation.

Difficulties with accommodation were not included in the five most serious unmet needs identified in the survey, but the fifth most serious (in order of frequency) of the partially met or moderate needs was ‘looking after home’, with 26 percent of consumers identified as having moderate problems. Combining these two groups (i.e. serious needs plus moderate needs) as the best indication of the overall need for services, the two highest rankings were psychotic symptoms and psychological distress, followed by daytime activities, the need for company, and problems managing money. The researchers advise that the averages inherent in the rankings outlined above can mask the severity of problems for those few consumers whose serious need is not shared by many others. For example the survey reports that lack of accommodation was a serious need for 155 people, some 6 percent of those surveyed, but stops short of identifying this figure as an estimate of homelessness.

Social resource issues

New Zealand publications concerning social services for consumers/tangata whai ora are to be found among the various evaluations and descriptions of service provision. A number of service providers do include social services among their activities, usually in combination with their other services. Descriptive material regarding the various service providers is found in Appendix 1. This review literature did not identify research or other analytical material that considered the need for social resources within the scope of general needs of consumers/tangata whai ora.

The need for inter-sectoral integration within government policy

While many authors call for the integration of services to help people who experience mental illness find, afford and retain adequate housing, not as many source the origins of some of the service fragmentation back to its basic source: the fragmentation of direction established by government policies that no longer reflect current reality.

An issue illustrating the dynamic where the provision of housing is shaped by non-housing policy agendas can be observed in the effect of changing health policy in recent years to eliminate residential care for people whose need for service is assessed at Levels I or II[13]. Where once these people were housed as part of their treatment, the treatment is now provided in the community through outpatient services or community-based programmes. The funding previously spent on the housing component of the services has been retained within the health budget, therefore effectively withdrawn from total housing expenditure, leaving the shortfall to be made up by private individuals in the open housing market (Paine, 1998). Such cost shifting can have major consequences for the individual. Provision of 'benevolent landlord' arrangements funded within the health sector remain, but do not fully replace the extent of housing lost in the course of the withdrawal of residential care for less seriously ill people.

The literature includes strong support for affordable long-term housing, in locations that are completely integrated into the community, where people who experience mental illness can lead ordinary lives, free of discrimination that results from the visibility of being clustered together. In a way that is similar to the provision of group housing for people who experience mental illness available via Community Housing Limited (CHL), the HHS 'benevolent landlord' arrangement[14] provides housing in which the mode of delivery owes more to the government's requirements about channelling expenditure, than to the needs of the people to be housed.

Group housing may not always be the best solution, even in a temporary sense, as it provides a focus for discriminatory reactions from communities. Bennion (2000) points out that the inappropriate use of the powers of the Resource Management Act 1991 can effectively limit the location of community-based

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[13] The Residential Support Service, funded by the Health Funding Authority (HFA), provides accommodation and clinical support and is funded at different levels. A level I residential service is funded for people assessed to have lower support needs associated with the effects of mental illness. Level IV services are for people assessed as having higher support needs.

[14] Originally instituted through Hospital and Health Services (HHS) and now incorporated into the District Health Board (DHB) mandate.

facilities, even though the Human Rights Act 1993 specifically forbids discrimination on the grounds of psychiatric illness.

A matter where policy integration appears to be seriously lacking is identified in the literature that discusses the experiences of consumers/tangata whai ora, is the 21-day rule. The current rule is that if they are hospitalised for more than 21 days, a person will lose a large proportion of their benefit, and (if applicable) their placement in a residential rehabilitation house (Ministry of Health, 2001a). This means that episodes of more serious illness are usually accompanied by the real risk that a person's housing arrangement will be disrupted, if they happen to live in a residential service setting. It is reasonable to speculate that the money saved by temporarily avoiding double funding for the person's accommodation (i.e. in the hospital as well as in the residential service house) will be small, compared with the eventual cost of the consumer's/tangata whai ora eviction from their residential placement.

Yet a further issue is the domino effect that the lack of satisfactory housing in the market can play in generating bottlenecks in the health system. Since the private housing market fails to provide a sufficient supply of affordable housing, people can sometimes be compelled to stay longer than they need to in temporary group homes or half-way housing. This means that people in hospital who may be well enough to move to Level III community housing may need to wait, and acute beds are occupied for longer than necessary. Robinson (1996a) found the need to separate housing funding from the assessed levels of need, so that the person with mental health needs can still be housed when their needs change.

Fleming and Atkinson (1999) found the presence in New Zealand of this dynamic, finding that the older teenagers of remarriage or re-partnered families tend to leave home at a rather younger average age than is usual. This evidence suggests that an underlying reason may be a poor relationship with the parent's new partner. Such young people are often at risk. They may already have an incipient mental illness or become stressed to the point of illness by educational disruption, lack of income, security and good housing.

5. Service provision in New Zealand

Role of resources and support services in sustaining independent living

Putting aside the benefits of clinical treatment, which are outside the focus of this research, the goal of adequately resourced independent living supported by a comprehensive range of support services is well-established in the literature as the most effective route to managing mental illness successfully. The literature documents how the availability, appropriateness and accessibility of clinical, material, housing and personal support services are crucial to the ability of consumers/tangata whai ora to manage their health, access appropriate housing, seek employment, develop social networks and sustain independent living.

The literature reviewed above outlines the factors relating to support services that contribute to the success of independent living. First, the material conditions must be in place: housing needs to be available and of an acceptable

physical quality, and consumers/tangata whai ora need enough income to be able to afford it. Second, consumers/tangata whai ora need a range of housing and other support services to help them find, negotiate and retain independent housing arrangements. Third, the other aspects of everyday life also need to be in place with networks of social contact, meaningful activities to participate in on a daily basis or employment if that is possible.

In the literature support service provision are categorised in various ways, with no recognised standard typology of support services. Most analyses of support service types follow whatever model is current within that particular field – e.g. clinical services are conceptualised differently from, say, housing facilitation services or social services. The sustainability framework for New Zealand developed in the course of this research provides the opportunity to consider service provision in any field, within the same overall structure. Furthermore, it then becomes a more straightforward process to identify where service gaps might exist, or where some form of resourcing in the lives of consumers/tangata whai ora is absent or difficult to access, where the consequences will be experienced by the individual as housing instability and/or negative mental health outcomes.

The New Zealand and overseas research has shown unsuitable housing can exacerbate mental illness, and hinder recovery. Independent long-term housing (i.e. ordinary housing, where a person feels at home) is consistently reported in the literature as producing better outcomes for people with mental illness than long-term group housing or cluster housing specially constructed or purchased for consumers of mental health services. First, such clustered housing attracts attention to the presence of mental health consumers in the community, and can fuel discrimination and hostility by other people in the locality, even if it is out of proportion with the real level of risk. Second, there is the risk that staffed housing arrangements, however well intentioned, will reproduce the institutional atmosphere that the accommodation arrangement seeks to replace. Clustered housing is not necessarily the answer, as it is argued that the creation of specialised residential programs with on-site staff reduces the chances of people with mental illness living in a normal environment.

In the New Zealand context, The Mental Health Commission's (1999c) objectives for housing for people with mental illness aim to achieve housing solutions that ensure consumers/tangata whai ora:

- have access to affordable housing of good quality;
- have access to information and advice about housing options;
- can move between different housing arrangements as their needs change, without being disadvantaged or losing services;
- are not disadvantaged by housing tenure;
- have the choice of a range of housing options according to their needs and preferences within reasonable economic constraints;
- are not in serious housing need;
- are free from discrimination in the housing market;

- are assured of accommodation which provides for privacy, personal dignity and safety;
- have their particular cultural requirements addressed (Mental Health Commission, 1999c:24).

The Mental Health Commission advocates including housing needs in the assessment of mental health needs, but nevertheless recommends those housing needs be met through all housing agencies fulfilling their particular responsibilities. The housing needs of people in the mental health sector would therefore be met within the range of particular housing services available to them, just as anyone else's would be. Rather than a proposal for housing issues to be added to the mental health sector's responsibilities, this is a plea for a truly integrated service where the efforts of all agencies (i.e. health, housing and welfare) are co-ordinated.

Examples from the Mental Health Commission's discussion paper (1999c) of models of service provision that reflect public and private sector partnerships are:

- Benevolent Landlord (e.g. the supported housing contracting policy operated by the HFA, which funds provision of community-based residential services for people with mental illness, where services provide a place to live and specified amounts of mental health support services to assist recovery);
- Supported Rental Accommodation (such as the service operated in Christchurch by Comcare);
- Home Link (see Quilgars, 1998): operated in Yorkshire, involving practical help plus a mutual support network and organised social events);
- Assertive Outreach Services (see Kings Fund, 1998): operates in Brixton – its aim is to build teams of outreach workers from all agencies that have responsibilities;
- Under One Roof (see King's Fund, 1998): operates in South London where all the services are located at the same place – effectively, a one-stop-shop.

New Zealand examples of provision of housing supports and support services

The following sections outline different forms of provision and service types, reflecting current provision in New Zealand for consumers/tangata whai ora with housing difficulties. Although the examples are provided within the model of the sustainability framework developed in this research (see Part 2 of this report), it should not be assumed that the scope of services, or the range of activities of any service provider should be confined within the internal boundaries of the framework. There are current examples where existing services provide housing facilitation services in conjunction with personal support services (such as Comcare in Christchurch), or clinical services are provided alongside personal support services (such as the non-clinical services provided within the mental health system to people receiving clinical mental

health services). Appendix 1 sets out the details of a selection of current support services.

It is not clear from the literature available that any particular combination of support types will necessarily yield better outcomes than any other combination. In fact, there has been almost no systematic research in New Zealand into the benefits of service provision, apart from periodic reviews and audits undertaken by the service providers themselves. Most of the literature is therefore descriptive only.

What is clear from the research findings from this project however, is that most consumers/tangata whai ora need access to all of the different types of service at some time during their experience of mental illness, and many will need all of the services on an ongoing basis.

Material support

Material support: housing supply

HNZC provides housing at income-related rentals or income-related levels of mortgage payments, on the basis of social allocation criteria that are designed to select in favour of consumers/tangata whai ora. Some difficulties for consumers/tangata whai ora exist, for example, where the desirable size of housing unit is not available. There is a general shortage of one-bedroom flats. Another source of difficulty is where the rent, in the usual way, is determined by the number of bedrooms rather than the number of occupants. Some consumers/tangata whai ora who need to live alone also need to have a second bedroom available for a friend or carer to use during times of more serious illness. The availability of the second room is usually unaffordable, since receipt of the Accommodation Supplement will also be based on a single occupancy, but could be crucial to managing serious illness effectively at home, rather than needing to go to hospital.

Local government provision of rental housing. The main issue is that there is not enough to fill the shortfall, and it is not available in many locations around the country. Where it is available, however, many consumers/tangata whai ora are happy to choose local government housing and regard it as an important source of stable housing supply.

HFA-funded housing. As well as hospital places, the residential rehabilitation programme funded by the HFA provides accommodation as the setting in which about 3000 consumers/tangata whai ora receive mental health clinical services, at any one time. NGOs can contract with the HFA to provide housing – e.g. the Otago Accommodation Trust, that aims to provide long-term good quality rental housing and also support co-ordination (co-ordination and advocacy). The model is based on the concept that security of tenure is a primary contributor of to well-being, and that their role as the owner of the client's homes allows them to provide housing security while providing other support that enables consumers/tangata whai ora to live independently. One issue raised in the New Zealand literature is the effect of the HFA withdrawal in recent years from funding accommodation in group homes for consumers/tangata whai ora assessed at Level I or Level II. The consequent reduction in housing for people previously housed as part of their mental health services has had to be

compensated by individual consumers/tangata whai ora in the private market (Paine, 1998).

Supported Accommodation is another form of benevolent landlord arrangement similar to the HFA funded housing described above. The accommodation might be owned by an NGO, or leased long-term by the NGO for sub-letting to individual consumers/tangata whai ora.

Housing associations, trusts etc. There are good examples of housing associations and trusts in the overseas literature, many from north America, which use private, community-based or joint-venture funding to build or buy housing in order to let it on a long-term basis to consumers of mental health services. There is much potential in the New Zealand context for this form of housing provision, which can offer an active role for consumers/tangata whai ora in governance and management, as well as long-term, stable independent living.

After conducting its own review of literature and reports of different models of housing service provision (Cairncross, 2000), the Wellink Trust in Wellington is currently in the early stages of leading the development of a plan to provide easy-access housing for short or medium term occupation. The aim of this is to provide 'in-between' housing where consumers/tangata whai ora do not have to comply with needs assessment procedures (as required by the health system), nor set up tenancy agreements (as required by the housing system). Such in-between housing would be very likely to help consumers/tangata whai ora avoid homelessness after eviction or other loss of accommodation.

'Third sector' housing. The not-for-profit sector (which can include housing associations and trusts in the previous section) wholly or partly funds (in combination with other funders) and provides community-based housing that increases the range of choices for consumers/tangata whai ora.

Material support

Income support

The responsibility for providing income support to eligible people belongs with Work and Income. No specific services were identified that focus on the actual provision of income for consumers/tangata whai ora. However, many housing facilitation service providers and personal support service providers assist consumers/tangata whai ora with the complex issues of establishing benefit entitlements, including eligibility for Accommodation Supplement, negotiating with Work and Income and the banks, and developing money management skills such as budgeting.

Service resources

Housing support: housing facilitation

Practical and other forms of help in finding and retaining housing is provided by relatively few service providers, and only in some parts of the country. Practical help can include almost anything that will assist consumers/tangata whai ora to find, occupy and maintain their tenancy of a house, and includes driving people around to see properties, negotiating with landlords, filling in forms at Work and Income, finding flatmates, putting out rubbish and mowing the lawns. The

needs of the individual consumer/tangata whai ora will determine just what is provided.

The Ministry of Health's review of non-clinical services (2001a) is a major step towards recognising the significance of non-clinical services in supporting clinical service outcomes. However, the scope of the non-clinical services is confined tot hose provided to consumers/tangata whai ora who are receiving their clinical services within residential settings, which is not the focus of this research to quantify housing need among those living independently.

More detailed descriptions of current support services are found in Appendix 1.

Social resources

Personal support services

The range of personal support services needed by consumers/tangata whai ora to maintain everyday living is wide, and from the descriptive material supplied by service providers, there can be some overlap between this category and that of social support. Few services appear to focus only on the social support needs of consumers/tangata whai ora for maintenance of family/whanau contacts, friendships and company, and for social networks and places to socialise in the community that all contribute to a sense of belonging and thence to improving mental health outcomes.

6. Conclusion

Although there is extensive literature both overseas and to a lesser extent in New Zealand that examines issues of mental health and aspects of support needs, there is little discussion premised on the complex interlinked needs that the sustainability framework in this research has identified.

The development of a conceptual framework was an unanticipated outcome from the research but it is a framework that makes identification of the research gaps more straightforward.

First, it is evident that much existing research focuses on clinical service delivery. Second, even where non-clinical services are considered the focus is on the delivery of health outcomes rather than housing outcomes. This may be attributable to the fact that the Ministry of Health, the Mental Health Commission and health service providers have largely taken the major responsibility for research about the consumers/tangata whai ora community. Research into material resources such as housing has been undertaken, but often the focus has been on low income housing rather than the housing conditions of consumers/tangata whai ora *per se*. Third, given the lack of integrated government policies and the absence of a conceptual framework for thinking about the complex inter-linking of factors impacting sustainable housing and mental health recovery, there has been little opportunity to develop research to addresses issues from such a perspective. This research report provides a call for case study research to looks at the integration of problem definition and service delivery. Some of the questions that may need to be the focus of future research are encapsulated in the following speculations that derive from the research findings as well as from the literature.

Being a consumer/tangata whai ora can have a wide range of consequences for how someone lives their life, and how they are responded to by others in the wider community. It will also affect their access to interlinked supports to enable lives to be lived without serious disadvantage. Housing that is unsuitable for mental health recovery is endemic, especially within the affordable price range.

Many consumers/tangata whai ora are supported by state benefits (sickness, disability, unemployment) which are not pitched at a level that gives consumers/tangata whai ora discretion over the kind of housing arrangement they might choose. Considerations such as size or style of house to accommodate visiting whanau, closeness to family or friends or to important support services must all take second place to affordability issues.

Housing that is unsuitable for mental health recovery is unlikely to be stable or sustainable over the long term. The quality of the housing and the lack of stability may exacerbate mental illness or decrease the likelihood of recovery. Networks of friends, whanau/family and support services appear to be significant for mental health recovery, but movement from place to place and house to house may destabilise these networks and compromise health outcomes.

Unsuitable housing, coupled with a wide range of other interlinked disadvantages creates barriers to sustainable independent living for consumers/tangata whai ora. The extent to which any one consumer/tangata whai ora or group of consumers/tangata whai ora in any particular area are subject to these disadvantages is unknown. Disadvantages identified in both the New Zealand and overseas literature include:

- ongoing and widespread discrimination;
- poverty resulting from long-term reliance on benefit-level incomes;
- difficulty securing employment because of fluctuating work capacity due to mental illness, as well as the effects of discrimination;
- disrupted education due to mental illness, particularly in adolescence;
- poor physical health as well as serious mental illness, and sometimes difficulty with access to health services;
- administrative selection processes that result in people with the most serious mental illness being allocated the housing least likely to support mental health recovery;
- failure of the housing market to supply adequate suitable housing at affordable rates, either in the private housing market or in the public sector rental market;
- lack of integration of government policies that result in the separation of housing issues from mental health issues in the policy context;
- lack of integration of the overall goals of support services.

The literature on the role of support services makes it clear that most consumers/tangata whai ora have a strong preference for independent living in ordinary housing, i.e. in the same circumstances as the rest of the population experiences. Given adequate levels of support, most consumers/tangata whai ora can indeed manage independent living successfully. A real choice of housing is needed, however, with ongoing support service availability to consumer/tangata whai ora, and also to landlords in times of crisis.

The literature delivers a plea for service integration, in order to ensure that all aspects of service needs are met for the individual. It has largely been assumed that the delivery of clinical service is paramount for consumers/tangata whai ora but it is clear that access to robust social and material resources are also extremely important. There may be as yet unidentified contributions to mental health recovery that would come from more explicit attention to the complex and inter-related factors underpinning lives of consumers/tangata whai ora.

The regulations that govern the environment in which consumers/tangata whai ora live require further consideration. It is possible that a clearer understanding of which regulations do have an impact, as well as the ways in which they affect consumers/tangata whai ora would create opportunities to enhance the quality of life to sustain independent living in ways that have not yet been seen.

Finally, there are a number of perceptions within the government, mental health communities and the wider public that require further investigation. Independent living for consumers/tangata whai ora is a desired policy outcome for government and for many service providers. It is an aspiration for many within the consumers/tangata whai ora community, and also amongst caregivers. Independent living, however, is apparently seen by the general public as less desirable. This view is supported in media constructions that consistently highlight negative social outcomes from consumers/tangata whai ora who are inadequately supported by the material, service and social resources available to them. The extent to which these perceptions are incongruent and irreconcilable needs further examination.

Appendix 1: Support Services

Support service provision in New Zealand

In New Zealand, several small community-based services for consumers/tangata whai ora that do in fact focus on assistance with housing difficulties have been evaluated in the last few years[15]. These services have received praise, and display features that seem more relevant and productive in the New Zealand context than some of those described in the international literature. One of the problems associated with a lack of service integration is that there is no central data base for this information and no easy way to keep a record of new services that come into being.

Community-based housing support service

The Comcare Supported Rental Accommodation Service was launched in July 1995 and evaluated in 1997. It is operated by Comcare Charitable Trust, a provider of community services including residential facilities for people with mental illness in the greater Christchurch area.

> The purpose of the service was to assess the problems that people with psychiatric disabilities had with moving from sheltered accommodation or hospital to private renting, also to assist those who had a history of transience or poor housing … There is no other Service providing this particular service and it is clearly needed (Comcare, 1997: p.20).

In effect, Comcare provides a 'benevolent landlord' service if needed to tenants, and places major emphasis on practical help, taking care of shifting costs, property upkeep and fire safety while keeping in regular contact to make sure housing needs are adequately met. They provide:

- help with flat hunting, including helping establish emergency accommodation and benefit entitlement while flat hunting takes place;
- help with negotiations with landlords;
- authority as head tenant on behalf of the tenant;
- help to find out if the consumer/tangata whai ora is eligible for an establishment grant and then help them choose appropriate goods and arrange for payment via Work and Income;
- liaison with a pool of landlords re availability of flats/houses, rent/bond advances and timing of rental payments to co-ordinate with Benefit payment timing;
- vetting of tenancy agreements to make sure all legal obligations are met;
- help to carry out property inspections before the tenant moves in;

[15] For example, the Comcare Supported Rental Accommodation Service in Christchurch, and the pilot project of Intensive Community Support (ICS) in Invercargill, commissioned by the SRHA and Patients' Aid Community Trust, Southland.

- help to understand the details of Accommodation Supplement and setting up automatic payments for rent and power;
- help with setting up payment systems for phone rental, often through the Disability allowance;
- help to arrange the shift, where the Mobile Work Crew will do it if consumer/tangata whai ora has no one to help them;
- help to choose affordable items for the new flat;
- a garden and property upkeep service;
- regular visits (where boundary issues can emerge between purely housing matters and other issues and need to be negotiated with the other service providers).

In short, Comcare provides a comprehensive community housing support package that, while focused on the private rental market, could be applied in any housing ownership/management setting. The housing support described above operates within a context in which other service providers make sure that clinical services are available, but a clinical case worker does not appear to be an explicit part of the operation, as it is with the ICS project in Invercargill.

Intensive Community Support

This pilot project of ICS took place over one year in Invercargill, commissioned by the SRHA and Patients' Aid Community Trust, Southland. This service is targeted towards people aged 17 years and over with psychiatric disabilities, including people living in the community who need higher levels of support during unwell periods – it facilitates earlier detection of such periods. Each client is assigned a case worker who provides a wide range of practical help, maintains frequent contacts (in agreement with the client) but does not provide clinical treatment – all clients have a separate case worker for clinical treatment, and access to an on-call crisis service.

The evaluation found that the daily living skills of clients had improved; competence in money management and budgeting that were large problems early on also improved along with social skills and the level of independent access to services, all requiring less input from the ICS case worker; and the mean length of days in hospital reduced, probably as a result of earlier detection of deteriorating mental health. Most of the suggestions made in the evaluation concerned ways to improve the quality of life of the consumers/tangata whai ora, by providing more opportunities for social activities, physical fitness, educational and vocational opportunities, etc. One suggestion was that for people not yet able to manage their money and budget effectively, a credit union would be an appropriate framework to receive benefits and arrange payments, and provide a weekly allowance for food and personal expenses, as problems with money management can have severe consequences. The aim would then be to increase competency and move the client on, to managing their own money, within a short time.

Accommodation for Mental Health Society (AHMS)

This service with a wide scope is provided by north of Auckland. It provides an employment service (real jobs for real pay, not sheltered employment),

supported accommodation services, and community support worker services, as well as residential services. A big issue for the area north of Auckland is the rural isolation – all the phone calls are toll calls, distance is an affordability barrier for all face-to-face transactions, and consumers/tangata whai ora are so isolated they cannot easily access group support. AHMS have worked on addressing discrimination issues, by building relationships with people/organisations in the community that will interact with the consumers/tangata whai ora, such as neighbours, shop keepers, the Council, Work and Income, and Housing New Zealand, so that if someone realises a person maybe having mental health problems they can get AHMS to help.

Wellink Trust

After conducting its own review of literature and reports of different models of housing service provision (Cairncross, 2000), the Wellink Trust is currently in the early stages of leading the development of a plan to provide easy-access housing for short or medium term occupation. The aim of this is to provide 'in-between' housing where consumers/tangata whai ora do not have to go through the process of needs assessment procedures (as required by the health system), nor set up tenancy agreements (as required by the housing system). Such housing would be very likely to help consumers/tangata whai ora avoid homelessness after eviction or other loss of accommodation.

Miramare

Miramare operates a brokerage service to provide both needs assessment and service co-ordination for psychiatric, alcohol and drug related disability. Services may include:

- personal care and domestic assistance;
- carer support;
- budget services (CORPAC);
- supported accommodation (Levels I-III);
- supported rental accommodation (OAT).

Otago Accommodation Trust (OAT)

OAT is affiliated to the needs assessment and service co-ordination parent body Miramare, and is funded by the HFA to provide 28 one- and two-bedroom rental flats for 30 consumers/tangata whai ora, including people with drug and alcohol disabilities, who cannot get housing through normal residential channels. OAT aims to provide long-term good quality rental housing and also support co-ordination (co-ordination and advocacy) rather than supported accommodation. The model is based on the concept that security of tenure is a primary contributor of to well-being, and that their role as the owner of the client's homes allows them to provide housing security while providing other support that enables consumers/tangata whai ora to live independently.

Framework Trust

This NGO (www.framework.org.nz) provides a range of community-based rehabilitation services for consumers/tangata whai ora. Funded by CFA and HFA. Services include

- social recreational and development centres;
- activity and skill development centres;
- accommodation service (Bridges);
- work co-operatives and small business enterprises;
- employment and training support;
- community support service (Awhi-ora);
- Access Radio programme;
- information and consultancy.

The supported accommodation service (Bridges) has accommodation units aiming to provide tenants with independence, privacy, security and a long-term environment. Only a small number of Framework Trust clients live in the supported accommodation service, as most live independently in the community. The Trust provides a community outreach service to consumers/tangata whai ora who have prolonged or episodic mental illnesses, who live within a 60 km radius of the current service base. The Trust would prefer not to be a landlord, and to put more resources into their Community Support Worker model for service delivery. Framework Trust reports a shortage of affordable and suitable independent accommodation, particularly in central and south Auckland. There is a shortage of housing stock in central Auckland, and the South Auckland housing stock is mostly unsatisfactory for mental health recovery.

Pathways

This service (www.pathways.co.nz/services.htm) began in 1989, initially in response to homelessness and the lack of support for people with mental illness in Hamilton City. The Trust is a partnership between community health, housing and income support agencies who aim for co-ordination. Pathways provides a range of services including residential, supported accommodation and respite care facilities, as well as services to support people in independent housing. Pathways operates a service similar to the CSW model with mobile teams to respond to individual needs, as well as crises and early discharge services.

Stepping Stone Trust

Stepping Stone Trust (www.stepstone.org.nz/Community.htm) is a Christian-based psychiatric residential rehabilitation service operating in Christchurch since 1990. Residential services focus on supporting consumers/tangata whai ora to independent living. Other services for those already living in the community reflect the CWS model, including assistance with development of life skills and social and community networks, and also with practical issues such as obtaining benefit entitlements, accessing other support services (including mental health services when required).

Linkages

Linkages (www.pathways.co.nz/linkage.htm) demonstrates a different approach. Established as a joint venture between Health Waikato and Pathways in 1999, it provides a brokerage service that aims to ensure that

consumers/tangata whai ora have access to services that meet their needs. The service collects information about service options and helps with the decisions about which to choose. No housing supports or services are provided directly, but the service options do include services that assist with housing difficulties.

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