Housing and Mental Health

Reducing Housing Difficulties for People with Mental Illness

A Discussion Paper

Mental Health Commission, August 1999

The Mental Health Commission thanks the many people who contributed to this report, especially Tony Paine, Lucy Loughnan and Bev James.

The Commission welcomes comment and feedback on this paper.
If you would like to comment please send your comments
by 31 December 1999 to:

Mental Health Commission
PO Box 12-479
Thorndon
Wellington

Ph: 04 474 8900 Fax: 04 474 8901
email: ngoss@mhc.govt.nz

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Contents

Foreword

This paper outlines key issues in housing provision for people with serious mental illness and suggests a policy framework. It draws on the limited research available on the housing needs of people with mental illness and on information available from the mental health sector. It is intended to generate discussion and better understanding of the issues in the mental health and housing sectors.

Access to adequate and affordable housing is critical to recovery from mental illness and to maintaining good mental health.

Over the last decade there have been changes in the way mental health services are delivered, with an increasing emphasis on providing care within the community rather than in hospitals or institutions. This has increased the need to make sure that people with serious mental illnesses have access to affordable, appropriate, good quality housing. While many people with mental illness do not have their housing interrupted by an episode of illness, some do.

Policy changes in the provision of publicly supported housing have altered the amount, type and range of housing support options. The number of people receiving financial assistance to pay for housing has increased, but there has been less emphasis on particular needs groups, like people with mental illness or disability. With the policy changes in both housing and health, agency responsibilities for addressing the housing needs of people with mental illness are at present unclear.

An integrated policy response is called for. We hope this paper will provide a useful starting point for further discussion and policy development.

Barbara Disley
Chair

Executive Summary

Access to, and retention of, appropriate housing is important to everyone's well-being and is a critical factor in the recovery of people with mental illness.

Housing problems are not confined to people with mental illness but having a mental illness can generate certain types of housing requirements, and push people into housing need. People with mental illness are more likely to encounter housing problems and the negative impacts of poor housing. Finding a house for the first time, keeping one's current house, or moving into different accommodation, can all be major problems.

In many cases, recovery requires specific housing arrangements that combine support, a quality physical environment and suitable social environment.

Housing policy must ensure that people affected by mental illness have access to housing that supports their recovery and maintenance of good mental health, and options that prevent them falling into serious housing need. A wide range of options is required. This paper discusses home ownership, rental accommodation and supported housing.

Current policies do not address the housing needs of people with mental illness, and agency responsibilities for addressing these needs are unclear. The following objectives for housing for people with mental illness are proposed.

Housing solutions must ensure that people with mental illness:

- have access to affordable housing of a 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 support 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.

A wide range of central and local government agencies have some responsibility for housing. They include:

- Social Policy Agency – responsible for overall housing policy
- Housing New Zealand – responsible for public rental housing

- Community Housing Ltd – assists providers to obtain housing suitable for group homes
- Housing Corporation of New Zealand – provides housing loans to low-income households that have difficulty obtaining loans from the private sector
- Work and Income New Zealand – administers the accommodation supplement and other benefits
- Health Funding Authority – contracts and monitors the providers of supported housing
- Ministry of Health – responsible for safety matters in supported housing
- Local Authorities - provide some public rental housing; determine the location, type and conditions of housing through district and regional plans; and approve resource and building consents.

Over the last decade, the Government's housing policy has moved from providing income-related interest rates and rentals as well as accommodation benefits, to relying almost exclusively on the Accommodation Supplement.

Many people with mental illness face higher than usual living expenses because of health-related costs. The Accommodation Supplement assists with housing costs but does not ensure that housing is affordable.

The Accommodation Supplement does not address problems of housing supply nor other aspects of market failure, including exclusionary practices as a result of discrimination.

For some people with mental illness housing affordability problems are likely to have been compounded by changes in benefits. These benefit changes pose significant problems for the providers of supported accommodation and for some people with mental illness. Some providers of supported housing report that they are subsidising housing from Health Funding Authority payments for support services.

If housing needs of people with mental illness are to be addressed fully, then assessment of an individual's housing needs must be included as part of consideration of their mental health needs. Housing services must be co-ordinated with treatment and support services and agencies with responsibilities for housing must improve their responsiveness to people with mental illness.

The key agencies in mental health, housing and income support need to work together to address these issues, clarify roles and responsibilities, and develop shared goals for meeting the housing and related support needs of people with mental illness.

There is potential for building on existing initiatives and for considering the wider implementation of new models for independent living being tried in New Zealand and overseas. As well, there are considerable

opportunities for public and private sector partnerships: one example is the benevolent landlord or supportive landlord scheme.

Identifying and meeting the housing needs of people with mental illness is a complex and difficult task, and progress in addressing the issues has been insufficient to date. However, during consultation on the development of this paper, the Mental Health Commission found that housing, income support and mental health policy agencies are willing to address the housing needs of people with mental illness as a matter of priority. The Commission is confident that the conditions exist for significant movement to occur in this important area, and looks forward to seeing progress.

Housing and Mental Health

1 Introduction

The Mental Health Commission's functions are to:

- monitor the implementation of the National Mental Health Strategy
- reduce discrimination against people with mental illness
- ensure the mental health workforce is strengthened.

One of the National Mental Health Strategy's two key goals is to:

Increase the health status of and reduce the impact of mental disorders on consumers, their families and the general community.[1]

The Commission believes that this goal can only be achieved with a fully developed range of mental health services and in an environment that will actively contribute to people's recovery. Suitable, affordable housing forms an integral part of that environment. However, the Commission is concerned that the prevailing market and current policy conditions for housing are not conducive to mental health recovery for those people for whom housing is an issue.

This paper is concerned with housing provision for people using mental health services and those with experience of mental illness. It:

- outlines the housing issues for people with mental illness
- provides a framework for housing policy for people with mental illness, and
- presents a range of initiatives in New Zealand and overseas to address the housing needs of people with mental illness.

The paper is intended to generate discussion among the mental health sector, the housing sector, the welfare sector and people with experience of mental illness, to improve housing opportunities for people with mental illness.

2 The Scope of Mental Health and Housing

This paper is concerned with the provision of all types of housing: home ownership, rental accommodation and supported housing. Discussion of mental health and housing often becomes focused on what is known as supported housing. Supported housing is a general term that refers to a range of accommodation with linked support services, run by organisations providing services to people with mental illness. It includes groups of units or apartments, hostels, and group homes with minimal to intensive support. As used in this paper, the term does not include support services provided for people in their own homes, nor does it include secure accommodation and hospitals.

1 *Looking Forward*, Ministry of Health 1994

Only a very small proportion of users of mental health services use or need supported housing. In any one month, between 35,000 to 40,000 adults use secondary or specialist mental health services. Mostly these are delivered to people living independently in the community, through outpatient clinics, day programmes, community support workers and home-based care. Only 6-7 percent (approximately 2500) of people using mental health services live in supported housing.

At any one time we can expect 20 percent of the New Zealand population to have a diagnosable mental illness, with around 3 percent having a serious, ongoing and disabling mental illness requiring treatment from specialist mental health services.[2] The severity of mental illness and the personal supports people have access to vary, and consequently the service needs of people with mental illness can vary. Some people only experience mental illness for short periods, others for very much longer. Some may need to receive treatment for periods within a hospital context. Others may not.

Diverse mental health support and clinical service requirements, combined with differing personal circumstances, mean that people with mental illness have a variety of different housing needs. Consequently, housing policy must be capable of addressing these needs and ensuring that people who have experienced mental illness have access to:

- housing that supports their recovery and maintenance of good mental health, and
- options that prevent them falling into serious housing need.

3 Mental Health Recovery and Housing Need

> The barriers [to getting a home] fall into two distinct categories: first, those specifically created by ill health, and social response to disability. Second, those that people with mental illness have in common with all people who are poor or living on very limited incomes: quality housing on the open market may be unaffordable or inaccessible. (Paine, 1998:4)

At any point in time, people with mental illness may be in one of three housing situations. They may be in:

- *suitable housing* - housing which is physically adequate and contributes to their mental health recovery requirements
- *unsuitable housing* - housing which is adequate in relation to generic housing provision but is not suitable for mental health recovery, or
- *serious housing need* - where housing is inadequate in generic terms and is not aligned with an individual's mental health recovery needs.

These categories are presented in Figure 1. However, the lack of research in this area means that there is no sound information about the number of people in each of these categories, the dynamics of movement between

2 *Blueprint for Mental Health Services in New Zealand*, Mental Health Commission 1998 p7

the categories, or the numbers of people with mental illness who have those housing experiences. Despite lack of information, the schema set out in Figure 1 highlights two fundamental issues.

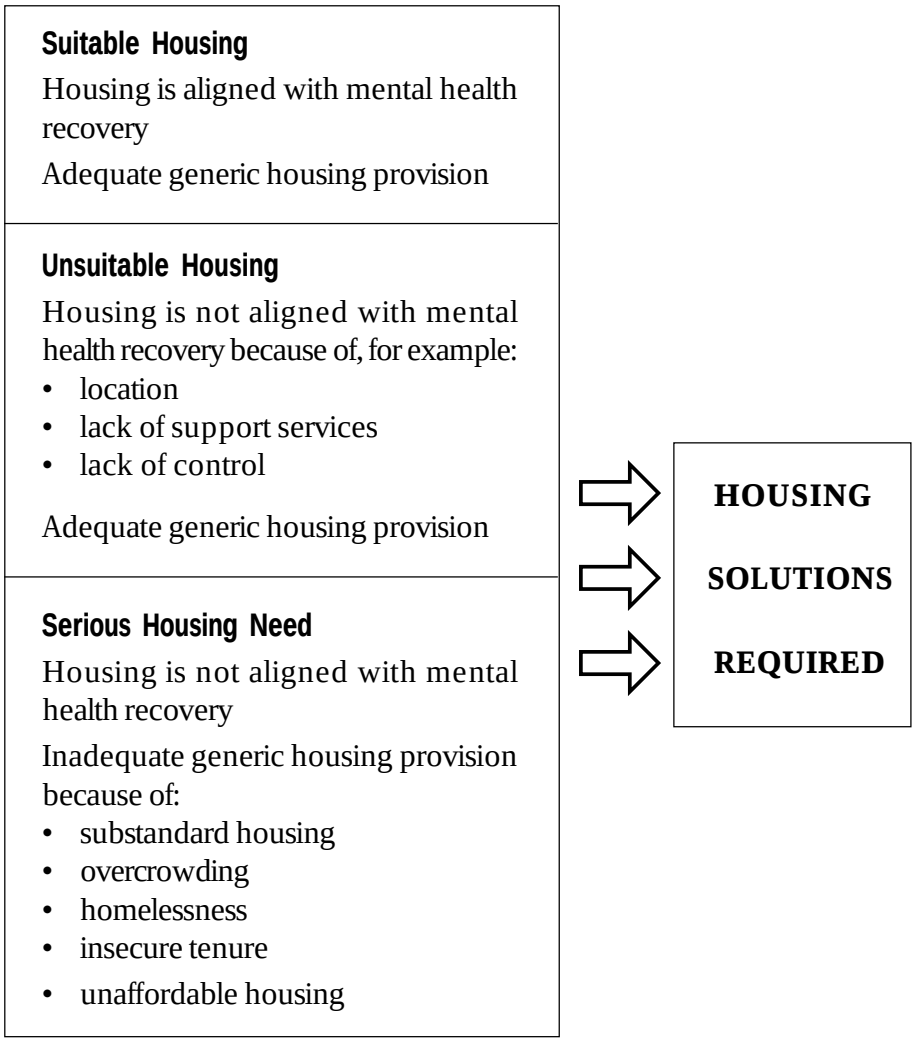
The first issue is that housing problems are not confined to people with mental illness. Any person who experiences any of the conditions below can be defined as being in 'housing need'.

Those conditions are:

- substandard housing with inadequate physical conditions and/or without basic facilities
- overcrowding
- homelessness, reflected in, for instance, the use of temporary dwellings
- insecure tenure
- unaffordable housing.

People in those conditions are frequently referred to as being in serious housing need (SHN).

Figure 1: The housing needs of people with mental illness



There is very limited research on the extent of housing need in New Zealand. A survey of serious housing need undertaken in 1988 by the National Housing Commission (since disbanded) estimated 17,500 households[3] had serious unmet housing need.[4] Other studies undertaken in 1993 and 1994 estimated between 40,000 and 48,800 households had a serious housing need, and confirmed that those most likely to be in housing need were Maori, Pacific Island people, single people, sole parents and private renters.[5]

The second issue is that having a mental illness can:

- generate certain types of housing requirements, and
- push people into housing need.

Some people may find that, although they are in affordable housing of adequate physical standards, the home does not provide an environment for mental health recovery (section 5 provides further discussion on this issue). Others may find that mental illness has led to an actual loss of their house and this can become a barrier to recovery.

4 Generic Housing Need Among Those with Mental Illness

> Many studies have had difficulty in identifying the direction of the relationship between homelessness and poor mental health. [However] It is clear that people with mental illness are likely to confront particular difficulties in finding, affording and maintaining appropriate housing … it also appears that poor housing and homelessness is likely to exacerbate existing mental health problems. (Saville-Smith et al, 1996:23)

The likelihood of encountering housing problems and the negative impacts of poor housing are increased for those experiencing mental illness. When people become ill they also become vulnerable to a range of housing problems. Finding a house for the first time, keeping one's current house, or moving into different accommodation, can all be major problems. This is because people with mental illness may find:

- their income reduced and earning capacity uncertain
- their ability to make choices impaired
- the nature of their illness makes living requirements, such as living or not living with others, more complex
- they are exposed to discriminatory practices, and
- the need for clinical services can make maintaining independent housing difficult for short, or sometimes long periods.

In these circumstances, a person with mental illness may face loss of their home, tenure insecurity, and transience.

3 A household is defined as one or more persons who usually reside together and share living facilities, such as cooking facilities, bathroom and living area. One or more families, or a family plus other individuals may constitute a household.

4 *Housing New Zealand, Provision and Policy at the Crossroads*, National Housing Commission, Wellington 1988 p77

5 *Our Health Our Future*, Public Health Commission, Wellington 1994 p33

The limited research in New Zealand shows that there are only a small number of homeless people. Nevertheless, the resulting effects can be serious for those individuals, and put pressure on health services. In particular, the individual will find recovery from mental illness difficult, and will be vulnerable to other health problems, such as chronic respiratory problems, skin complaints and musculo-skeletal problems.[6]

4.1 Homelessness and transience

A 1997 survey of 2516 people using mental health services in the then Northern RHA region, conducted for North Health, found that 4 people (0.2 percent) were homeless during the whole of the 3 months prior to the survey, and that 62 people (2.5 percent) had been homeless for part of the time.[7] This same survey also indicated high levels of transience among mental health service users and reported that 222 (8.8 percent) of those surveyed had moved house three or more times during the preceding six months.

Surveys of Auckland and Wellington long-term mental health service consumers and their housing experiences, conducted in 1996 for the Ministry of Housing, also found small numbers of homeless people, and people with 'no fixed abode', or in temporary dwellings such as caravans or in camping grounds. Both the Auckland and Wellington surveys found that transience was common amongst users of mental health services. Almost half of the people in the Wellington group had moved house in the previous year. In Auckland, 58 out of 112 people interviewed had lived on the streets, in a caravan, or used the Night Shelter at some time. Further, a high percentage of the people interviewed, including some who at the time of interview were living in satisfactory housing, had had experience of being homeless. This study also points out that it is difficult for a person to move out of a homeless or itinerant situation.[8]

Reasons why people experiencing mental illness move from one type of accommodation to another are varied.[9] Affordability is one factor. Some people who have problems with housing costs and budgeting drift into transient accommodation. Others become transient through conflict with others, and unsafe living arrangements. However, the most important reason why people move from place to place is because of hospitalisation for acute mental illness.

4.2 Hospital admission

Two thirds of people using mental health services in the Wellington area surveyed by Robinson[10] cited their admission to hospital as a critical point in their loss of housing access. Their experience is consistent with the concern of mental health consumer groups that people using mental health services need to have security of housing tenure during periods of acute mental illness.

6 Bines W *The Health of Single Homeless People*, Housing Research #128, Joseph Rowntree Foundation 1994; Saville-Smith, K, McClellan, V, Mainey, A, and McKay, P, *Health Risk Housing. A Preliminary Review of Associations between Housing and Health*, paper prepared for Te Puni Kokiri, Wellington, 1996 p21

7 Kydd R, Mahoney J, and Turbott S, *A Survey of the Needs of Users of Mental Health Services who Require High Support*, Department of Psychiatry and Behavioural Science, School of Medicine and Health Science, 1997, report prepared for North Health, University of Auckland, Auckland.

8 Robinson, D *Housing Experience of Mental Health Consumers in Auckland*, Ministry of Housing, 1997, and Robinson, D *Housing Experiences of Psychiatric Consumers in the Wellington Region*, Ministry of Housing, 1996.

9 Robinson 1997; 1996

10 Robinson 1996

5 Housing - Contributing to Recovery

The relationship between housing and recovery from mental illness is well recognised in overseas research and by users of mental health services and mental health service providers.[11] The research shows that the provision of adequate, affordable and secure housing is critical to recovery, continued well-being and independence. Good housing brings mental and physical benefits, and the ability to exercise some choice over one's accommodation is an important factor in gaining and maintaining health. Conversely, poor housing can impair a person's ability to recover from mental illness and function independently.

Stresses related to inadequate housing, such as discomfort, poor state of repair, dampness, dilapidation and pest infestations, have been shown to adversely affect mental health.[12] One New Zealand study suggests that the most immediate housing stressor for people with mental illness is the physical condition of a dwelling.[13] In addition, housing costs can add to stress, both directly and indirectly, by encouraging overcrowding, reducing the ability to heat a house or undertake repairs, and preventing a move to better accommodation. Another source of stress affecting people with mental illness arises from the discrimination they may experience in accessing and retaining housing.

In many cases, recovery requires specific housing arrangements that combine support, a quality physical environment and suitable social environment. These arrangements may include:[14]

- 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 Mental Health, Housing Markets and Housing Policy

Many people who use mental health services, mental health service advocates and service providers are concerned that access to suitable housing is decreasing, and problems of serious housing need are increasing among those experiencing mental illness.[15] Serious housing need appears as a particular problem in some urban areas such as Auckland, and in some rural areas where there is very little rental accommodation and housing stock is in poor repair.

11 Adams, A and Wilson, D *Accommodation for Older People with Mental Health Problems*, Social Care Research #87, Joseph Rowntree Foundation 1996 ; Nelson, G, Hall, G and Walsh-Bowers, R *The Relationship between Housing Characteristics, Emotional Well-Being and the Personal Empowerment of Psychiatric Consumer/Survivors*, Community Mental Health Journal, 1998 31: 1 p 57-69; Farrar, Young and Malin, *Housing and Mental Health: A brief Guide for Commissioners, Commissioning Mental Health Services*, Thornicroft G and Strathdee G London: HMSO 1996

12 Kearns, R, Smith, C and Abbott, M, *Housing Stresses and Persons with Serious Mental Health Problems*, Health and Social Care 1 1993 p263 - 274; Bines 1994; Saville-Smith et al 1996

13 Kearns et al 1993

14 Nelson, Hall and Walsh-Bowers 1998

15 *Mental Health Accommodation and Housing Policy: Submission to the Labour Party Policy Committee*, Auckland District Council of Social Services 1999

The emergence and proliferation of agencies tackling the homeless in the major urban centres such as the Homeless Team based at the Taylor Centre in Ponsonby, Auckland is clear evidence of the enormity of the problem. (Auckland District Council of Social Service 1999:1)

Lack of systematic research on the housing needs of people with mental illness makes coming to any definite conclusions about the nature and extent of housing failure difficult. What is clear, however, is that there have been significant changes in the housing market in the last decade. These changes appear to make finding and maintaining suitable housing more challenging for people with mental illness.

6.1 Home ownership

Home ownership dominates the New Zealand housing market. Owner-occupiers can be divided into two groups – those with mortgages and those who are mortgage free. Private organisations such as banks, insurance companies and building societies are the main lenders. However, the Housing Corporation of New Zealand (HCNZ) continues with a small role in providing loans for low-income households as a lender of last resort for those who have difficulty obtaining finance from the private sector.

Local authorities also have a significant role in the home ownership market, which impacts on both new and existing housing. While local authorities are not housing financiers, they influence the construction, condition, type and location of housing. This is done through their role in preparing district and regional plans that govern the use of land and other resources. Councils use their district plans as a framework for assessing resource consent and building consent applications, and deciding whether to approve them.

If financially viable, home ownership is a positive option for people with mental illness, as it provides independence, reinforces people's integration within their communities and families, and tends to be associated with security of tenure. These benefits are reflected in research, which has found that owner-occupiers have the most stable housing situations.[16] In part this may be due to their living with other family members. Also, as an owner the individual has much more control over his or her housing circumstances, unlike a renter or boarder who may be forced to leave that accommodation.

However, home ownership can become a burden for those owners with mortgages who become ill and as a consequence have reduced and uncertain incomes. They can face the threat of the loss of a home through unsustainable mortgage repayments and other bill payment arrears. Loss of a home through mortgagee sales may also occur in situations in which there is no fundamental affordability problem if an individual has, because of illness, not been able to ensure that payments are up to date or ensure that their loan has been appropriately restructured to meet changed circumstances.

16 Robinson 1997:19, 39; 1996:25

People with serious mental illness may find it difficult to buy a home because of the costs incurred in saving for a deposit and servicing mortgage repayments, particularly in some regions such as Auckland, where house prices (and consequent mortgage commitments) are the least affordable. There is also some evidence of discrimination in accessing loans and insurance.[17] People with mental illness now find it harder to access housing finance than previously, as public lending services have diminished sharply and they are faced with meeting lending requirements on the open market. There has been a large increase in availability of private finance but people with serious mental illness have difficulty accessing funding from private sources and there is no indication such difficulties have reduced. It is virtually impossible for people with mental illness to obtain mortgage protection and income protection insurance. Barriers to obtaining insurance mean that getting a mortgage is beyond the reach of many people affected by mental illness.

These problems of affordability and home loan management may have been exacerbated by some key changes in the home ownership market including:

- The diminishing role of Housing Corporation of New Zealand (HCNZ) as a lender to first homeowners and those in serious housing need. HCNZ's current role is to provide loans for low-income households who have difficulty obtaining loans from the private sector. In 1990 the HCNZ accounted for around 10 percent of all loans, and in that year approved 25,193 loans. HCNZ loan approvals for the period July 1993 – June 1994 were down to 1334, and for the year ending June 1997, only 77 loans were approved.[18]
- Replacement of HCNZ's ability to lend at income-related interest rates with the Accommodation Supplement and the move to charging of market-related interest rates.
- A decrease in Maori access to public sector loans, with the transfer of Maori housing loans and rental accommodation provided by the Ministry of Maori Development to mainstream agencies in 1993 and 1994.

6.2 Rental housing

The rental market is divided into the public and private sectors. Housing New Zealand (HNZ), the main public sector rental provider, is also the single biggest owner of rental housing in New Zealand, with around 65,000 rental properties (24 percent of all rental accommodation). HNZ is required to rent vacant units primarily to people on low incomes, and to give priority allocation to people who are living in accommodation detrimental to their health or wellbeing, or who are in emergency accommodation.

Local authorities also provide public sector rental housing, but their provision has traditionally varied from one area to another. Most local authorities have never been significant providers of rental housing. Only the larger authorities have taken on this role and the extent to which they

17 *Supported Accommodation for People with Psychiatric Disabilities*, A Working Paper for the Mental Health Commission, 1998 p18

18 New Zealand Official Yearbook 1993:401; New Zealand Official Yearbook 1998:460

provide rental housing is very varied. One study reports that Auckland and Hutt City councils have sold most of their housing stock, although Wellington City Council has decided to retain its role in rental housing. The Wellington City Council provides several types of accommodation for people using mental health services. In contrast, Auckland councils are not major providers of rental accommodation to people with mental illness. They have no policies relating to them, and no reliable statistics on how many may be tenants.[19]

Around 72 percent of the rental market consists of private rental dwellings. The private rental market is characterised by a large number of landlords with few properties. Many do not see themselves as long term landlords, and so security of tenure for tenants is not guaranteed.

Renting can have a number of advantages for people with mental illness. It is a flexible form of tenure. Unlike owner-occupation, it does not require significant capital investment and the costs of rates, house insurance and maintenance are usually part of the rental. But there can be problems including:

- affordability problems - particularly with bonds and the move to market rentals in public sector housing
- insecurity of tenure, with many landlords selling properties to reap capital gain
- shortage of rental housing. This can be particularly acute in rural areas where there is little private rental accommodation, and in areas where both HNZ and/or local authorities are divesting themselves of housing stock. In inner city urban areas, boarding houses and hostels are threatened as the central business district is increasingly seen as desirable for luxury apartment living
- poor quality housing. This appears to be more of a problem with private, rather than public housing. People interviewed in one study were generally satisfied with HNZ accommodation, and it was seen as providing stable accommodation.[20] However, lack of standards and regulations for private boarding house accommodation providers is a particular issue
- inappropriate location or environment. One study reported that users of mental health services in public rental accommodation commented on problems with 'noisy neighbours'[21]
- potential for discrimination from landlords or other residents, and
- potential for eviction where renters in acute periods of illness have been unable to manage the regular payment of rent.

With regard to discrimination, there is little empirical evidence on the nature and extent of discrimination experienced by people with mental illness seeking rental accommodation. Surveys in Auckland and Wellington showed little evidence of discrimination by housing providers. However, there was a strong tendency for people to seek housing from sources that were believed to be sympathetic or supportive, such as HNZ and local authorities.

19 Robinson 1997:10

20 Robinson 1997:27

21 Robinson 1996:33

The same research also found that people living in private rental accommodation moved the most.[22] This may indicate some degree of discrimination, or insecurity of tenure. A survey of mental health organisations found that 75 percent reported that consumers had difficulty in accessing accommodation.[23]

6.2.1 Boarding houses

In the absence of other suitable accommodation, and where public sector housing provision is lacking, boarding houses and hostels fill a gap. Often, they provide 'housing of last resort' for some consumers, while for some others they are a positive choice.[24] However, their quality varies enormously. While some boarding house landlords take on a support role for people with mental illness, many houses operate with minimal facilities and no structured support services. The environment can be an unsafe and exploitive one for people with mental illness. Some landlords do not seek Health Funding Authority funding because they cannot meet the required standards for provision of supported accommodation services. Yet they may be controlling aspects of tenants lives, including management of money.[25] In some instances, boarding houses are also administering medication. Women in boarding houses are particularly vulnerable, and have been reported as experiencing violence, abuse and theft.[26] The lack of a regulatory framework and monitoring of boarding houses are urgent issues to address. There is also a need to identify how landlords can be assisted to support their tenants with mental illness, particularly as some are doing so in the absence of any other mental health support services.

6.2.3 Changes in the rental market

Significant changes in the overall rental market include:

- A reduction in the share of public rental dwellings. Over one third of rental dwellings were public sector houses in 1986, compared to just over one quarter in 1996.[27] Thus the capacity of the public rental sector to meet the needs of the most disadvantaged has been reduced.
- An increase in the proportion of the population in rental accommodation, from 23.5 percent in 1986 to 24.6 percent in 1996.
- Concentration of renting among the young and low-income groups (under $25,000). People renting are more likely to derive their income from benefits, and are less likely to be employed. Two fifths of Maori people and nearly half of Pacific peoples live in rental accommodation.[28]
- A move to market rents in the public sector rental market.
- An overall increase in HNZ and local authority rents by 4.4 percent from July 1996 to June 1997, compared to a private rental increase of 3.6 percent over the same period. In 1996 HNZ tenants had the same median weekly rent level as for private sector rentals. Large increases have been recorded in areas with high state rental stock, particularly Porirua, Lower Hutt, and South Auckland.[29]

22 Robinson 1997:7

23 Peters, J *Stigma and discrimination against people who have a mental illness: mental health organisations' views - a survey summary*, Waitemata Health, Auckland 1997

24 Carter, M *Living in Bed and Breakfast in the 1990s*, Housing Research #221, Joseph Rowntree Foundation 1997

25 *Supported Accommodation for People with Psychiatric Disabilities*, A Working Paper for the Mental Health Commission, 1998 p17

26 Auckland District Council of Social Services 1999.

27 Statistics New Zealand 1998:16

28 *New Zealand Now. Housing*, Statistics New Zealand, Wellington 1998 p29 - 40

29 Statistics New Zealand 1998:68, 70, 78; New Zealand Official Yearbook 1998:459

- Many local authorities have reviewed their role in rental housing, opting to sell housing stock.

These changes in the rental market are reported to pose both affordability and access problems for people using mental health services.

6.3 Supported housing

Supported housing for people with mental illness provides accommodation with mental health support services at varying levels of support. Although supported housing is a small component of the housing market for people with mental illness, it is nevertheless a very important component for people with the most serious mental illness. Mental health service users, service providers, funders, mental health advocates and others have raised many issues concerning supported housing. Only a brief discussion is provided here as further work is being undertaken elsewhere, such as the Health Funding Authority review of supported accommodation.

6.3.1 Meeting individual needs

At 180 supported housing places per 250,000 population, New Zealand has a medium number of supported accommodation places, compared with international data.[30] One of the current issues with present supported housing options is the lack of flexibility to meet consumer needs given the historical structures around care levels. This may be a more significant issue to consider than numbers of beds per se. If available beds are not utilised in the most effective, efficient way then increasing the number of beds may not increase the access to services to the level anticipated. To this end, the Health Funding Authority will be reviewing its supported housing contracting policy to better meet the needs of the consumers of these services. This review will also identify any intersectoral work that needs to occur within the context of supported housing initiatives.

6.3.2 Providers of supported housing

Providers of supported housing are funded by the Health Funding Authority and residents (through their benefits) for the housing costs and support services involved in running supported accommodation. Some organisations access houses through Community Housing Limited (CHL), a subsidiary of HCNZ which supplies houses to community organisations. A substantial proportion of its tenancies, 50 percent, are held by providers of supported housing for people with mental illness.

Community Housing Limited has increased the number of properties supplied to providers of supported housing for people with mental illness from 259 properties (786 beds) in September 1995 to 494 properties (1343 beds) in June 1999.

30 *Supported Accommodation for People with Psychiatric Disabilities*, A Working Paper for the Mental Health Commission, 1998 p5

6.3.4 Changes in Supported Housing

Like the other housing sectors, supported housing has experienced significant changes in the last few years. For supported housing, these changes include:

- the increased emphasis on supported housing as an alternative to institutional care
- an increasing number of places in homes with high levels of support
- a shift from group houses to independent but supervised living programmes. The focus of this approach is on integration of individuals into the community, with the expectation that provider support will diminish over time[31]
- a decreasing number of places in homes with low levels of support.

These changes have contributed to a growing number and complexity of issues concerning supported housing.

6.3.5 Advantages and problems of supported housing

The advantages of supported housing are that it can provide a staffed environment that offers education and recovery programmes, and help with day to day living tasks. However, while supported housing works well for some people at a particular stage of their illness, there are a number of problems with the current provision of supported housing. These include:

- A shortage of approximately 130 places in supported housing.[32] There are calls for more places in supported housing, as a response to sub-standard private rentals and in order to free up acute inpatient services.[33] In 1997 it was estimated that up to 40 percent of people currently in acute in-patient care could be living in the community if suitable housing and support services were available.[34]
- Gaps in the range and mix of services. Critical gaps include:
  - a lack of supported accommodation for people with dual mental illness and substance abuse problems
  - a lack of accommodation options that meet Maori needs. The target is that at least 50 percent of Maori who need supported accommodation should have the choice of kaupapa Maori or mainstream services, by July 2005[35]
  - a lack of effective culturally based services for Pacific people[36]
  - other groups who are not well served by supported housing include women caring for children, adolescents, and people who are homeless[37]
  - some accommodation options, such as low support group home places, are being reduced
  - some locations are very short of supported housing places (see Appendix 1).

31 *Supported Accommodation for People with Psychiatric Disabilities*, A Working Paper for the Mental Health Commission, 1998 p7

32 *Blueprint for Mental Health Services in New Zealand*, Mental Health Commission 1998 p99

33 *Supported Accommodation for People with Psychiatric Disabilities*, A Working Paper for the Mental Health Commission, 1998 p5

34 *National Acuity Review Final Report on New Zealand's Mental Health Acute Inpatient Services*, Paper prepared for the Ministry of Health by Deloitte & Touche Consulting Group, 1997

35 *Blueprint for Mental Health Services in New Zealand*, Mental Health Commission 1998 p52

36 *Blueprint for Mental Health Services in New Zealand*, Mental Health Commission 1998 p71

37 Robinson 1997; 1996

- Lack of flexibility. Because accommodation and support services are linked, as a person's support needs change, he or she may have to change accommodation. Some people may need supported housing long term, or for life. This may not be easy to provide where there is an expectation that people will eventually move out.
- The institutionalised nature of some supported homes diminishes residents' control over significant areas of their lives and sometimes isolates residents from the community.
- Some people remain in group homes when they would prefer to live independently, because they cannot afford to rent or own a home, or they cannot get the support they need if living independently.
- A shortage of adequately trained workforce for supported housing.
- The failure of providers and the closure of houses in some areas have exacerbated the shortfall in supported accommodation. Providers have expressed conerns about viability due to:
  - lack of available housing that is both appropriate and affordable
  - compliance costs of health and safety requirements
  - high establishment costs
  - complex contracting and funding arrangements
  - changes in the benefit regime affecting eligibility of people with mental illness for the Invalid Benefit, and abolition of the Sickness Benefit (see discussion in section 6.6). Some providers consider these changes are reducing their viability
  - difficulties in providing for residents with high support needs
  - difficulties in obtaining planning consents and working through community consultation processes.

> NIMBY (Not in my back yard) has been a common feature of neighbourhood and community response to the establishment of staffed housing. Concerns about safety, mental health service failure and unresponsiveness, provider credibility, property values and neighbourhood cohesion tend to dominate these responses. In some areas, vocal and organised opposition has stopped establishment or forced housing and service providers into lengthy planning hearings… [Some] local authority district plans may be discriminatory and appear to be attempts to exclude people with disabilities from living in certain neighbourhoods. Others are more supportive. (Paine 1998:9)

Supported housing providers are particularly concerned about what they see as discriminatory practices by local authorities in their district plans and resource consent processes, and unreasonable community opposition to the legitimate rights of people with mental illness to reside in the community.[38]

38 Paine, T *Housing and Housing Support in New Zealand for People with Mental Illness*, paper prepared for the Mental Health Commission 1998

6.4 The Resource Management Act

The Resource Management Act 1991 (RMA) requires local authorities to prepare district plans and provides the framework for considering resource consents. Providers of supported housing may need to obtain a resource consent, particularly if they are undertaking construction work, or use of a building is being changed. It must be recognised that the RMA does not in itself disadvantage people with mental illness. The intent of the RMA is to enable people and communities to provide for their social, economic and cultural wellbeing, provided that their activities are compatible with standards of environmental protection.[39] While the RMA allows social effects to be considered, there is nothing in the Act that proscribes certain types of facilities, nor does the Act favour one group over another. Furthermore, case law indicates that the mere existence of opposition to an activity is not evidence of an adverse social effect.[40] Therefore, opposition to supported housing does not of itself constitute grounds for not granting a consent.

6.4.1 Councils' interpretation of the Act

Although the legal framework is an enabling one, the ways that councils deal with proposals for supported housing vary markedly from area to area. Some councils reflect the needs of people with disabilities in their plans, while others have not taken these into account.[41] Similarly, some councils are aware of the needs and rights of people with mental illness when they are considering applications for resource consents, while others appear less than helpful. In many cases, problems emerge when supported housing is not considered to be a permitted activity under a district plan.

Resource consents may require providers that are setting up a house to consult with affected parties and/or the community as part of their consent application. Consultation will be necessary if supported accommodation is not a permitted use in the district plan. There is debate among providers about appropriate ways of undertaking community consultation. Some providers believe that requirements to consult are discriminatory and contravene the rights of the house's residents.[42] However, others regard consultation as a means of building a relationship with the community. Of course, consultation brings with it risks of generating negative responses.

Clearly, there are many complex issues concerning the establishment of supported housing in communities, and district plans are central to working out a fair and equitable approach for all. Councils need to develop greater awareness of the housing needs of people with mental illness living in the community. Organisations interested in the provision of mental health services also have responsibilities. They are able to influence the development of district plans in several ways, including making submissions on the preparation and amendment of plans. Furthermore, any person can request a Territorial Local Authority to change a district plan [s73 of the RMA]. The Ministry for the Environment is developing a document

39 Brooker Resource Management Vol 1, A5.06

40 Brooker, A5.11

41 The Mental Health Commission is currently surveying councils' district plans to identify their potential impact on providers of residential services, including instances of discrimination. They also plan to produce a discussion paper and 'good practice' guide for councils to alert them to issues for providers of residential services.

42 Holibar, F *Supported-Living Accommodation for People with Psychiatric Disability – A Summary of Current Issues*, paper prepared for the Mental Health Foundation 1998 p7

which will offer best practice guidelines for organisations having to go through resource consent processes.

6.5 Housing policy changes

Changes in the housing market over the last decade have reflected profound changes in the Government's role in housing provision and its housing policies. The Government has moved from a pluralist approach to housing assistance that involved public rental housing provision and lending using income-related interest rates and rentals as well as accommodation benefits, to relying almost exclusively on the Accommodation Supplement.

Although Government remains the largest provider of rental accommodation in New Zealand, in recent years there has been an increasing emphasis on the private sector for the provision of mortgages and rental accommodation. Lending by the Housing Corporation has declined dramatically, and the use of income-related interest rates to ensure mortgage affordability has ceased with the introduction of the Accommodation Supplement which is available to both renters and homeowners.

Although there continues to be provision of publicly owned rentals through HNZ, that stock is being operated largely under a private sector profit-driven approach. There is similar pressure on local authority housing to show higher rates of return on assets. People who have difficulties accessing affordable housing are now reliant on the Accommodation Supplement administered by Work and Income New Zealand to assist them in meeting housing costs. A non-taxable cash payment, the Accommodation Supplement is available for renters, boarders and homeowners who face high accommodation costs relative to their incomes.

The Accommodation Supplement is paid to people whose accommodation costs are more than 25 percent of their net benefit income (or the Invalid Benefit for those who are not beneficiaries) for those renting or boarding. For home owners to be eligible their accommodation costs must be more than 30 percent of their net benefit income (or the Invalid Benefit).

For those who are eligible, the amount of Accommodation Supplement they receive depends on their housing costs, household composition, income and cash assets. However, the Accommodation Supplement is only paid up to a maximum amount. The maximum varies depending on whether the person is single or married, with or without children, and the area in which they live.

The Accommodation Supplement is the primary form of housing assistance provided by Government and aims to provide assistance to those most in need. Unlike previous forms of housing assistance the Accommodation Supplement is tenure neutral. However, the amount of assistance which can be provided by Accommodation Supplement is restricted. It does not fully cover the gap between a person's housing costs and their income. Only 70 percent of the gap between 25 percent (or 30 percent in the case

of mortgages) of the income and actual housing expenditure is paid. Some people who are eligible for the Accommodation Supplement do not get the full 70 percent paid, because of the maxima placed on the Accommodation Supplement.

For many people with mental illness, who face higher than usual living expenses because of health-related costs, the failure of the Accommodation Supplement to ensure that housing is affordable is particularly problematic.

Finally, the Accommodation Supplement does not address problems of housing supply or other aspects of market failure including exclusionary practices as a result of discrimination.[43]

While the Accommodation Supplement is directed at addressing housing affordability problems, and expenditure on the Accommodation Supplement has increased rapidly, affordability problems still remain critical:[44]

- housing costs have risen by 48.3 percent between 1988 and 1997, a greater increase than the consumer price index, which increased by 27.5 percent over this period
- housing expenditure, for most households the largest component of household expenditure, increased from 20.5 percent to 24.5 percent of household expenditure from 1988 to 1997
- Government expenditure on housing assistance increased from an estimated $500 million in 1991, prior to the introduction of the Accommodation Supplement, to $843 million on the Accommodation Supplement alone in 1998/99. On average, Accommodation Supplement recipients received $35 per week in September 1994, this had increased to $49 per week by June 1999
- 30.8 percent of households in the lowest 20 percent of incomes, spent more than 40 percent on housing costs in 1996.

There has been an overall increase of 12 percent in the number of Accommodation Supplement recipients between June 1994 and June 1996.

6.6 Benefit changes

For some people with mental illness, housing affordability problems are likely to be exacerbated further by recent changes in benefits. Prior to October 1998, many people with mental illness were receiving the Sickness Benefit or the Invalid Benefit. Now, the Sickness Benefit has been abolished, the criteria for the Invalid Benefit have changed, and the Community Wage has been introduced. Some people who previously would have been eligible for the Invalid Benefit or the Sickness Benefit now only qualify for the Community Wage. This provides around $60 less per person per week than the Invalid Benefit, and about $25 less than the Sickness Benefit.

These benefit changes pose significant problems for the providers of supported accommodation. For many, benefits account for a considerable proportion of their income, estimated at one third by the group of

43 The limitations of the accommodation supplement were well recognised at policy development stages, and it was recommended that there would continue to be a need for programmes specifically designed to meet the needs of groups such as victims of domestic violence, people with disabilities, the frail elderly, ethnic minorities and residents of sparsely populated rural areas.

44 Statistics New Zealand 1998:65-77

providers at the top of the South Island. Until July 1995, all residents in supported accommodation services automatically had their benefits maximised to the level of the Invalid Benefit. When the maximised benefit was abolished, benefit funding was reduced for those residents who did not qualify for the Invalid Benefit. They were given access to the Sickness Benefit instead. Prior to last October new entrants to supported accommodation services received either the Sickness Benefit or the Invalid Benefit. Now some receive the Community Wage and make a smaller contribution towards their accommodation costs. Providers absorb accommodation costs that are no longer covered due to reductions in client benefit levels. The Top of the South Mental Health Providers are concerned that these changes "could well see the provision of community care diminish alarmingly." It appears that the costs of accommodation, as distinct from support costs, are being shifted on to the mental health sector. The impacts of benefit changes on individuals with mental illness, and on supported accommodation providers, need to be addressed urgently.

7 Objectives for Housing Solutions for People with Mental Illness

> …the existing range of housing options do not necessarily provide the best balance of the different aspects of housing such as degree of independence, provision of support and the ability of the consumer to control his or her living situation. Many consumers are seeking a package of these elements that cut across existing housing types … many consumers live in the gaps between these types. (Robinson, 1996:45).

People with mental illness have a variety of life circumstances and diverse housing needs. However, the housing policy that explicitly recognises their needs is limited to a supported housing policy that does not respond to that diversity. If people affected by mental illness do not fall under the supported housing umbrella their housing needs are largely ignored and they must attempt to survive in a housing market that fails to recognise the particular problems they face. Those problems range from:

- low and uncertain income
- loss of a home and possessions
- occasional difficulties in managing their housing arrangements due to acute illness
- significant fluctuations in health status and needs and consequent housing requirements
- occasional or on-going needs for home-based support, and
- vulnerability to discrimination in the rental and lending markets.

To progress development of housing solutions for people with mental illness, the Commission puts forward in this section a set of objectives for such solutions, and some practical actions for achieving those objectives.

The objectives are based on the National Mental Health Strategy's 17 principles for guiding mental health service delivery and development.

National Mental Health Strategy's Guiding Principles

The *National Strategy* principles include the following requirements for service delivery and development:

- Empowerment of individuals
- Full participation in society
- Better specifications for services
- Maori involvement
- Consistent safety standards
- Cultural safety
- Improving access
- Best possible outcomes
- Respecting personal dignity
- Minimising disruption to people's lives
- Sensitivity to changing needs
- Cost-effectiveness
- Integration at all levels
- Individual rights
- Control over mental health
- Supportive social environments
- Working intersectorally

In finding housing solutions for individuals it must be recognised that all tenures have potential benefits for people affected by mental illness. Tenure solutions need to be matched to the needs, preferences, capacities, and financial resources of individuals. The overall aim must be to ensure sustainable housing for the individual that is accessible, affordable, of good quality, secure in tenure and conducive to mental health recovery.

7.1 The Commission's proposed objectives

The Commission proposes the following set of objectives for housing for people affected by mental illness.

Housing solutions must ensure that people with mental illness:

- have access to affordable housing of a 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 support 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.

7.2 Implementing the objectives

These objectives need to be supported by a policy and research agenda that is developed by all agencies with housing responsibilities. A wide range of central and local government agencies have some responsibility for housing. They include:

- Social Policy Agency – responsible for overall housing policy
- Housing New Zealand – responsible for public rental housing
- Community Housing Ltd – assists providers to obtain housing suitable for group homes
- Housing Corporation of New Zealand – provides housing loans to low-income households that have difficulty obtaining loans from the private sector
- Work and Income New Zealand – administers the Accommodation Supplement and other benefits
- Health Funding Authority – contracts and monitors the providers of supported housing
- Ministry of Health – responsible for safety matters in supported housing
- Local Authorities – influence the provision of housing in three important ways:
  - provide some public rental housing
  - determine the location, type and conditions of housing through district and regional plans
  - approve resource and building consents.

If the housing needs of people with mental illness are to be properly addressed, three things must happen:

- assessment of an individual's housing needs must be incorporated as an integral part of considering the full range of the individual's mental health needs
- housing services must be co-ordinated with treatment and support service planning, and
- agencies outside of the mental health sector who have responsibility for housing must improve their responsiveness to people with mental illness. The mainstreaming policy of community-based care and treatment requires suitable housing to be included as a basic component of recovery.

> Interventions which tackle either mental health or housing conditions alone [are] not found to prevent subsequent service failures … Assessment of an individual's accommodation needs should be a central component of any overall assessment of mental health need. (Farrar, Young and Malin 1998:114)

There is clearly a responsibility on the part of the mental health sector to ensure that they are able to assess housing need, identify where an individual's housing is inadequate or is at risk, and to assist in ensuring that a suitable housing environment is provided. But other sectors also have responsibilities to work with the mental health sector in addressing a number of policy and implementation issues related to housing, benefits and health policy. It is especially important that the objectives for housing for people affected by mental illness are supported by all agencies with housing responsibilities. For most people with experience of mental illness, their contact with a mental health service takes up only a small part of their lives. The actions of other public and private sector organisations in developing policies, delivering services, and creating an environment where people with mental illness are assured of their rights, are essential for mental health recovery.

7.2.1 Policy development and co-ordination needed

Agencies need to work together, in close consultation with people with mental illness, to address a range of issues including:

- how to ensure that housing tenure is protected during periods of acute illness
- how to ensure that people with fluctuating needs have access to appropriate levels of care without disruption of their housing situation
- the adequacy of the Accommodation Supplement for people with mental illness, and in particular its adequacy in addressing the needs of people with mental illness living in group situations or boarding houses
- how to encourage the supply of good quality accommodation, particularly concerning boarding houses and hostels
- clarification and co-ordination of funding for housing and other living expenses across the welfare, housing and health sectors
- clarification and better specification of the social responsibility requirements of government agencies
- how to provide temporary housing and housing for those who are highly mobile
- how to improve the responsiveness of district planning and regulation to the housing needs of people with mental illness.

We need more information on the overall housing needs of people with mental illness and what contributes to housing failure. In particular, information is required on:

- the demand for and supply of housing for people with mental illness
- the extent and nature of unmet housing need among people with mental illness
- a national profile of supported accommodation service users
- the extent of transience and homelessness, and the particular housing needs of this group
- the extent and dynamics of discrimination and housing market exclusion for people with mental illness in the home ownership market
- the extent and dynamics of discrimination and housing market exclusion for people with mental illness in the rental housing market.

Closer co-ordination and increased consultation among all agencies involved will also be required. This would help to:

- clarify roles and responsibilities in respect of housing people with mental illness
- develop agreed goals concerning housing and related support needs of people with mental illness
- identify and develop mechanisms for systematic policy and operational co-ordination between agencies at national and local levels
- establish and evaluate a range of services to meet the housing needs of people with mental illness
- address issues related to discrimination and public education
- develop processes for monitoring and reporting on implementation

7.2.2 The role of local authorities

Territorial local authorities can make a difference by:

- ensuring that their district plans are responsive to the housing needs of people with mental illness, especially that providers of supported accommodation are not discriminated against by provisions in the district plan
- considering opportunities for providing rental accommodation for people with mental illness, with suitable supports
- acting as an underwriter for lending to community housing groups. One example is Christchurch City Council which underwrote a loan to the Housing for Women Trust to provide low cost housing for women.

7.2.3 New approaches

There is potential for building on existing initiatives and for considering the wider implementation of new models for independent living being

tried in New Zealand and overseas. These need to involve the many public and private agencies that influence housing for people with mental illness.

There are considerable opportunities for public and private sector partnerships. One example is the benevolent landlord or supportive landlord scheme. Currently funded by the Health Funding Authority in Christchurch and Dunedin, this may be an approach that could be adopted more widely. An outline of this approach, and some overseas models is given in Appendix 1.

8 Conclusion

Access to, and retention of, appropriate housing is important to everyone's well-being and is a critical factor in the recovery of people with mental illness. People with mental illness are over-represented in those groups traditionally disadvantaged in the housing market, and these disadvantages may be compounded by those resulting from mental health problems and discrimination against people with mental illness.

It is clear from the evidence presented in this paper that current policies do not adequately address the housing needs of people with mental illness, and that agency responsibilities for addressing these needs are unclear. Development of solutions requires an integrated approach that involves a range of agencies concerned with housing, income support and mental health in clarifying their respective roles and responsibilities, and developing an integrated policy response to meeting the housing needs of people with mental illness. This initiative might be led by the Social Policy Agency, as the primary advisor to Government on housing policy.

Such an inter-agency initiative would need to ensure that its work programme addressed the issues of access to, and retention of, appropriate housing, affordability of available housing options and quality and safety issues - particularly with respect to hostels and boarding houses. The work programme would need to be developed in close consultation with people with mental illness and service providers to capture their experience and knowledge of the current housing problems confronting people with mental illness, and ideas on possible solutions.

There is already sufficient evidence of serious housing need in some areas, such as homelessness in Auckland, on which to act immediately. The Health Funding Authority and Housing New Zealand should give priority to developing and implementing solutions in these areas.

In the longer term, policy development and the implementation of solutions will require a stronger information base than is currently available. Consideration needs to be given to utilising the considerable body of information that has already been gathered, and what significant information gaps it is both feasible and useful to address. One important information gap concerns the current housing situations of Maori with mental illness and how their needs for access to appropriate housing might be met.

Identifying and meeting the housing needs of people with mental illness is a complex and difficult task, and progress in addressing the issues has been insufficient to date. However, during consultation on the development of this paper, the Mental Health Commission found that housing, income support and mental health policy agencies are showing willingness to address the housing needs of people with mental illness as a matter of priority. The Mental Health Commission is confident that the conditions exist for significant movement to occur in this important area, and will continue to monitor future progress.

Appendix 1
Examples of Public and Private Sector Partnerships

Benevolent landlord - The concept of the benevolent landlord entails the owner or primary tenant of a dwelling accommodating the special needs of people with mental illness. They may do this by:

- ensuring continuity of tenure during acute illness
- carrying out essential property maintenance such as rubbish disposal and mowing of lawns if required
- advising and linking tenants with mental health and community services as required
- providing chattels and furniture if needed
- subsidising rentals, either on an ongoing basis or during a crisis.

Some families have expressed interest in developing a benevolent landlord arrangement, by providing an attached flat for their own relative, or a family funded support house for a group of consumers.

Two examples of this approach are funded by the Health Funding Authority. However, it is not clear whether funding of such schemes should be a health or housing responsibility.

Other examples of public and private sector partnerships here and overseas include:

- *Supported Rental Accommodation Service* - This service is operated in Canterbury by Comcare Charitable Trust. It assists people to find their own home and provides on-going assistance with accommodation, such as managing relationships with landlords, and property maintenance. The establishment of a one-stop shop accommodation service is a high priority, in order to assist anyone at a disadvantage in the private housing market. This service would assist people with house hunting, advocacy in dealing with private landlords, help in obtaining bond money, setting up tenancy agreements, and so on.
- *Home Link*[45] - This is a Yorkshire programme, which provides on-going, low level support for people with mental health problems living in the community in independent housing. Users of the service are all long-term users of mental health services. Set up jointly by health, housing and social service agencies, the programme has two components:
  (a) workers provide practical assistance and general support with any tasks associated with running an independent home
  (b) a mutual support network – tenancies are allocated close together, and social events are organised for tenants. This is based on the idea of promoting 'good neighbour' relationships.

  Both clients and agencies identified benefits of the model. For the clients – the service helped them attain and maintain independence,

45 Quilgars, D *Supporting People with Mental Health Problems in Ordinary Housing, Findings*, Joseph Rowntree Foundation 1998

lowered stress, increased social contacts, and had a positive effect on mental health. For agencies – the service freed up mental health professionals to concentrate on those who needed higher level interventions, reduced housing management input, was cost effective, and resulted in significant improvements in agencies working together.

- *Assertive Outreach Services*[46] - This Brixton programme is focused on young people with a history of severe mental health problems. Its aim is to get agencies, including local government, health services, voluntary organisations and user groups, to work together to improve people's access to housing and employment. Outreach worker teams include members from all participating organisations. They provide advice, treatment, care and rehabilitation services, with 24-hour support. Services are tailored to individual needs.
- *Under One Roof* [47] - This South London initiative has been set up for homeless people, with the aim of giving them better access to services, and providing for their multiple needs. The services of housing officers, benefit staff, social workers, specialist mental health workers and voluntary organisations are located in a single place.

46 *Three sites chosen for new mental health programme*, King's Fund, press release 2 December 1998

47 *New Integrated Service opens for Homeless People in South London*, King's Fund press release 20 March 1998.

Appendix 2
Provision of Supported Housing in 1998

The HFA 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.

The Mental Health Commission's Blueprint established guideline levels of provision for these services.[48] Overall total national provision is close to the Blueprint guidelines, but there are significant gaps in the northern and southern parts of the country. The largest gap is for high level supported housing in the north, where provision in 1998 was at only 63 percent of guideline levels.

The table below compares numbers of supported housing places funded by the Health Funding Authority at 30 June 1998 with Blueprint guideline numbers for each region.

Total numbers of places in supported housing, funded by Health Funding Authority at 30/06/98 and Blueprint guideline numbers

	North		Midland		Central		Southern		Total	
	Funded places	*Blueprint guideline*	*Funded places*	*Blueprint guideline*	*Funded places*	*Blueprint guideline*	*Funded places*	*Blueprint guideline*	*Funded places*	*Blueprint guideline*
Supported housing places with high level support	331	520	380	300	435	368	246	322	1392	1511
Supported housing places with low level support	425	390	208	225	307	276	184	242	1124	1133
Total supported housing places	**756**	**910**	**588**	**525**	**742**	**644**	**430**	**664**	**2516**	**2644**

48 *Blueprint for Mental Health Services in New Zealand* Mental Health Commission 1998 p99