# Navigating a Pandemic:
# Exploring Housing, Homelessness, and Mental Health during the Covid-19 Pandemic

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**ANTHONY HALL**


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# Abstract

It has been almost four and a half years since Covid-19 emerged and changed everyday life for people in New Zealand. The Covid-19 pandemic resulted in an unprecedented health response, which included lockdowns, social distancing measures and restrictions on the everyday lives of New Zealanders. Focusing on New Zealand, this thesis explores housing, homelessness and mental health during the Covid-19 pandemic. I aimed to provide a snapshot of the experiences of people who lived in emergency housing or were otherwise homeless during the Covid-19 pandemic. Additionally, I wanted to understand the experiences of those housing case workers who supported the homeless during the Covid-19 pandemic. I undertook a qualitative study involving semi-structured interviews with five participants. Some themes that emerged from these interviews included challenges in access to services, healthcare and information concerning Covid-19. The concept of autonomy in the context of public health policies also emerged, and the impacts of social isolation and feelings of powerlessness as a result of the Covid-19 pandemic restrictions were explored. Analysis of the participants' experiences revealed underlying neoliberal narratives and internalised delegitimization. The participants demonstrated a variety of coping strategies, including familial connections, positive fatalism and humour, that were used to navigate their lives and the challenging Covid-19 pandemic. This study emphasises the importance of understanding the lived experiences of individuals facing homelessness, particularly during unprecedented events such as the Covid-19 pandemic, in order to produce equitable policy change that considers the diverse needs and challenges of vulnerable populations.

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# Glossary

| Māori | English |
|---|---|
| Aroha | Love |
| Hūmārie | To be sensitive, calm and reliable |
| Koha | A gift, present or offering |
| Korero | A conversation, discussion or meeting |
| Koroua | An elderly Māori man |
| Kotahitanga | Solidarity or unity with a person or group |
| Mahi | Occupation; hard work necessary to get the job done |
| Mana | (Broad meaning) Agency to act, power, prestige, status, authority, also recognises absolute uniqueness of individual, central to action |
| Manaakitanga | Kindness, respect, responsibility and reciprocity |
| Tamariki | Children |
| Tane | Man |
| Tangata Whaiora | People seeking wellness |
| Tangata Whenua | People of the land |
| Te Tiriti O Waitangi | The Treaty of Waitangi – the founding treaty of New Zealand, signed in 1840 |
| Tikanga Māori | Māori customs, values and knowledge |
| Wahine | Woman |
| Wāhine | Women |
| Whānau | Familial members belonging to kinship group |
| Whanaungatanga | Creating genuine reciprocal relationships that advocate empathy, understanding, commitment and support |

# 1 Chapter One: Setting the Scene

Covid–19 is a recent phenomenon that has greatly changed everyday life for people and their communities since its emergence in New Zealand on the 28th of February 2020. The Covid-19 pandemic has caused a range of societal changes, including psychological health issues, including fear, anxiety, disconnection and uncertainty (Anderson et al., 2020). These ongoing stressors are particularly difficult for families and individuals in lower socioeconomic groups, such as the 'working poor', whānau in social housing, and homeless populations. These groups already have fewer financial and social resources to call upon in times of need (e.g. finance, medical, housing and safety), which has been amplified by the changes within society due to the Covid-19 pandemic (Le Dé et al., 2023). The research aim was to explore the experiences of whānau and individuals in emergency housing or experiencing homelessness. An additional research aim was to understand the experiences of housing case workers working alongside Waikato homeless populations during the Covid-19 pandemic.

For this thesis, I interviewed people who have lived experiences of homelessness and those who support them to understand the importance of secure housing and the reality of the barriers in place to obtain and sustain secure housing. The interviews and research also focused on the Covid-19 pandemic and the additional challenges and opportunities faced by people experiencing homelessness and organisations that were actively supporting them during the lockdown measures and ongoing restrictions.

## 1.1 Research Justification and Direction

Much of the current research surrounding the effects of the Covid-19 pandemic is quantitative. The research into the physical health impacts of Covid-19 is vitally important. However, there is an opportunity also to research the human side of the impact of this global

trauma. This thesis offers a qualitative approach to research on the Covid-19 pandemic, which is currently lacking at the time of writing. We have statistics about how the pandemic affected the New Zealand population. However, this data can only tell part of the story.

An argument can be made that there is a need to address and understand the effects of the Covid-19 pandemic on vulnerable or marginalised populations here in Aotearoa, New Zealand. As there is only a small amount of research on the effects of the Covid-19 pandemic on vulnerable populations here in New Zealand, it would be appropriate to investigate how this pandemic has affected whānau or individuals in emergency housing or are otherwise homeless in New Zealand. As such, this thesis offers an in-depth and qualitative investigation into the psychological effects of Covid-19 on whānau and individuals in social housing or experiencing homelessness.

## 1.2 The Research Aims

A recent psychological study undertaken in France analysed the major methodological obstacles to conducting research in homeless populations. Chevreau et al. (2021) found that the experience that service providers and staff have with homeless clients is invaluable to research looking into homelessness as a psychological phenomenon. The authors argue that when research is done with the trusted support of persons currently homeless, those researchers are more likely to have the lived experience and skill set to establish a working rapport. Additionally, those researchers who are stakeholders in the homelessness environment possess the needed expertise in how to engage with vulnerable populations such as those who are currently homeless: “it helps to focus the study on the right issues, build trust with service users, and allow direct application of the acquired knowledge to the care of the target population.” (Chevreau et al., 2021, p. 192). Accordingly, my experience working within a social housing agency grants a unique opportunity for an interconnected, responsive, and empathetic

qualitative research. This positionality and research imperative will add to a growing knowledge base and collaborative experience with individuals currently homeless or in social housing during a major worldwide pandemic. Additionally, this research can provide a more personable humanistic approach and enable a responsive dialectic per the needs of those living in social housing or otherwise homeless. The level of rapport that results from this positionality would benefit qualitative research methods that utilise humanistic rapport-driven frameworks.

## 1.3 The Research Methods

Case studies have been a popular and useful methodology in researching homelessness and other minority populations. A case study can provide a deeper level of understanding and meaning by studying a small number of individuals' experiences, as opposed to studying a larger number of individuals, with less depth. As Gerring (2007) summarises, "sometimes, in-depth knowledge of an individual example is more helpful than fleeting knowledge about a larger number of examples. We gain better understanding of the whole by focusing on a key part.". By using an inclusive pro-social humanistic psychology perspective, a case study approach can focus on the hardship, inequity and exploratory issue while maintaining a participant's mana by addressing and fostering talk on prevailing resilience and strength factors (Hodgetts et al., 2020). While there is some survey research into the effects of Covid-19 on psychological well-being, there is little or no in-depth understanding of the psychological impacts of the pandemic on people who are in social housing or are homeless. A case study would expand current research into the effects Covid-19 has had on persons who are either homeless or in social housing while providing an up-to-date discourse on individual accounts of the pandemic and its effect on their lives. Others could refer to this study in future research to create a greater understanding of the impacts the Covid-19 pandemic has had on populations within social housing and those who are experiencing homelessness.

(Johnson, 2009) research into the provision of mental health to Māori who are homeless uses (Murray, 2000) levels of narrative analysis, including personal, interpersonal, relational and ideological or societal levels of analysis. This is a culturally inclusive psychological perspective as it considers important Māori world views that may be in the areas of social, physical, emotional, political and spiritual. (Murray, 2000) believes that the use of narrative theory can assist in the development of more critical health psychology by enhancing alternative knowledge and considering social processes, moving beyond the dominant personal level of analysis, which ignores social and contextual aspects of illness. The use of narrative analysis could be particularly useful in the study of indigenous homeless populations as an individual's culture is greatly influenced by social, physical, emotional and spiritual factors. This method is inclusive of the cultural factors that influence their lived experiences of mental health and homelessness.

## 1.4 The Research Overview

Chapter one gives a brief contextualised overview of the research project, and the research aims of this thesis, followed by a short summary of the research methodology and an overview of the following chapters. Chapter two consists of a literature review providing research about homelessness, housing security, neoliberalism narratives and the Covid-19 pandemic. The chapter begins with an overview of homelessness, an exploration of the concept of "home", and delves into the state of social housing, emergency housing and homelessness in New Zealand. Second, I review housing insecurity in New Zealand, including the importance of and challenges to secure housing. Third, I provide a brief overview of neoliberalism narratives that guide public perceptions and contextualise it with homelessness, looking into the concepts of responsibilisation, delegitimization and the concept of the 'undeserving poor.' Lastly, the literature review details the Covid-19 pandemic in the context of New Zealand. I

look at New Zealand's response to the Covid-19 pandemic, the challenges on mental health and well-being, and the consequences to the healthcare system. We finish off the literature review outlining some of the impacts Covid-19 had on the New Zealand Māori population. Chapter three provides the methodological approach to this thesis and explains the theoretical framework that underpins this research. This chapter also details the approach to the analysis, ethical reviews and an introduction to the participants in this study. Chapter four provides an analysis of the experiences of the five participants who were interviewed for this thesis, and each participant's narrative is explored contextually. Chapter five contains discussion of the key findings from the participant interviews and narrative analysis. Chapter six provides a conclusion which includes a review of the present study, and research and clinical recommendations for future research.

# 2 Chapter Two: Literature Review

## 2.1 Introduction

This chapter begins by defining and explaining the concept of homelessness, social housing, and emergency housing alongside the multifaceted concept of 'home'. An investigation into homelessness in the context of Aotearoa, New Zealand, follows, leading to an exploration of the importance of secure housing for all members of the collective community and its importance to general well-being and to both physical and mental health outcomes. Next, I identify what the literature describes are some of the barriers and challenges that people face in obtaining and sustaining secure housing. Accompanying this brief overview of challenges to homelessness is a reflection on some of the wider societal narratives that guide and shape perspectives on social housing and homelessness. Next, I review the Covid-19 pandemic with a focus on the New Zealand government's measures to limit and reduce its spread throughout the nation's population and how these measures impacted communities. The key questions that guided this literature review were to explore New Zealand's response to the Covid-19 pandemic, which included lockdown measures, restrictions to movement and changes to how social services were provided to the public. This literature review also investigates what the current literature notes as possible contributors and consequences for vulnerable populations such as those experiencing homelessness, living in social housing, or placed into emergency housing.

## 2.2 Defining Homelessness

In New Zealand, the Statistics New Zealand definition of homelessness is widely accepted and referred to and adopted by organisations: "Homelessness is defined as a living situation where people with no other options to acquire safe and secure housing are: without

shelter, in temporary accommodation, sharing accommodation with a household, or living in uninhabitable housing" (Statistics New Zealand, 2015). This definition is broad and encompasses the 'hidden homeless' which are often underrepresented in official data. For example, the New Zealand Social Housing Register may exclude people who are staying with family or friends. Such people who have nowhere else to live are captured under the definition of homelessness above, which reflects inconsistencies between government agencies recording data around housing needs. The 2018 New Zealand Census attempted to represent a portion of those 'hidden homeless' estimating that the number of people sharing accommodation with another household temporarily in a crowded dwelling was about 30,000 (Amore et al., 2021). The 2018 New Zealand Census showed a minimum estimate of approximately 102,000 people experiencing Severe Housing Deprivation at the time of the census in March 2018. This figure was made up of four categories: people living without shelter, people living in temporary accommodation, people who were sharing accommodation, and people who were living in uninhabitable housing (Amore et al., 2021). To more fully understand what homelessness means for those affected, it is helpful to consider the notion of home and what it provides to people.

## 2.3 The Concept of "Home"

The concept of 'home' encompasses a range of social psychological, and cultural values that go beyond having a roof over one's head. The concept of 'home' has been widely researched, with some studies focusing on the factors that make a house a "home" (Boulton et al., 2022; Karjalainen, 1993). Boulton et al. (2022) studied Māori housing needs, well-being and policy, and they explain that their participants saw "'home' as being about connection to people, land and identity" (p. 50). Boulton et al. (2022) also noted that 'home' represented "aspects of emotional, physical, and spiritual well-being…" (p. 51). This multifaceted

understanding of home emphasises the importance of stability and a sense of belonging in a person's living environment.

The significance of having more than simply a house or temporary place to live is crucial to understanding the broader impacts that housing has on individuals' lives. Research suggests that the quality and stability of housing are vital to mental and physical health, social relationships and community engagement (Holding et al., 2020). Després (1991) argues that one of the essential features of the 'home' is the idea that home is a sanctuary from outside pressures, and "a place where one can control the level of social interaction, and a place for privacy and independence" (p. 98).

Homeownership rates in New Zealand have declined over recent decades, particularly among Māori populations. According to (Statistics New Zealand, 2021), the homeownership rate for Māori has decreased from 57.4% in 1991 to 47.2% in 2018. This decline reflects broader socio-economic challenges and disparities in housing affordability. The difference between homeownership and renting is an important factor to consider in the concept of 'home'. Renting in New Zealand is often associated with insecurity and poor housing conditions, particularly when compared to many European nations where renting offers protections for tenants and more stability (Bierre, 2007). These problems and the potentially transient nature of renting undermine the establishment of a 'home'.

Social or emergency housing is available for people for whom home ownership and private rental homes are not an option. While social housing provides more stability compared to emergency housing, access is limited due to high demand and limited supply (New Zealand Government, 2019). However, being in social or emergency housing does not always fulfil these deeper needs associated with having a 'home.'

## 2.4 Social and Emergency Housing in New Zealand

Social housing in New Zealand is a form of housing assistance provided by the New Zealand government to support individuals and families who cannot access housing in the private rental market because of various circumstances. Social housing applicants must meet specific criteria related to age, residency, serious housing need, and income and assets (Ministry of Social Development, 2024). If the applicant meets these criteria, they need to submit an application and be interviewed for assessment by Work and Income. If accepted, the applicant is then placed on the Housing Register waiting list until a suitable property becomes available. For people who are in urgent need of housing with nowhere to live in the now or next 7 days, assistance is available by contacting Work and Income. For people who do not meet the eligibility criteria, there are not many other options available for permanent housing. Consequently, people experiencing homelessness may rely on living in vehicles, the use of homeless shelters, or the support of friends and family.

In 2020, the state of housing in New Zealand was a significant concern, with various reports highlighting the issues of availability and adequacy. According to the Housing in Aotearoa: 2020 report by Statistics New Zealand, these issues were due to challenges in keeping up with population growth and increasing demand for housing (Statistics New Zealand, 2020). The 2024 OECD Affordable Housing Database indicator shows that New Zealand's social housing stock is lower than that of many other OECD countries, which suggests room for improvement (OECD, 2024).

Social housing options include homes provided through Kāinga Ora – Homes and Communities, Community Housing Providers (CHPs) and Emergency and Transitional Housing. Kāinga Ora (formerly known as Housing New Zealand) owns and manages a large portion of the public housing stock in New Zealand. A significant part of Kāinga Ora's mission

is to deliver “more public, transitional and affordable housing to help meet supply” (Kāinga Ora, 2020, p. 1). At the height of the Covid-19 pandemic, Kāinga Ora’s housing supply was increased from 727 homes in 2020 to 1915 homes in 2021 (Kāinga Ora, 2021). Kāinga Ora works alongside Community Housing Providers, often non-profit organisations offering social housing options (Ministry of Housing and Urban Development, 2024). Also, some Māori organisations and iwi provide social housing options to support their communities.

Emergency and transitional housing options provide short-term housing for people in urgent need. Ultimately, these short-term options aim to help transition tenants into permanent housing. During the Covid-19 pandemic, New Zealand’s emergency and transitional housing played a crucial role in providing short-term accommodation to support individuals who had nowhere to stay. These individuals included people who were experiencing homelessness before the pandemic but also included those who had found themselves experiencing homelessness as a result of the Covid-19 lockdowns and economic repercussions. Over 650 temporary homes, which were mainly sourced through motel accommodation, were made available for people in need (Ministry of Housing and Urban Development, 2020).

## 2.5 Housing Insecurity in Aotearoa New Zealand

New Zealand, often considered a wealthy nation, faces significant challenges regarding housing affordability and insecurity. According to the OECD Better Life Index released in 2011, the average New Zealand household net wealth was USD 514,162, which was higher than the OECD average of USD 323,960 (OECD, 2011). Despite this apparent wealth, housing affordability has been a persistent issue.

In New Zealand, house prices have risen at a faster rate than the average wage, and the Housing in Aotearoa: 2020 report stated that the Auckland median house sales price in mid-2020 was around 11.5 times the median household income (Statistics New Zealand, 2020).

Rising property prices have made it harder for people to own their own home, and increased housing costs such as rent and mortgage payments, have caused housing to become unaffordable for many and housing insecurity to rise. In the context of New Zealand, one indicator of the prevalence of individuals and whānau struggling with housing insecurity is the number of applicants on the New Zealand Social Housing Register. At the end of January 2022, a total of 25,887 applicants were on the Social Housing Register, waiting to be placed into public housing by Kāinga Ora or Community Housing Providers (New Zealand Government, 2022a). The term 'applicants' potentially hides the full number of people who are in need of housing. In many cases, applicants are not simply unhoused individuals but are likely also to have dependents, partners or extended family who live with them all or some of the time. This means that most people are not in poverty alone, and the true number of applicants is likely to be understated. The Government Housing Dashboard shows an increase of 9,578 applicants on the register since March 2020, with more than half of these applicants added to the register in the period of March 2020 and September 2020 (New Zealand Government, 2022a). Social Housing Register demographic data released by the Ministry of Social Development shows that at the end of September 2021, Māori applicants made up 50% of the total applicants on the Register (Ministry of Social Development, 2021). These statistics show that there is a significant lack of affordable and secure housing for Māori, who are a population already identified as overrepresented in homeless populations.

King et al. (2017) provides detailed accounts on the economic, structural, and social disparities for Māori since the European arrival to Aotearoa and the implementation of the Treaty of Waitangi and consequential laws passed as a result of colonialism. The following subsections provide information to begin to understand why many modern Māori are in economic, social and structural positions that are unfavourable. This includes the fact that large

percentiles of Māori are identified as being in the precariat group, who as a result, have few options but to rely on social institutions and the welfare state (p. 116-120).

## 2.6 The Importance of Secure Housing

Secure housing is of high importance in improving outcomes for those experiencing insecure housing or homelessness. To be considered secure, the housing itself must be of a quality standard which considers the main aspects of the health and security standards. Poor quality housing, such as homes that are cold, damp and mouldy, can lead to negative effects on both physical and mental wellness (Liddell & Guiney, 2015). Additionally, whānau and individuals already presenting with existing health conditions may find symptoms exacerbated by the unsafe conditions of unsuitable housing (World Health Organization, 2018). The definition of a healthy home and living environment used by the World Health Organization (2018) is one that: "supports a state of complete physical, mental and social well-being" and can provide a sense of 'home'.

Secure housing for whānau and individuals is widely recognised in literature as being fundamental to healthy communities and provides a foundation to which citizen engagement, cooperation and well-being may be achieved. This premise is acknowledged overseas with Evan Siddall, president of Canada's Mortgage and Housing Corporation succinctly stating:

> "Safe, adequate and affordable housing is a catalyst that enables Canadians to achieve other goals – from raising healthy children to pursuing education, jobs and opportunity. When affordable housing is in short supply, Canada's whole economy suffers" (October 18, 2016).

Access to secure housing not only affects the health and well-being of citizens but may also have an impact on a nation's economy. The World Health Organization's housing and health

guidelines explain that poor health outcomes due to people living in insecure housing often result in financial difficulty (World Health Organization, 2018). Contextually, when communities have a significant number of citizens without secure housing: “This creates a cycle between poor health and household, local and national economic outcomes” (World Health Organization, 2018, p. 11). This insight underscores the interconnectedness of housing security, health, and economic stability. Poor housing conditions can cause a range of health issues, which in turn causes an increase in healthcare costs and reduces a nation’s productivity. When individuals are unhealthy, they are less able to work and contribute economically, which perpetuates poverty cycles. As such, poor health outcomes due to housing insecurity affects not only the individuals who are directly affected, but also the wider community and nation.

## 2.7 Challenges to Secure Housing

Several predominant determinants are identified in literature around insecure housing and homelessness across Aotearoa. Income insecurity, employment opportunities, and job sustainment are some of the barriers identified as part of the factors that can lead whānau and individuals to fall into impoverished conditions, leading to insecure housing outcomes such as social housing, transitional housing, or homelessness (New Zealand Government, 2019).

## 2.8 Cost of Living

Studies focusing on New Zealand homelessness have had a longstanding focus on persons and whānau who are financially impoverished, either living in insecure forms of housing, or considered homeless (Cochrane et al., 2017; Cresswell, 2018; Johnson, 2009; Kearns, 1995; Kell & Peace, 2002). A lack of dwellings in New Zealand and the continued cost attributed to housing have contributed to the rise of individuals and whānau living in precarious living conditions, including social housing, transitional housing, emergency housing, or

homelessness. The cost of living and housing prices keep many whānau and individuals out of their own homes and sometimes homeless, but what other barriers exist that prevent owning, renting, and sustaining a home?

## 2.9 Deinstitutionalisation

Deinstitutionalisation and the shift from state-run institutions and hospitals to community projects and Non-Government-Organisations (NGO) outreach programmes is considered a positive step in the reconfiguring and setup of a more equal and inclusive society because it promotes community-based care which empowers individuals to be integrated into society (Dear & Wolch, 1987a). However, the deinstitutionalisation process also created a situation where some individuals cut off from the familiarity of services that were previously provided to them, ended up becoming homeless, and were unsure of the social programs offered and how to access these services (Dear & Wolch, 1987a, 1987b, 2014). Additionally, community programmes and NGOs have also been notoriously underfunded (Jenkins, 2019). Further, funding is usually based on narrow outcome measures, which makes it either difficult, or, unachievable for services to assist individuals who require a much higher level of care due to their acute mental health presentation (Huang & Hooper, 2011). This gap in services means that many vulnerable individuals may not receive the extensive support they need, which can lead to increased rates of homelessness and housing insecurity among this group of people. In addition to the underfunded support entities and gaps in their services, people may find themselves struggling in the attempt to navigate the social services available.

## 2.10 Navigating the Social Welfare System

Navigating the wide range of social welfare systems available can be a complex and daunting proposition for people attempting to receive support. King et al. (2017) provides an

illustrated figure that shows how many different welfare and private institutions her example participant is involved within the modern social welfare system. This "obstacle course" of services, which is shown in Figure 1 of chapter (2:9) in King et al. (2017), has been illustrated and identified into five groups based not just on their need but also their desirability. Notably, the services that are considered 'Have to go & Need to go' the most important to survival are considered by some to be the least caring and supportive for whānau in the community. For example, an interviewed advocate from Māori Women's Refuge gives a comprehensive living recount of the difficulty and "red tape" put in front of individuals attempting to seek social services. She states:

> "When engaging with services, people in (name) situation talk about having to pretend to be someone they are not, in order to be acceptable to agencies they 'have to go to' and in order to access their entitlements" (King et al., 2017, pp. 122-123).

She recognises the hardship brought to those people who, at this stage of their life journey, require support from social services, and in amongst the increasing level of requirements and standards placed upon them, be accepted by social services while maintaining themselves, while under increasing stigma presenting as judgment and criticism from service providers and others inside their community.

## 2.11 Mental Health and Addiction

Psychological stressors and other mental health factors have often been identified as barriers in relation to access to services (Johnson, 2009; Smith et al., 1993), housing outcomes and homelessness (Kearns, 1995). A 2004 study by the Australian Housing and Urban Research Institute outlines several key connections between mental illness and homelessness, identifying that the mental health and illness of participants, including issues such as hospitalisation or drug abuse, are more likely to put them at risk of homelessness (Robinson, 2004). The latter,

in turn, increases mental health distress, which can create a cycle that can be hard to escape from. Robinson (2004) suggests that the inability to sustain long-term and stable housing is often correlated with a deterioration of mental health outcomes. Johnson (2009) explored the provision of mental health services to Māori who are homeless. She highlights the importance of strong therapeutic relationships in a mental health setting, the need for a collaborative approach between agencies in service delivery, and the importance of incorporating Tikanga Māori in restoring patients' well-being and dignity. However, mental health should not be considered as the fundamental cause which leads whānau and individuals into states of poverty, insecurity and homelessness (Robinson, 2004).

## 2.12 Homelessness Itself – A Barrier to Supports and Secure Housing

The inability to access services is what prevents homeless people from accessing the services that might help them to escape from homelessness and, in time, become more securely housed. In exploring the link between homelessness and barriers to healthcare, (Johnson, 2009) identified examples of where homeless people were unable to access services such as DHB Drug and Alcohol support services because those individuals were not able to provide a physical address. People experiencing homelessness having to provide a physical address prior to service access is a barrier to community integration, and further marginalises individuals in critical need of support into housing. This community integration support is what Goldfinger et al. (1999) identifies as a necessary part of positive housing outcomes for those experiencing homelessness. The idea of good health and well-being being a factor in obtaining and then being able to sustain secure housing is well established which makes the experience of homelessness itself a barrier to secure housing. Scanlen (2009) conducted research on the complexities of provision of primary healthcare services for the homeless population in New Zealand. She emphasises the need for recognition of the barriers that this population faces in

accessing healthcare, as well as recognising the ongoing struggle to maintain both physical and mental health well-being as a homeless person in Aotearoa. Scanlen (2009) suggests that government organisations and policy makers need to consider these barriers in the process of establishing accessible health services. The points raised by Scanlen (2009) continue to be relevant today as the cost of healthcare continues to rise in New Zealand, as reported in a 2024 survey conducted by the investment company Stake (Stake, 2024).

While the barrier to accessing healthcare can be a significant contributor to homelessness, it is not the only cause. Cresswell (2018) notes on their analysis of barriers to maintaining accommodation: "All of the barriers that were discussed could be summarised by saying that not one thing causes homelessness. Consequently, there is a need to acknowledge the complexity of homelessness and the impact that the socio-political environment has on homelessness" (p.87). These factors exist not apart from each other but rather culminate together into a multifaceted presentation that increases whānau and individuals' chances of entering a state of housing insecurity, poverty and homelessness. James et al. (2022) summarises that the pathways to homelessness tend to be an amalgamation of personal, structural, and political factors. Specific to Aotearoa, the (New Zealand Government, 2019) identifies driving forces of homelessness to include housing shortages, exponential rent hikes and unaffordable housing options for families, the high cost of living, limited employment opportunities, lack of social services, as well as cultural discrimination and disadvantage.

## 2.13 Neoliberalism Narratives – Shaping Perceptions of Homelessness

Neoliberalism is a societal narrative emphasising free-market philosophies, individual responsibility, and minimal state intervention (Clapham, 2018). Neoliberalism promotes policies that complement the processes of commodification, marketisation, financialisation, privatisation and individualisation (Clapham, 2019). In context to this thesis, the neoliberal

narratives in social policies frame homelessness as an individual's consequence of actions (Hodgetts et al., 2014; Howarh & Andreouli, 2017)This neoliberal narrative propagates themes of responsibility, delegitimization, and the construction of the 'undeserving poor' narrative.

### 2.13.1 Responsibilisation

In the context of this research responsibilisation refers to the shift of accountability for social welfare from the state and its social and economic policies onto the individuals experiencing homelessness (Howarh & Andreouli, 2017). This narrative posits the reduction of state support for housing and the promotion of self-responsibility (Murphy, 2020). The inclusion of the neoliberal narratives of market rationality and economic rationalisation has permeated through the domain of human culture and experience (Howarh & Andreouli, 2017) developing the concept of responsibilisation in all aspects of people's lifeworld. As such, people experiencing homelessness who are unable to secure private housing that is often inaccessible or unaffordable (Statistics New Zealand, 2020), are left without sympathy as people look down on them for being unable to self-sustain housing outcomes.

### 2.13.2 Delegitimization

Delegitimization occurs when minority groups, such as those experiencing homelessness, are perceived as not worthy or deserving of support by others, in particular, the state and social welfare. Persons experiencing homelessness often fall short of expectations embedded in this narrative, which often categorises them as deviants and untrustworthy (Wacquant, 2009). Delegitimization creates a hostile community landscape, as compassion for vulnerable people is discouraged. This leads to declining support for social welfare initiatives created to provide services to the homeless community.

### 2.13.3 The Concept of the 'Undeserving Poor'

Core contrasting factors in neoliberalism are the concepts of the 'deserving' and 'undeserving' poor. Regarding homelessness, this narrative postulates the question of whether someone or their family has done enough alone, without support, to be worthy of 'deserving' assistance with housing. Murphy (2020) argues that this neoliberal narrative perpetuates punitive approaches to the homeless where support is only provided for those deemed 'deserving'. This perspective on the 'deservingness' of support does not consider the multifaceted factors contributing to homelessness. Factors include the lack of housing, systemic and structural inequalities in housing and labour markets (Leggatt-Cook & Chamberlain, 2010), socioeconomic inequalities (Hodgetts et al., 2014), financial and economic stress (Oak, 2015), or national emergencies such as the Covid-19 pandemic.

## 2.14 The Covid-19 Pandemic

The Covid-19 pandemic and the associated lockdown measures which were first implemented in March 2020, have significantly impacted the housing situation in New Zealand. While the Covid-19 pandemic initially decreased the 'visible homeless' as the New Zealand government provided emergency housing solutions, such as motels, the long-term effects of the pandemic have contributed to an increase in housing insecurity for many individuals and whānau.

## 2.15 New Zealand's Response to the Pandemic

The Labour government, re-elected in 2020, took immediate action to restrict the spread of Covid-19, implementing the first lockdown-level measures, which greatly restricted all citizens at its highest level (four). Those in their own homes or in relatively secure rental accommodation had a considerable advantage. Although the lockdown situation created many

problems for people, they at least had a place to live. The situation was very different for people without secure housing or those in transit since the lockdowns made it incredibly difficult for such people to find and move into housing. The government lockdown restrictions were unprecedented and included a prohibition of non-essential travel and business activities, including heavy restrictions on private accommodation, social housing and other tenancy movements (New Zealand Government, 2022b). The lockdown restrictions affected stakeholders in the housing and rental space, with tenants not being able to move from, to, or between homes. NGOs and social housing providers working inside the lockdown restrictions had to get special authority from the government as citizens housed, or homeless, had to wait for those measures to be lifted or modified to allow movement under the lockdown protocols. A New Zealand study on the impacts of Covid-19 on Māori in Tāmaki Makarau (Auckland) found that not only were Māori disproportionately impacted by Covid-19 lockdowns in the areas of labour constraints and job losses but were also overrepresented in data for Emergency Housing Special Needs Grants (Independent Māori Statutory Board, 2021). Data has shown the extent to which Covid-19 has impacted movement in housing markets and economic effects for populations including Māori, but what effects have Covid-19 had on the mental health and well-being of people in social housing or those who are homeless? An investigation into healthcare systems identifies some of the Covid-19 pandemic's effects.

## 2.16 The Rapid Response into Emergency Housing

When cases of Covid-19 escalated in late March 2020, the New Zealand Government and social housing agencies enacted a rapid response in which "rough sleeping in New Zealand was all but eliminated in just six weeks" (Davison, 2020). This was achieved through a fast response to move people experiencing homelessness from streets, cars and temporary shelters into motels all across New Zealand. The driver behind this push to move the homeless into

emergency housing was the impending nationwide Level 4 lockdown, and the possible health implications of having a community of people who could not follow the mandatory health guidance; the requirements to self-isolate and contact trace for example, would have been difficult to accomplish within the homeless population. As well as potential barriers to following health advice, the homeless population have been identified as being some of society's vulnerable in terms of the prevalence of chronic health issues and transient lifestyles, both of which are major risks when it comes to illnesses such as Covid-19 (Le Dé et al., 2023).

The effort to rapidly house the homeless population in urban centres was unprecedented. For instance, Wellington City Missioner Murray Edridge was quoted as saying, "Potentially, we may be the only capital city in the world that doesn't have a street living community right now" (Davison, 2020). This was made possible largely due to a significant increase in government funding and support, as well as the sudden availability of motels and other units due to a drop-off in tourists and other travellers. Thus, it was largely a temporary solution. Both housing providers and the Government saw this rapid housing strategy as a successful initiative that came about due to the Covid-19 pandemic. Following on from the rapid housing of the homeless into temporary emergency housing, the Government and housing providers both sought to ensure that people did not return to homelessness.

New Zealand's Government and District Health Boards published advice at all stages of the pandemic to guide social service agencies. An example of this is the "Managing Covid-19" guidance for social and temporary housing providers, which set out the responsibilities of accommodation providers and guidance on how to reduce the spread of Covid-19 and how to prepare for cases in temporary housing properties (New Zealand Government, 2022c).

## 2.17 The Psychological Impact of the Covid-19 Restrictions

Given the Covid-19 pandemic was ongoing at the start of this thesis research, studies into the psychological impacts of quarantine and lockdowns worldwide are still emerging. Nonetheless, Brooks et al. (2020) reviewed 24 studies from a wide variety of countries and found that the psychological impacts of isolation due to the pandemic were wide-ranging, substantial, and have the potential to be long-lasting. The psychological impacts identified during and after a lockdown or isolation period included post-traumatic stress symptoms, anger, frustration, anxiety, and financial stress. The international research on the impact of the Covid-19 pandemic on persons experiencing homelessness is limited. However, most studies have focused on physical health implications rather than mental health. For example, one U.S. study on youth experiencing homelessness during the Covid-19 pandemic identified a high frequency of emotional distress, increased substance use, and decreased access to services for basic needs and mental health concerns (Auerswald et al., 2020).

## 2.18 The Consequence of the Covid-19 Pandemic on Healthcare Systems in New Zealand

In New Zealand, the potential implications for New Zealand's healthcare system will be important to consider when exploring the impact of the pandemic on mental health and well-being. Some people experienced their non-urgent health appointments being delayed or not attended to thoroughly as a result of practitioners being more focused on Covid-19-related procedures, such as testing, and this may have exacerbated existing health conditions for some people (Imlach et al., 2022). Health services had to suddenly change the way they delivered healthcare, including the use of email communication, online appointments or phone consultations. While the shift to online services was important to reduce the spread of the

Covid-19 virus, Ioane et al. (2021) explained how this shift resulted in services that "effectively disappeared" (p. 98) for people without access to the Internet. Not all New Zealanders have access to the internet or a digital device (New Zealand Government, 2020a), and the shift to online healthcare services as a result of the Covid-19 restrictions is an example of how the pandemic detrimentally affected access to services for physical illness and mental health services.

The digital divide is one example of the barriers to healthcare that existed for some Māori prior to the Covid-19 pandemic. McLeod et al. (2020) discussed the potential impact of existing inequities in healthcare for Māori in particular; these inequities are already an unmet need for Māori healthcare, which reports greater rates of hospitalisations and illnesses from preventable or avoidable conditions and disease. The potential burdens on New Zealand's healthcare system due to the pandemic are likely to continue exacerbating these inequities.

## 2.19 The Impact of the Covid-19 Pandemic on New Zealand Māori population in Aotearoa New Zealand

As previously noted, Māori are overrepresented within the homeless population, making it crucial to consider their experiences during the Covid-19 pandemic. The Covid-19 pandemic intensified economic hardships for Māori, who were already disproportionately affected by poverty and unemployment (Independent Māori Statutory Board, 2021). The Māori Identity and Financial Attitudes Study (MIFAS) is a nationwide survey-based study exploring Māori attitudes towards society and economic development. The researchers collected data during the Covid-19 pandemic about the mental, psychological and well-being experiences of Māori (Houkamau et al., 2021). The MIFAS survey found that 19.65% of respondents "suffered adverse psychological outcomes (including stress, sadness and in some cases depression)," (p. 10) with a range of causes, including the confinement of lockdown measures

and financial stress due to job loss as a result of the pandemic (Houkamau et al., 2021). The findings from the MIFAS survey, when considered alongside the existing inequities that Māori face, show that the Māori population in New Zealand was disproportionately impacted by the Covid-19 pandemic and the associated government responses in various ways.

# 3 Chapter Three: Methodology

This chapter provides an outline of the research positioning and theoretical assumptions used to develop, conceptualise, and understand the individualised experiences of the research participants during the Covid-19 pandemic in the Waikato area, New Zealand. I explore my rationales for ethical considerations regarding why particular research approaches were adopted and adapted into this thesis. Finally, through the use of critical reflexivity, I delve into the complexity experienced during the research endeavours and consider my own assumptions during this period.

## 3.1 Why Did I Choose to Research This Topic?

To understand why I chose to research the effects that Covid-19 and its associated lockdowns had on individuals who are homeless or in social housing, one must understand the realisations I experienced during both my undergraduate degree and subsequent honours degree in Psychology and the shock I experienced living and working within the social housing sector and other mental health support services in Hamilton, New Zealand. I grew up in an upper-middle-class family on a block of land in Drury, South Auckland. My family were professionals in their chosen fields and were able to provide every opportunity under the sun for me and my siblings. I did not 'want for naught'. While studying social psychology and sociology in Hamilton, away from my whānau, I started to see a side of our society that I had previously been ignorant of. I thought the problem of homelessness only affected a variable few persons per city, yet I was utterly wrong about this. The more I researched and spent time working in roles involved with social housing, mental health and homelessness, the deeper I looked at Aotearoa New Zealand society and the cities around me. I started to see the dark underbelly of a society filled with impoverished people, families, and children living under the poverty line with poverty-driven sicknesses and malaise, trying desperately to exist within our

stonewalled cities and their rules. When Covid-19 developed in March 2020 here in New Zealand, I was working at the front line in an attempt to secure housing for homeless people. Over this period, I was privileged to meet the most resilient population of the tangata whenua in Hamilton and learn from their experiences whilst empowering them via housing access and mental health support. During this time, it occurred to me that this experience would be exciting to study further in order to bring people who have experienced homelessness and emergency housing during Covid-19 pandemic and their stories to a broader audience.

## 3.2 Research Approach

The topic of homelessness and social housing is complex, and a wide range of theoretical frameworks have been adopted and criticised in the field of housing research and homelessness. A methodological approach that would reflect the complex scenario of being homeless or in social housing during the Covid-19 pandemic and what effects on members of this participant community required in-depth consideration. I required a system that would allow for both the consideration of the subjective experiences shared by participants and the nuance embedded within socialised responses and their empirical accounts. This meant analysing participant experiences contextually and delving deeper to interpret the influences behind their experiences, which are influenced by wider social narratives on homelessness, social housing, the socio-political economy, and current systemic social frameworks. As a result of analysing numerous theoretical frameworks and their implications, I have determined that the following theoretical perspectives provide both an inclusive research paradigm and an appropriate theoretical framework for this thesis.

## 3.3 Theoretical Framework

In the following subsections, I outline the theoretical framework, theories and epistemological perspective that underpins this thesis.

### 3.3.1 Epistemological Perspective: Social Constructionism

My research embraces social constructionism as its epistemological perspective. Social constructionism is the idea that reality is subjective, and that meaning is "based on the interaction between the individual's interpretation of the experience and the social context in which it occurs" (Cronley, 2010, p. 320). This social constructionist perspective acknowledges that all knowledge is created within a historical and cultural context and that it is through communication with others that this knowledge gives meaning to people's experiences (Burr, 2015). Social constructionism provides a foundation to argue that there are a multitudinous number of experiences people conceive as 'reality' and that those experiences do not simply exist 'out there' somehow independent of human interactions and subjectivity (Kemeny et al., 2004).

Kemeny et al. (2004) highlights the value of social constructionism in housing research as it allows researchers to explore ideas, concepts and issues that are not typically considered important or "viewed as being of practical concern" by policymakers (p.2). For example, policymakers presenting facts to support their policy objectives have trouble using findings from perspectives that provide information outside of the simplicity of objective realism. Social constructionism positioned itself to consider the 'grey area' around and enmeshed within a phenomenon, a subjective lens considering the wider social, political and economic context, which is not 'black-and-white' in presentation. This encourages a more complex analysis of phenomena that considers people's experiences with, to, and around wider societal discourses

in the field of housing research. Scholars such as Kemeny et al. (2004) have adopted the social constructionist 'pathways' approach to take account of the complexity of homelessness.

### 3.3.2 Humanistic Psychology Theory

Underpinning my research and its perspectives is an acknowledgement of the principles of humanistic approaches. Humanistic psychology is a multifaceted approach that seeks to avoid deficit approach models and instead moves towards an inclusive paradigm attributing strengths, attributes and resilience factors within psychology research (Clay, 2002; Lewis-Beck et al., 2003; Wong, 2017). This unique perspective is a non-reductionist approach, which promotes a participant-orientated focus towards understanding a phenomenon through the lived experiences and rationales of research participants (Lewis-Beck et al., 2003). Wong (2017) describes the importance and value of a participant's voice for research that strives towards 'humanising the experience' rather than focusing on a specific and often perceived negative phenomena/dysfunction.

The humanistic model advocates for offering an empathetic approach to research offering unconditional positive regard to participants, which creates an exploratory research atmosphere that is warm, supportive, non-judgemental and trusting relationship. Humanistic psychology was challenged by mainstream psychology during its inception by Abraham Maslow in the 1950s for using a qualitative approach over quantitative measures which were traditionally seen as the only scientific way of understanding. Humanistic psychology has since gained much recognition and popularity by researchers for its ability to give highly credible accounts to describing psychological phenomena experienced (Moss, 1999). I argue that humanistic theory is a viable research perspective in this thesis that embodies the importance of rigorous 'down to earth' pragmatic practices, as well as creating a research environment that holds credibility through its validity and reliability (Lewis-Beck et al., 2003; Moss, 1999;

Wong, 2017). In summary, a humanistic psychology foundation provides an empathetic, positive, and resilient view of the people living in social housing and homelessness during the Covid-19 pandemic.

### 3.3.3 Phenomenological Theory

The theoretical perspective of phenomenology is recognised and sits alongside the humanistic perspective in this thesis as both promote the value of understanding the subjective lived experiences of those persons we attempt to understand. Phenomenology asserts the importance of focusing and investigating participants' unique subjective lived experiences (Pietkiewicz & Smith, 2014). This theory asserts the idea that we all experience phenomena in our own subjective worlds, which are unique to us and not easily described to others. Phenomenology puts an emphasis on the subjective 'lifeworld' shared by participants rather than on specified instances within the narrative or scope of research. This 'lifeworld' consists of a person's beliefs, relationships, discourses and associated nuances in and around phenomena. There are two main traditions to the construction of one's 'lifeworld' described in phenomenology: Heidegger, who proposed an interpretive approach, and Husserl, who placed emphasis on a descriptive path (Langdridge, 2008, 2017). This thesis takes a reflective interpretive approach, recognising that what I can understand about a participant's lifeworld will be co-constructed, enmeshed, and intertwined by my own subjective lifeworld. By implementing the phenomenological lens in this thesis, I can attain a deeper understanding of the participants involved through an exploration of the snapshots of the lifeworlds they shared with me and how participants apply meaning-making to phenomena experienced (Langdridge, 2008, 2017; Pietkiewicz & Smith, 2014).

## 3.4 Narrative Research

To better understand the complex nature that is a person's own experience within a social world, this thesis recognises narrative theory as a way to understand and give notion to a person interviewed and their experiences shared while additionally acknowledging the embedded nuances and societal discourses permeating throughout their recounts of lived experience. People throughout human history have used storytelling to describe the world, recite beliefs, and make sense of the universe around them (Murray, 2000). Narrative theory is an appropriate method of research in the attempt to understand the experiences and stories of participants in this research. People who reside in emergency housing or are homeless, and those case workers who support this group in the social housing community space, are living with the issues that are at the heart of this thesis. A narrative approach is a way of drawing out insights and knowledge that is often overlooked. Narrative research focuses on the experiences of people through their stories and identifies possible connections between the story and their socio-cultural context, within the wider societal discourse.

There is no story without social world influences, just as there can be no social world without the creation of stories. Stories are created, modified, and maintained by not only showing the nature and placement of one's social self within their social world, events, and timelines but also by the social worlds' pervasive dominant cultures, which are embedded into one's personal and societal perceptions of themselves (Mankowski & Rappaport, 2000). Through these narratives, one formulates an understanding of the structures of our social world and its influences on perceptions, behaviours, and responses as the relationship between the social world's narrative and the storytellers evolves over time (Murray, 2000). It is through this amalgamation of experiences, cultural contexts and social discourses that one can see a narrative that has become embedded in one's identity and behaviour.

## 3.5 Case Study Approach

A case study approach has been implemented in my research conducting semi-structured interviews with five research participants. Case studies are used to collect and produce nuanced local knowledge that is contextually grounded in human behaviour and events (Hodgetts & Stolte, 2012). They are not designed to produce universal truths but to understand more deeply and to explore the connections between the personal and societal levels. Case studies have been a robust methodology in researching homelessness and other minority populations, as this method enables the collection of abundant data from participants from a relatively small sample size. This form of data collection is particularly effective when researchers are unable to or have no access or time for large population sizes (Gerring, 2007).

A case study can provide a deeper level of understanding and meaning by studying a small number of individuals' experiences, as opposed to studying a larger number of individuals with less depth. Gerring (2007) summarises, "sometimes, in-depth knowledge of an individual example is more helpful than fleeting knowledge about a larger number of examples. We gain better understanding of the whole by focusing on a key part." (p.1). Case studies provided a robust method of displaying detailed contextual snippets of the living human social experience through a localised and nuanced lens while still acknowledging and addressing the wider dominant social system that manifests itself through larger societal narratives within peoples' experiences and understandings of their lifeworld and how they are 'supposed' to live in the wider social system, its values, it's beliefs, rituals and behaviours.

## 3.6 Ethical Relational Engagement

Homeless populations are known to be one of the most marginalised and vulnerable people in New Zealand (Hodgetts et al., 2021; Johnson et al., 2018; Johnson et al., 2013). To

better understand, build relationships, and to not leave my participants further re-traumatized or in a worse position, the data collection method was guided by social psychological thought on relational and culturally appropriate research. Dehumanising research designs often mean participants are 'left for wanting', having their lives disrupted, experiences mined, and trauma re-lived with little compensation, action and change offered in exchange (Johnson et al., 2012; Stolte & Hodgetts, 2014). So, with the above thoughts in mind, it became imperative for my research to endeavour to advocate, promote, and provide positive, long-lasting and meaningful relationships with homeless persons and those in social housing and with the supportive agencies working alongside them.

Hodgetts et al. (2021) explain that there is not one single theory that can encapsulate homelessness as a whole. Instead, these authors draw on a conceptual bricolage of theories in an attempt to capture the intrinsic and often highly complex nature of homelessness. Using the points raised by (Hodgetts et al., 2021) and (Hudson, 2010), my approach to doing research with people who are homeless or in social housing implemented a relationally ethical approach informed by Māori ethical principal practice concepts of manaakitanga – kindness, respect, responsibility and reciprocity; hūmārie – to be sensitive, calm and reliable; whanaungatanga – creating genuine reciprocal relationships that advocate empathy, understanding, commitment and support; and kotahitanga – solidarity and unity with a person or group. Alongside tikanga Māori ethical guidelines is Te Tiriti O Waitangi principals' framework of partnership, participation, and protection (Hudson, 2010), which are at the forefront of the idea that my research will be inclusive and respectful of those participating in the study.

## 3.7 Ethical Approval

Ethical approval was applied to and accepted by the ALPSS Human Research Ethics Committee at the University of Waikato Division of Arts, Law, Psychology & Social Sciences (see Appendix A: Research Ethics Application).

## 3.8 Participant Contact and Consent

After obtaining ethical approval from the University of Waikato ALPSS Human Research Ethics Committee, an approach was made to social housing agencies and providers I happened to be familiar with in the Hamilton, New Zealand area to recruit participants. I distributed a participant information sheet (see Appendix B: Participant Interview Information Sheet) to the social housing providers approached to provide context for my research. I also attached the participant consent form (see Appendix C: Participant Consent Form). I approached four social housing providers in Hamilton New Zealand. Two out of four were willing to have a conversation about my research. I met with the leadership of those social housing agencies considering my proposal and spoke to them about my research. I explained how research into social housing and homelessness can help steer future government policy by helping to identify gaps in current funding and research. I explained how it may be beneficial to their services.

As per the requirements of the social housing provider that approved my request to recruit participants, the process for recruiting individuals through this provider required me to talk to particular teams within their organisation. They requested that I do not reach out personally and contact persons under their care, and that their team would use their already established rapport to recruit interest in the research. The intention was that front-line staff working in the specific teams would identify potential participants who fit the criteria provided.

The front-line staff then approached those persons and spoke to and passed on the participant information sheet I had provided them. This allowed participants to consider their involvement and to initiate contact if they wished involvement. If the interest was shown by a potential participant after being introduced to the research, their primary case worker would then set up a time for the participant and me to meet.

Before any interview took place with each participant, we engaged in a korero introducing myself, my research, and why I had asked them to be involved in the research project. All participants followed suit, introducing themselves and talking a little about their current circumstances, mood, and any stressors or motivations they currently felt prior to the start of the official interview. The process of having the pre-interview korero was dialogical in nature as it both created the foundation for whanaungatanga to be established and, secondly, showed the participants that this was not a drive-by interview and that my intentions come from a place of aroha showing hūmārie. The participant's involvement was discussed in detail prior to the interview beginning, and there were always some biscuits and drinks to be shared and a laugh or two. The opportunity to ask questions about the study, the process, and their involvement in it, was provided. Once the participant was happy to start, I prepared a consent form which was discussed thoroughly prior to conducting the interviews (see Appendix C: Participation Consent Form).

## 3.9 Participant Safety

Due to the nature of the research, there was always going to be a possibility of some participants experiencing emotional distress when discussing difficult subjects. Stressors such as the memories of negative experiences during the Covid-19 pandemic, homelessness, life in social housing, and the mental or physical health tolls of housing precarity. I planned to minimise the risk of any harm occurring before, during and after interviews by supplying a

number of community services who would be available to talk to if the topic had brought up particularly strong negative emotions or triggered trauma responses or rumination. I planned to avoid engagement with participants who presented severely unwell. To minimise the risk of causing additional distress or harm to participant well-being, I consulted each participant's assigned front-line staff member before engaging in order to ask for signs of unwellness or any known triggers or topics I should be careful not to bring out or stick onto for long periods of time. Before the interview, participants had been given the option of bringing along a support person such as a friend, family member or their clinical support if desired as well as the option to pause or end the session at any time if needed.

Before the interviews began, I went through the participation information sheet (see Appendix B: Participant Information Sheet) to outline our topics of discussion and remind us of the purpose of our interview. Additionally, I had created an interview guide for myself that helped steer me through the interviews (see Appendix D: Interview Guide – Draft). I found that providing time to prepare for the discussions allowed participants to reflect on their experiences more deeply and allowed for a much more voluminous, richer dialogue. I ensured that I was aware of their emotional affect during our korero and had plans to respond to distress if it occurred, such as by taking a break or contacting support services. Participants were made aware that all analyses of the interviews would not contain any identifying information.

## 3.10 Participants

Statistics taken from New Zealand's Ministry of Development suggest that 50% of the applicants on the New Zealand social housing register who were homeless, in social housing, or transitional housing self-identify as Māori with the other 50% being made up of either New Zealand European, Pacifica, or other (Ministry of Social Development, 2021). My recruitment

process considered these demographic statistics and sought to adopt recruitment strategies that would ensure the inclusion of at least 50% Māori participants.

There were two groups (A) & (B) of participants included in this study: Group (A) participants consisted of two wāhine and one tane who had the experience of being in social housing and/or homeless, and Group (B) consisted of two housing case workers who primarily worked alongside and in support of tangata whaiora on their caseload in the social housing and homeless space. Group (A) individuals were at least 18 years of age, fulfilled the requirements of being either in social housing or experiencing homelessness during the Covid-19 pandemic starting in March 2020 in New Zealand. Group (B) was made up of service provider front-line staff working alongside whānau and individuals who were either in social housing or homeless during the Covid-19 pandemic from March 2020 in New Zealand.

The purpose of interviewing two different groups of participants was to try to gain an understanding of the experiences had by both participants groups living in and/or working in social housing or homelessness during the Covid-19 pandemic and associated lockdowns: What were the experiences had by both groups of participants over this period of time? What were the challenges and how did they navigate public and social services over this time, and what ongoing effects has the Covid-19 pandemic had on participants, their whānau, and their shared experiences? What has the experience of the Covid-19 pandemic had on front-line service staff who were actively engaged with tangata whenua over this period of time, and how have their perspectives, observations and understanding of the challenges of their role changed by their experiences in social housing during the Covid-19 pandemic?

While the experiences of these particular interviewees cannot be used to extrapolate and speculate the experiences of wider society during this time, they provide a snapshot of the complex and ever-changing story of people experiencing homelessness and offer an example

of the unique challenges and opportunities faced during a global pandemic. Next, I will introduce the participants. The names used in this thesis are pseudonyms for the purpose of privacy, protecting the identities of each participant.

### 3.10.1 Participant Group (A)

The participants in Group (A) were people who were experiencing homelessness at the time of the Covid-19 lockdowns in New Zealand.

The first participant is Maraea. Maraea is a middle-aged Māori wahine who is strongly independent, resourceful, and fiercely whānau-orientated. Maraea spent much of our time together discussing her experiences from the perspectives of her father and other family members. During the Covid-19 lockdowns, Maraea lived in a variety of different locations, including multiple emergency housing motels, a friend's abode 'couch surfing', and ended up staying in one of her sister's home by the end of the Covid-19 pandemic. During her time in emergency housing, Maraea created her own "motel family" who all shared a sense of whanaungatanga. Maraea's experiences display her innate ability to adapt and be a positive, engaging community member.

The second participant is Kristina. Kristina is a middle-aged Māori wahine who, before the Covid-19 pandemic, had lived primarily in privately owned properties or rentals for most of her life, either with whānau or partners. Kristina has multiple children of varying ages, some under her care and others old enough to be on their own. Kristina is diagnosed with cancer and had recently left an abusive relationship with her now ex-partner. During the Covid-19 lockdowns, Kristina lived in two emergency motel accommodations in two separate district areas. She also stayed with her brother at his home for a short period and at a friend's home for a short time before having to leave due to a conflict.

The third participant is Jeremy. Jeremy is a middle-aged New Zealand European male who has spent part of his life working in both New Zealand and Australia truck driving. Jeremy explains that he has a wandering soul and likes moving around daily; thus, his profession as a truck driver works well for him as it allows for constant travel. During the Covid-19 lockdowns, Jeremy resided in several different forms of accommodation. Jeremy described staying in many motels self-funded, a period of living inside a shipping container on a farm, staying with people he had only just met days prior to one of the lockdowns, and at one point sleeping on a park bench. Jeremy's experiences during the Covid-19 pandemic reflect an often-missed category in homelessness research and show how even those with active employment are not immune to experiencing homelessness.

### 3.10.2 Participant Group (B)

The participants in Group (B) were housing case workers in New Zealand during the Covid-19 pandemic.

The fourth participant is Amelia. Amelia is of New Zealand European descent and has primarily lived in New Zealand throughout her life. She works as a housing caseworker for a non-government organisation that provides housing outreach support for people referred to the service from Adult Community Mental Health Services and the Ministry of Social Development. Amelia had to adapt to the new circumstances and modify her full work role's application and processes to suit the climate of restrictions during the Covid-19 pandemic. Amelia lives with her partner in their own home and comments on the difference between people like herself who had or could get the resources before and those who just had to make their situation as good as they could before the Covid-19 lockdowns occurred.

The fifth participant is Richard. Richard is a European male who has lived in New Zealand for over ten years at the time of his participation. Richard's work experience is vast

having been employed in construction, house painting, prison outreach programs, and as housing case worker. Richard has several children which he places before himself in all manner of regard, and who attributed to his high level of self-care during the pandemic. Richard spoke about the difficulty building rapport and developing a sense of whanaungatanga with his clients over the Covid-19 pandemic lockdown periods. Prior to the first Covid-19 lockdown in New Zealand, Richard had worked as a housing case worker for only a few days which brought with it a variety of new obstacles to overcome.

## 3.11 Interviews

The Covid-19 pandemic and the associated lockdown measures implemented were a challenging time for all people in New Zealand. The memories of that time, and the experiences lived by the research participants are still a topic of popular conversation. Participants were asked to suggest locations and times for an interview that would not be a burden on their time or finances, with myself working around those limits. Agreements made prior with my employer allowed me some flexibility in meeting those requested times/locations. The time scale between the information session, recruitment, and interview varied per participant due to the individual circumstances of that participant. This gap between recruitment and interview provided the participants with time to consider themselves, their experiences, and the subject matter in context.

In addition to the initial explanation and recruitment, participants were provided prompts in the form of the participant information sheet to consider before and during the interview to help create continuous flow during our time together (see Appendix B: Participant Information Sheet). The major themes given by these prompts included: What did the participant's everyday lives and experiences look like before the Covid-19 pandemic entered New Zealand; the impact associated lockdowns had on their everyday lives; how they

navigated social services during the pandemic; did they believe the Covid-19 pandemic or the associated lockdown measures implemented in New Zealand had an impact on their or that of their family's physical or mental wellness; and what does everyday life look like now, years later after the pandemic. Participants were asked to complete a participant consent form before the interview began and were given the choice to withdraw consent and remove themselves from participating in the research at any time with no consequences as a result (see Appendix C: Participant Consent Form).

The interviews followed a semi-structured approach, which allowed the participant's narrative to flow and evolve as stories and experiences evolved over time. This approach to interviewing aims to reduce the researcher versus participant power dynamic (Furness et al., 2016) and create a more immersive balanced research environment. There was a concerted effort on my part to not undermine participants' stories/experiences. Instead, through active, attentive reciprocal engagement, a dialectic was created that was not only purposeful to the research goals but also promoted the empowerment of participants to tell their subjective narrative (Flick, 2009) by being genuine, empathetic, and mana-maintaining. Hodgetts and Stolte (2012) note that by building strong relationships and establishing rapport with participants, they will feel more able to be open in their story responses and detailed information, which is crucial to the case-based research process (Hodgetts & Stolte, 2012).

Interviews for group (A) were based on the location of choice preferred by and suggested by the participant. All of Group (A) preferred to be interviewed in their current dwelling in which they felt was the safest and was within their financial budgets. These included places such as emergency housing motels, friends' houses, and family homes. Before I attended each interview, I requested what choice of biscuit they preferred and brought them along to the interview. Once receiving acceptance to enter a participant's dwelling, an introduction was done acknowledging who I was as an individual, who I was as a researcher

and why I am interested in their experiences and stories from the time of the Covid-19 pandemic. After the participation consent form and recording device explanation were discussed and signed (see Appendix C: Participation Consent Form), we sat down and started the interview. I chose not to write during the interview and instead focused on the participant's narrative. Each participant received a small koha ($50) at the end of the interview to show appreciation for their stories, time, and patience. All participants agreed that they may be contacted again for any follow-up questions I had regarding their responses given at the time of the interview.

Group (B) participant interviews primarily ended up happening at their places of work in meeting rooms at times they had provided which suited their busy days. Group (B) participant interviews followed the same semi-structured format and questioning as Group (A), except there was also an additional client-centred focus on the challenges experienced in providing support to people whom they worked with during the Covid-19 pandemic. This included challenges to housing people and their families, access to resources and equipment, maintenance and contact with clientele, what solutions were found to solve problems, and whether they found the government Covid-19 responses were adequate or, notwithstanding, lacking.

## 3.12 Transcription

As part of the consent process, each participant agreed for their interviews to be recorded using a voice recording device. To record each interview, an Apple iPhone 'Voice Memos' application software was used as it was quick to access and non-invasive to an environment. Recording software enabled me to be fully present and able to use active listening skills during interviews, allowing for a more natural flow of discussion, uninterrupted and organic. I transcribed each interview first by use of Microsoft Word's transcription function.

While quick in its transcription comparatively to manual transcription, the software was unable to accurately differentiate who was speaking at times and would often transcribe with poor accuracy when encountering deep voices from the researcher or participants, and at times failed to identify the beginning and end of statements. Because of this, a manual transcription afterwards was required to rework the transcription to a readable usable account. As transcription software was unable to capture the physical or subtle nuances involved in interviews, I added notes during the manual transcription to more accurately show and understand the interview's dynamics and depth. Manual transcription, while meticulous, was essential for contextualising participant experiences and more accurately conveying nuance, nonverbal expression, and other emotive language.

## 3.13 Challenges in the Recruitment Process

In conceptualising the research recruitment process, I was aware of numerous potential obstacles that could slow down or constrict participant recruitment. However, it was not until research recruitment was underway that I really understood how arduous this process of recruitment would become. In approaching and securing the support of social service agencies, several hindrances to the recruitment process became apparent. While services always provided time to meet, there was a general reluctance to be involved in the research for several reasons. Time constraints, staff resources, funding, and environmental/individual risk to interview participants were provided as reasons why some social services may not be able to provide support to the research. In addition, there was uncertainty around the potential effects the interviewing process may have on participants involved, for example, re-traumatisation and mental health deterioration. There was also a concern for how the analysed information may be presented. These concerns are valid and include the potential risk of pathologizing vulnerable populations who are already both over-researched and stigmatised. Additionally,

not-for-profit agencies working with vulnerable populations must consider what risks could arise from the research being undertaken and whether the results may impact their image and reputation, causing inquiry into methods, results, costs, and service restricting, and in the worst case for both the service and those vulnerable populations they work with, a complete loss of funding (Chevreau et al., 2021).

Agencies working with social housing and homeless populations were provided with access to the ethics approval granted by the ALPSS Human Research Ethics Committee (see appendix A: Research Ethics Application); an additional ethical application was required to be completed and reviewed by the agencies' own committee or board. These ethical review processes took between one and approximately four months to complete before answers were provided, allowing research to go forward or not. In hindsight, my strategy to request access via agencies to vulnerable populations and to wait until hearing back from those agencies was flawed. My anxieties around pressuring people led to stagnant waiting periods before I sent follow-up emails. Once follow-up requests had been made with agencies, replies to my formal requests became more fluid, turning my experience into a learning lesson. The Agency I had approached that allowed my request for research to commence asked for changes to be made to the participant information sheet as part of their conditions for recruiting participants. The major change was to reduce the complexity of the language used in the information sheet as it was argued that some of the clients would not understand what was being said in the current document. Additionally, the organisation's changes were focused on their implication in the research and how their service would not change as a result of the findings of the research. I have not added this modified participant form to the appendices to avoid identifying the organisation that asked to remain anonymous.

The most significant challenge facing the recruitment process through agencies was the inability to recruit participants myself directly. As a conditional requirement for access to

clientele in participating services, initial contact and information dissemination must first come from a frontline staff member working alongside a potential research participant. The staff member would then promote, explain, and offer the research opportunity to potential participants. Unfortunately, this method of recruitment required a concerted effort by those frontline case workers who were already inundated with high workloads and risk management events. Additionally, there had to be some kind of intrinsic motivation for those case workers to implement and direct themselves to the recruitment process on my behalf. The result was that I would be waiting several months before an update response, with very few staff members involved providing an update on whether they had managed to secure any potential participant interest. In hindsight, this method of recruitment was approached because I had a naive assumption that agencies and people working alongside the homeless shared my vision about the value of research for drawing attention to homelessness and social housing experiences during the Covid-19 pandemic. This assumption was unrealistic as everyone I approached during my participant recruitment period clearly had their concerns, work, and wellness to put first before they could even consider my complex request.

## 3.14 Analysis and Interpretation

Narrative analysis was chosen as an appropriate framework to conceptualise and interpret the nuanced and often extremely complicated scenarios that cannot be quantified. This approach was chosen as the basis for this study because homelessness is a complex issue (Cresswell, 2018). Acknowledging that there is no single cause of homelessness was important in approaching the present study's analysis in an attempt to minimise any inherent biases when considering the participants' lived experiences. As part of the interview process, participants spoke about their life circumstances beyond the experiences of the Covid-19 restrictions that were the focus of the interviews. Having information about the context in which the participants

grew up, their family dynamics, and their personalities provided for a richer account of their experiences of the Covid-19 pandemic and associated lockdowns.

Narrative analysis recognises that participants are experts in their own lives. People who may be in the same situation on the surface may have entirely differing worldviews, cultural backgrounds, and life experiences, and this impacts how they experience and deal with adversity such as homelessness. Interpreting participant interviews using a narrative analysis approach highlights how the individual shapes the narrative of their own life (Atkinson & Delamont, 2010). This is crucial in truly understanding people's experiences. Using a narrative analysis approach to interpret these interviews, I have understood how individuals experienced homelessness within their sociocultural context. Unlike quantitative research methods that provide statistics or generalised trends, a narrative analysis brings to light the unique voices and perspectives of the participants. It allows further exploration into the nuances of how people interpret their own experiences, which are entirely unique to each individual and a result of their life experiences (McAdams, 1993).

In the context of the present study during the Covid-19 pandemic, a narrative analysis approach is particularly valuable to understand the experiences of homeless people and support workers. In addition to understanding the immediate impacts of the pandemic and associated responses, I was also able to explore how these events intersected and existed alongside the pre-existing challenges and systemic barriers faced by the participants. The Covid-19 pandemic amplified barriers that already existed for this community, such as lack of access to healthcare and support services, digital and technological inequalities, and pre-existing health vulnerabilities. My narrative analysis relates the key concepts identified in the literature review to the narrative analysis of the participants. I identified some common experiences between the participants and expanded on these.

## 3.15 Critical Reflexivity

To further complement the research gathered through case studies, I adopted a critical reflexivity strategy to assist in all parts of my research, drawing on my own working experiences and observations, having been involved in the field as a housing case worker. A crucial part of this strategy was ensuring that I checked my own personal biases regularly. Having grown up in a sheltered and safe environment means that I sometimes experience cognitive dissonance when comparing the experiences that I have had in life and the experiences of the many people I have met in my adulthood, and I often find myself reflecting on the inherent assumptions and beliefs that I developed as a child and in my formative years. While completing this thesis, I made sure to continually challenge my assumptions and beliefs to reduce my personal bias in the interview process and analysis of the research. Additionally, I would write down or note specific thoughts or notions I had during interviews to be considered during my analysis portion of my research.

# 4 Chapter Four: Analysis

This chapter presents an analysis of the accounts of five participants from New Zealand. The first three participants – Maraea, Kristina and Jeremy – had experienced homelessness at the time of the Covid-19 pandemic. The fourth and fifth participants – Amelia and Richard – were housing case workers at the time of the Covid-19 pandemic.

## 4.1 Analysis: Maraea

This section investigates the narrative of Maraea. Maraea is a middle-aged Māori wahine who is strongly independent, resourceful, and fiercely whānau-orientated at the time of her participation in this research. After they spoke about the research project, a social worker provided me with Maraea's contact details, and she had given consent for contact. As per the ethics of this research around privacy and consent, some details have been omitted from the analysis to protect anonymity. Maraea has close relationships with her family and would spend many moments reminiscing about their actions. She would often speak through the lens of another family member when talking about her experiences. Maraea's living situation at the beginning of the lockdown period was particularly precarious regarding the possibility of 'slipping through the cracks' during the country's response to the first Covid-19 outbreak.

As Le Dé et al. (2023) explains that most of New Zealand's policies were aimed at the 'typical' homeless populations, such as those persons living in crowded shelters or streetside in makeshift shanties. There was and is potential for those who would be considered to be part of the 'hidden homeless' not to be catered for during the pandemic. New Zealand's statistics on homelessness do not account for those who are technically homeless but may be staying with family or friends, 'couch surfing', or living in overcrowded houses. If you are part of this group, there is less chance you will be noticed by social services and less able to apply and be accepted onto the New Zealand Social Housing Register. This means that the 'hidden

homeless' may miss out on the support that is needed. In the months leading to the first Covid-19 Lockdown, Maraea had been staying with friends 'couch surfing' at the time and could have missed out on the opportunity to move into emergency motels.

Just before the Covid-19 Level 4 lockdown measures were initiated around Aotearoa, New Zealand, on the 26th of March 2020, Maraea had been asked to move into motels around Hamilton by social services working alongside her. This move into motels was due to a new initiative by the then Labour government to get as many people as possible off the street before initiating a countrywide lockdown. Maraea initially lived in a motel with a partner, but soon after the Covid-19 Level 4 lockdown restrictions were initiated, she moved in with her father at another motel. She made this choice to move locations due to the variety of health concerns her father was going through that required her ongoing support and maintenance. Maraea identified herself as a caregiver for her father, who was sick with a serious medical condition. Much of Maraea's narrative would be spoken through the lens of her father. This could be an effect fostered by a lack of one's own identity or a way Maraea could legitimise her behaviours and actions during the Covid-19 pandemic. Her father tragically passed away during the pandemic while in emergency housing. Throughout the interview, Maraea consistently brought her father into the narrative and, as such, showed the respect and love she shared for him.

Maraea explained that her family blamed their dad for the reason they did not have a home and had to live in emergency housing. She explained that her family did have several homes in which they owned and noted several locations where the family lived over her lifetime. However, she revealed that her father had made a bad financial decision that he did not share with the family, and when it was revealed, it was too late to save them from becoming homeless:

> **Maraea:** "We still blame my dad that we all ended up in [emergency housing] ... my mum and dad owned their house. We moved to Hamilton ... My dad made a bad financial decision without telling us. And when he told us all it was too late. They had to sell their house, and everyone ended up in emergency housing..."

It was clear early on in the interview that Maraea herself had experienced insecure housing in a variety of different ways over her lifetime. While Maraea herself was in emergency housing or staying with friends, she explained that her sister was placed in social housing, while her mother eventually found a rental home in Hamilton. Maraea talked about the surprise her mother had had when after losing their family home, her mother and she had to investigate the current rental properties and markets. Maraea's mother had not expected such an extreme change in cost between when she had to rent and modern-day rental prices. Maraea was laughing while explaining how her mother had said she rented it for $14 in the sixties.

> **Maraea:** "The last time she had ever rented, she said it was a one-bedroom flat for $14.00. Like in the sixties. I told her it's not like that anymore."

It was common throughout Maraea's narrative for her to exaggerate stories such as this using humour and laughter. Maraea would often use humour as a coping mechanism when she spoke about actions, decisions, or thoughts put forward by others in her whānau or close friend group that she deemed 'cheeky', non-realistic or absurd. The use of humour as a coping strategy is an example of a protective factor that helps a person to cope with the stress of life. According to Earvolino-Ramirez (2007), humour plays an important role as an internal factor in allowing a person to overcome life's adversities and moderate their own emotions in response. It was clear throughout our interviews that there was a great sense of humour in Maraea's narrative and story-telling practices, and that this played an important part in her resilience throughout her life.

The use of humour as a coping strategy was also apparent in the way Maraea and her family coped with the many uncertainties about Covid-19 in the early days of the pandemic. Maraea and her family had little to no access to media, cell phones, or knowledge of Covid-19 at the time New Zealand went into Level 4 lockdown. A Rapid Evidence Review about the social impacts of Covid-19, commissioned in May 2020 by New Zealand's Ministry of Social Development, noted the importance of widening access to digital technology to reduce the digital divide inequities impacting people experiencing social disadvantage, such as those exposed to housing issues and material hardship (Anderson et al., 2020). The New Zealand Digital Inclusion Action Plan (2020-2021) stated that the internet became a "vital tool during the lockdown to get help to people who needed it" and for people to be able to access official information and updates about the ongoing situation (New Zealand Government, 2020a). Better access to the internet could have reduced the anxiety Maraea and her family experienced in the early days of the pandemic when there were so many unknowns about Covid-19 as a virus and also about the lockdown and isolation rules. Being able to find information about where to access vital services, such as health or social support, would have been very difficult without internet access, especially as the expectations to stay at home were so strongly emphasised. Ioane et al. (2021) explained how social support and welfare services switched to online support during the pandemic, so "effectively disappeared" for those without access to the internet. The lack of information and lack of access to support services would have compounded the anxiety felt by people like Maraea and her family, which may have led to an increased mistrust in government services.

During the initial days after the restrictions had been initiated country-wide, Maraea and some family members were followed and stopped by the police with flashing blue and red lights while driving to the local supermarket. The police had spoken to the family and said that only one person was allowed to enter the supermarket at a time and that they needed to wear a

mask. Using her storytelling and humour skills, Maraea recalled the cough's usefulness when police were around “because they’re scared of you when you cough”.

> **Maraea:** “My brother-in-law ... he was eating all these lollies and coughing in his tissue. And he had all his red lollies come out and [the police] thought it was blood, and they all just backed up and left.”

It was clear from the onset of our time together that Maraea did not hold the police in high esteem, nor did she recognise the government Covid-19 lockdown initiative as being particularly helpful to her or her whānau. The creative use of the above avoidance strategy was one example of an ingrained distrust Maraea has in government systems which extended to Covid-19 and its associated lockdowns. This distrust of government was pervasive throughout Maraea’s narrative surrounding Covid-19, in particular the use of vaccines.

Ultimately, Maraea did not trust the vaccination process and did not ever get vaccinated for Covid-19. Some of her family had become unwell after receiving their Covid-19 vaccination, and another recounted tearful experiences where and how they received their ‘jab’. When asked why she did not get the vaccine for Covid-19, Maraea explained it was because her father did not believe in it. Maraea was unable or unwilling to explain the reasoning of why her father or herself did not want to get the vaccination at first, but then did note she was concerned that ‘they’ (the government) were sorting people into labels and barcodes. This is an example of one of the many conspiracy theories that surrounded the Covid-19 vaccination. A social media analysis in the early days of the pandemic explained that there was an “infodemic” when it came to Covid-19; an “infodemic” is a term used to describe an overabundance of information, both accurate and inaccurate, which makes it difficult to find trustworthy information when needed (Islam et al., 2020). This “infodemic” was caused by the many uncertainties about Covid-19, particularly where it originated and the lack of an existing

treatment or vaccine. The overabundance of misinformation impacted the vaccination efforts worldwide, with Covid-19 vaccine hesitancy studies citing misinformation, especially that which has been sourced from social media, to be a contributing factor to hesitancy (Prickett et al., 2021). The level of distrust Maraea felt rose as the number of required vaccines increased. Maraea became sceptical of the information the government was providing:

> **Maraea:** "They said there was only one [Covid-19 vaccination], and then there was another one. And then there's a booster. Then I thought, nah, something's up there."

This shows the distrust Maraea, and her family have for government institutions and how this distrust may have started intergenerationally with her father and his experiences of government. Maraea's narrative then shifted back to her father's experiences trying to get a home pre-lockdown and the challenges faced, which moulded her views of social housing, providers, and the community system.

Maraea spoke about her father's stubbornness and unwillingness to accept a home unless it caters to his specific needs, even if they are outside his living means. For example, her father would only accept a home if it was large enough to hold 4-5 bedrooms and a double garage with the location at Thames in the Coromandel. Maraea explained that her father's Ministry of Social Development case worker had mentioned they had found a house to his specifications. However, Maraea's father was not accepted into the property as a renter as he was recognised as a gang member and "the landlord wouldn't have him in it." As her father had been involved in gang activity over his lifetime, he was unable to access public housing due to the stigma of gang life. The way Maraea vocalised her father's experiences and frustrations in applying to social housing implied a feeling of delegitimization of her father's request for housing. Maraea's father's gang affiliations were keeping him out of contention in a successful application for housing and, by proxy, her, as she saw herself as his caregiver and

would have gone to the home if he was successful in those applications. There was disappointment and blame in Maraea's reflection of her father derived for his life choices and the lack of permanent housing he could provide for his family at the time. While acknowledging her and her father's experience navigating social services and housing, Maraea shared the difficulties her son experienced trying to navigate the same agencies during lockdown.

Maraea talked about her son and partner's money issues which became a problem during lockdown after her son "wanted to do everything the legal way". Recently, her son and his partner had a child together and, as such, required personal transport to support the family. He had purchased a vehicle and paid it weekly alongside other outstanding bills. Because he wanted to do everything "the legal way," as Maraea put it, they declared to the Ministry of Social Development that he and his partner were living together. What Maraea was alluding to as the opposite of "the legal way" is marriage-type relationship fraud. This type of benefit fraud in New Zealand involves a beneficiary incorrectly declaring their relationship status as 'single' to receive more financial assistance than they would be entitled to if they were truthful about being in a de-facto relationship (Gavey, 2021). Unfortunately, the benefit rate for a single person is higher than that of those living in a partnership, with declared partnerships receiving less than two separate persons (Healey & Curtin, 2019). As such, the son and his partner's payments were reduced due to revealing their partnership to the Ministry of Social Development. The family started to have financial problems, with their benefits being amalgamated and reduced due to their honesty and desire not to get in trouble with the government for withholding information. Maraea was both angry and saddened by the fact that her son, even at her behest not to be, had been truthful, and as such in her eyes, been punished for this action (St. John et al., 2014). She explained she had warned him stating "it was good that you wanted to go the legal way, but not with WINZ, never with WINZ, you never win." This identifies the stresses and strains experienced by Maraea who is trying to help whānau

inside the social welfare system which is not inclusive to the lived realities some families experience. She was angry and disappointed that her son would not lie to social services to be better able to provide for his new family. This behaviour could be described as a conflict of values or a superposition between what should be and what is; this belief that social services do provide what a family or couple needs is not congruent with the realities experienced, a contradictory position. Maraea made clear her dislike of WINZ (Ministry of Social Development), saying she "can't stand them" and chooses not to go into the establishment. Maraea's disdain for the injustice of having to survive within the social welfare system was evident in the way she navigated the Covid-19 lockdown and public restrictions.

Maraea notes that she did try to adhere to the community restrictions while the first Level 4 lockdown was under effect. However, the recurring lockdowns she mostly either ignored or found ways around compliance with restrictions:

> **Maraea:** "The first lockdown, it was fine. The second lockdown I was just walking up and down the street all the time. The first one wasn't too bad. Novel experience, almost."

Maraea then spoke about how the lockdowns negatively affected her father who, because of ongoing need for dialysis, had to record when they were leaving with the manager of the motel, and where they were going, and why. This greatly disrupted their day and made the process of getting her father to the hospital difficult as it was required for them to find the manager before leaving the motel. This was difficult to achieve if the motel management where busy with others or outside the complex at the time. In addition to the issues of leaving the motel as per the Covid-19 restrictions and directions, her father was not allowed a support person with him at and through the dialysis process in the hospital, and as such would get dropped off. However,

afterwards, when he was drained by the dialysis process, he had to immediately leave the hospital ‘rain or shine’ and sit outside until someone picked him up.

> **Maraea:** “[During the lockdown], as soon as he was finished with the [dialysis] machine, he had to get out of the hospital and sit outside, when it was raining or not, and wait for a ride ... they wouldn’t let him back inside.”

Echoing the strict measures in place at hospitals during the lockdowns, Maraea also spoke about not being able to be there for the birth of her sister’s babies who had come during the lockdowns. Maraea stated again that the hospitals were unable to facilitate whānau being there who were not directly involved. The lockdown measures meant that some of Maraea’s family’s cultural traditions and norms were deemed inappropriate at this time due to concern around further Covid-19 infection spread. While Maraea understood that these measures were important, this did not mitigate the loss of key moments that she deemed important as part of her culture.

The restrictions during lockdown also applied to private social gatherings, and thus, the cultural behaviours her whānau continued engaging with were seen as inappropriate in the community as they went against the Covid-19 health guidelines, which included social distancing and restrictions on social gatherings. Maraea spoke about her whānau meeting at her mother’s home to celebrate her birthday despite the lockdown measures. There was an attempt to limit the numbers by organising seeing their mother/friend at different times. Maraea laughed, recalling her mother’s birthday. However, people just turned up haphazardly when they could, and the event ended up being a small party outside her mother’s home. Maraea also spoke about having her father’s birthday at the motel during lockdown. The management allowed it but asked for the event to be restricted. Word spread that it was her father’s birthday and because of his affiliation with a gang, far more people turned up than expected on

motorcycles which the motel management stated was inappropriate. The gang members and their families were an addition to the family whānau and his mokopuna. While complaints were made initially by the motel management who were following lockdown protocol, they choose to be inclusive about the cultural engagement and did not involve police allowing the celebrations to run the course.

**Maraea:** "I mean, half the [gang] showed up … But they let it go."

**Researcher:** "Did [management] end up being good sports?"

**Maraea:** "Yeah, they're used to seeing them all pull up."

The social gathering restrictions were difficult adjustments for Maraea, especially with the added pressure of acting as caregiver for her father. Although there was a great sense of duty to care and provide for her father, she also felt captive to her father's needs during the daytime. As a result, Maraea used to go out at night even though it was expressly forbidden by lockdown protocols. She explains jumping over the fence and being caught out multiple times by the motel management and motel workers, as Maraea was not supposed to be at her father's motel. However, she felt she needed her own time away from her daily life looking after her father. She notes that people from the motels commonly walked the streets at night around the motel areas.

**Maraea:** "I could go out when I knew dad was home sleeping."

Maraea speaks about having to use alternate routes to get into and out of the motel where her father was staying. Jumping fences at night and hiding behind cars as they go inside the premises to do things like making her father dinner. It was around halfway through the interview when it became clear that Maraea, who had been staying at a motel with her dad, was actually not meant to be there and as such had been asked to leave or been removed by security when caught at night by the motel staff. Maraea explained that motel management has said she

was not employed by an official support working agency. As such, the motel would not accept her as a caregiver for her father and removed her from the premises each time she was found to be there.

> **Maraea:** "[the manager] said she could see me sneaking around in and out of the motel at night. I was trying to climb the fence and I put holes in the fence. [The manager] said unless I was officially his caregiver, I wasn't allowed there."

This action shows how far Maraea was willing to go to support her father in his old age. It was already evident that her father was a large part of her identity, but this revelation cultivated an even greater sense of the amount of respect and mana he carried in her lifeworld. These protective, mother-like instincts and values displayed for her father were evident in how she navigated her emergency accommodation space and the whanaungatanga built with patrons living in the shared motel environments.

Maraea's support and willingness to go the extra mile also extended to her neighbours in emergency housing. Maraea speaks about going 'binning' for items such as clothing, cooking utensils and tableware equipment for both her and others in her vicinity at the time.

> **Maraea:** "Go in the kitchen and there's hardly anything they had, no pots or anything. So, I started going binning at night, to the clothing bins and that. You know people leave all their stuff in there? I went down to [a clothing bin] in town one night and found heaps of cups cause [the motel] had no cups. Another time, got heaps of dishes…"

The process of 'binning' is going through the clothing and boxes of items left at clothing bins and thrift shops after trading hours. The main motel where Maraea was staying during the times when she was not looking after her father did not have many items available for patrons' use. Maraea explained that this was due to other patrons at the motel complex. She complained that

other patrons at her motel did not wash dishes, steal items, or hide them in their bags and mattresses for personal use. Spending nights salvaging items from clothing bins to take to her motel and donating for all to use, she felt appreciation from others at the motel for her work. Maraea relived a moment when she got very angry at some of 'the boys' at the motel due to all the new cups and dinnerware she had found binning had disappeared from the kitchen area. Maraea recounted storming through the corridors of her emergency motel, yelling at others to clean and return items so that others could use the shared facilities. This recounted event shows Maraea's values around social justice, communal living, and cooperation. Her willingness to go into 'battle' for others and her high level of resilience and innate ability to hold people accountable for their actions.

Maraea recounts a high commitment to cleanliness and takes it upon herself to clean her own motel room, preferring to do her own cleaning rather than having the motel cleaner, clean her rooms. Maraea has pride in the value of cleanliness and spoke about her reputation throughout the emergency housing and 'street' scene in which she was known as the 'neighbourhood home cleaner'. She explained that she would go into other people's homes that she was invited to, and while talking or drinking with the people living in the motel room, she would clean their temporary home. Sometimes she would even clean their bathroom and toilet if she felt it was filthy and action was required.

> **Maraea:** "[I'd] take, like, ten minutes in the toilet and [they're], like, what is she doing? She is cleaning it?... and most people like you for doing that. Yeah, some of them [like my cleaning] too much and say, 'come back anytime', yeah."

This was another example of how Maraea developed connections and relationships with her neighbours and in her community, fostering whanaungatanga. Maraea made many friends in the motels and "looked after" some of them who were, in her opinion, too timid to stand up for

themselves. Maraea displays the values of the Māori concept of whanaungatanga throughout her time at the motels, creating and sustaining ongoing relationships with family, patrons, and newly created friendships.

The importance of whanaungatanga and community cohesion in social housing communities was of particular importance to everyday life as Maraea spoke about instances of criminal aggression and linked some of it to gang affiliations. The nature of the information provided on the criminal activities Maraea experienced during her stay in emergency housing was extensive but would make her and others too easy to identify. So, to maintain anonymity I could only display a generalised example of the amount of the behaviours experienced.

**Maraea:** "There was fighting and smashing up your rooms and stealing your stuff."

Maraea explained that these aggressive behaviours were typically done by younger men and involved attempts to intimidate others and take personal belongings and money. She described a time when she witnessed a young gang member yelling and threatening an old man. She could not intervene and just watched, disgusted with the situation before her. Thankfully, persons related to the aggressor appeared and dragged the young man away, yelling angrily at him for creating a public scene with an old man. Maraea noted that these aggressive behaviours and theft were common at the motels, with televisions and equipment being stolen when people were out doing daily activities such as shopping or work. The instability and lack of security were ongoing issues that made creating a motel 'motel family' even more important for people to have to be able to live in the emergency housing environment.

Maraea's relationships and associated manaakitanga built throughout her emergency housing community were significant. This became clear when, during a time of shock and sadness at finding a friend of hers had ended their life, her small 'motel family' came to her aid in the most remarkable reciprocal mana-enhancing display of kinship. Maraea experienced

visiting a friend she called “Auntie”, who lived down the road from Maraea’s emergency housing. The door was not locked when she arrived, and after failing to receive a welcome by knocking and calling out, Maraea entered the property and found her friend had ended her life. She had always taken care of many of her ‘motel family’, but in this dark moment, the motel family bonded together in a show of kotahitanga for Maraea. Her ‘motel family’ looked after her, including providing her with comforts and food and standing watch over her at all times. Their concern for her psychological and physical well-being was their priority over this time of mourning, with Maraea explaining:

> **Maraea:** “They would not let me. They wouldn’t leave me alone by myself. I wasn’t even allowed to go to the shops by myself. Oh, because they were the only ones there for me.”

It was clear by the way she described the support she received that she appreciated every moment, and it provided time for her to process the shock of her friend’s death. Her supportive ‘motel family’ provided her with emotional and physical support, intuitively granting her the time and safety to process the extremes of emotions she was going through. The whanaungatanga she had created around herself outside of her direct family unit acted as a much-needed protective factor in keeping her safe at this time. This goes to show the importance of the creation and maintenance of relationships throughout the community and the resilience of those people who are collectively living rough.

In summary, Maraea’s narrative was one in which she placed a high level of value in community kinship and establishing whanaungatanga amongst her peers. While Maraea’s experiences during the Covid-19 lockdowns were challenging, she attributed her well-being to the support she had around her through the ‘motel family’ she had cultivated. Maraea displayed a narrative of distrust around the vaccinations and their efficacy, choosing to not to be

vaccinated against the Covid-19 virus. Finally, Maraea found the lockdowns did not put into consideration her cultural traditions due to the restrictions placed on social gatherings and hospital visitations.

## 4.2 Analysis: Kristina

This section investigates Kristina's narrative about the Covid-19 pandemic. Kristina is a middle-aged Māori wahine who, before the Covid-19 pandemic, had lived primarily in privately owned properties or rentals for most of her life either with whānau or partners. I was introduced to Kristina by a friend who works closely with tangata whaiora in the local community, who had brought up the research while in passing and gained consent for me to make contact. Kristina let me know early on in our interview that she is "not very well" battling a cancer diagnosis. This cancer diagnosis makes her day-to-day tasks more difficult as she endures her cancer treatment. Kristina has five children of various ages, from toddlers to teenagers to adults. The children were not present with her during the interview but played a pivotal role in her everyday narrative. The day before the first lockdown, the 25th of March Covid-19 lockdown, Kristina moved in with her friend after a domestic violence incident occurred and a police safety order was issued to protect her from potential violence. Like Maraea, Kristina showed great affection towards her father and whānau in our interview and provided a unique perspective on her everyday life over the Covid-19 pandemic. Kristina had strong views on Covid-19, vaccinations and the restrictions mandated.

> **Researcher:** "What were your symptoms when you had Covid-19 the first time?"
>
> **Kristina:** "Oh, I mean like I had got a flu. But I got more of a body ache and a headache. I just slept for days which actually was really quite nice. But I was unvaccinated. I didn't have one vaccination in my body, and I got it like, less. Mine wasn't as near as bad, nowhere near as bad as my father who was vaccinated and had

> all three (Covid-19 vaccinations). So, Dad had the booster and everything in his industry, like they had to have that, he was the industry they had to have the lot first."

Kristina's father worked in one of many industries in New Zealand for which the government mandated vaccines for employees under the COVID-19 Public Health Response (Vaccinations) Order 2021 (New Zealand Government, 2021). Kristina talked about the number of cases of Covid-19 in and around her family during the Covid-19 pandemic. She described being surprised at who in her family got vaccinated and how many times those persons became infected with Covid-19. Additionally, she compared the experiences of her family against herself who initially got Covid-19 before she was vaccinated and did not get reinfected afterwards. In addition to being curious about the patterns and effects relating to the vaccinations, Kristina expressed curiosity and some concern around the effects of Covid-19 on general health.

As mentioned in Kristina's introduction, she is battling cancer which leaves her feeling ill and drained. A point of interest was raised when Kristina suggested that Covid-19 had increased the number of regular illnesses such as the 'cold' etc that she was experiencing on top of flare-ups from her current cancer diagnosis.

> **Kristina:** "…so I'm not very well. And yeah, since Covid has been around, my own health that actually has nothing to do with Covid has got worse, which I think is quite strange because I don't know if it's changed the chemical makeup in the air or whatever. But yeah, it's other illnesses that are actually coming out stronger, like I've had cancer since I was 24, and it's flared up heaps in the last like 4 years since Covid has been around."

This experience echoes a study conducted by Van den Bulck et al. (2022) who found there was an increase in acute disease diagnoses in the first year of the pandemic. The research into this

is still very much ongoing, Kristina seems to be one of many who experienced this increase in illness since the beginning of the Covid-19 pandemic. Kristina shared later on that she had lied to her family initially about getting the Covid-19 vaccination. Due to health concerns related to her ongoing battle with cancer, her physicians and nurses were asking her regularly to come to the hospital and receive the vaccination. Kristina did eventually get a single vaccination after she recovered from her first and only transmission of Covid-19. Upon exploring the reasons why Kristina did not want to receive the Covid-19 vaccination initially, she explained that she was diagnosed at an early age with oppositional defiant disorder (ODD), which she still believes is very relevant in her behaviours as an adult. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the main feature of ODD is a persistent pattern of angry or irritable mood, argumentative or defiant behaviour, or vindictiveness toward others (American Psychiatric Association, 2013). As such, she would actively not do a behaviour or action if it was requested of her, particularly if it came from a position of power over her, i.e. Mother, Father, or any older, more authoritative figure such as teachers or police officers. A multinational study named The PsyCorona Survey was launched to create a historic global record of behavioural responses to the pandemic (Kreienkamp et al., 2020). One of the survey's findings was that the Covid-19 ‘rule-breakers’ were people who do not like being told what to do, particularly when the ‘rules’, such as social distancing or mandated vaccines, threaten their behavioural freedoms. This tendency to resist behaviours that encroach on her personal freedoms was strong in Kristina's narrative. Kristina went on to explain she has multiple mental health diagnoses, including the aforementioned ODD, Bipolar Disorder, Post Traumatic Stress Disorder, and Attention Deficit Hyperactive Disorder. She spoke about becoming reactive to others, particularly authority figures, throughout the interview. However, Kristina does mention a friend who works in social services whom she has at times consented to have an authoritative counsel over her. Kristina states that this social

worker friend was different to other authoritative figures in her life and had always been there for her and that she trusted this person wholeheartedly. Due to the preservation of the privacy of both Kristina and the social worker, I could not include specific statements. However, the level of respect and reverence presented for this social worker throughout Kristina's storied experiences displayed what a remarkable social worker, friend, and figure this lady had become in her life.

Kristina was proud when she identified that she had been in full-time employment before the Covid-19 lockdown restrictions were implemented. Kristina's work dried up quickly after the Covid-19 lockdown measures took effect because her job was not recognised as an 'essential service'. Kristina was offered to stay with a friend at her house as she had the time to help with her friend's children. The friend was a single mother and an essential worker who did many hours with early starts and late finishes. Typically, the friend had support from her family but at the time of lockdown, this support could no longer happen. Kristina took the role of support and would babysit the children while her friend worked. Unfortunately, this living situation went awry due to a conflict between Kristina and her friend over drug use in the home.

> **Kristina:** "Then she started, like, not coming home and stuff. And I was like, 'this is weird', but I didn't really care because, like, there wasn't anything to do. But then she started smoking meth, so she brought that into the house [and] caused a whole lot of, like, chaos. She lost her children. She still doesn't have them back now."

The unfortunate deterioration of her friend into methamphetamine use caused their relationship to crumble, and Kristina could not stay at her friend's home with her own younger children. This led Kristina back into emergency housing with her younger children.

Kristina explained that she had lived in multiple locations and motels over the Covid-19 pandemic and the multiple lockdowns implemented by the New Zealand government.

Kristina had fond memories of the motels where she had been granted emergency motel accommodation, explaining that she had been lucky enough to be placed into motels that were not full of young people and gang members. She describes other families or couples who were pleasant and just trying to survive under the new conditions inside emergency motel living. However, she explained that being in one of the 'good' motels did not mean you were safe from dangerous people. Kristina went on to describe a time when she lived in a 'good' motel and had to witness a "fella turning up and just smashed the shit out of everything". The offending person later on in the interview was identified as Kristina's now ex-partner, whom she had previously reported on in our interview. Kristina explained that the domestic violence incident was a major factor in why she was allowed to move past the lockdown borders that were created between New Zealand's regions, up to the Waikato region emergency housing. It has been documented that domestic violence increased significantly during the pandemic for many reasons, including unemployment, economic uncertainty and social isolation, just to name a few (Piquero et al., 2021). Adding to her already complicated situation, Kristina revealed that she had some serious pending charges made against her by the legal system due to breaking Covid-19 restrictions. She explained the offending behaviour:

> **Kristina:** "Like I'm telling you, I retaliated towards my ex last year that I got in my vehicle. Yeah, he did do wrong and turned up and he did do wrong by me. But I got in my car, drove 200 kilometres to their house and wasted the whole house by myself. Three cars, five dudes. Yeah. And then ended up taking off in one of their vehicles."

Kristina blamed the Covid-19 lockdowns as the reason for the lack of both medical and psychological support she received after she was attacked by her ex-partner in a motel, stating that because of the limited availability of primary healthcare physicians, psychologists and support services, she began to decline:

> **Kristina:** "I really, really did lose myself and I actually have got really, really hard out charges on me at the moment. And I do believe that is the actual effects of lockdown. Because I didn't get the right psychological [trauma support] and medical [care], and no support with the welfare of my kids when the attack happened from my ex-partner where he strangled me and nearly killed me."

An online survey conducted by Imlach et al. (2022) found that 55% of participants had delayed seeking healthcare during the first Covid-19 lockdown in New Zealand due to a variety of reasons, such as concerns that health services were busy or unavailable, the fear of Covid-19 infection, and other factors such as cost or lack of appropriate transport. While healthcare services were still available online or via telephone consults, Choi et al. (2021) found that some people felt distressed about seeking healthcare support over the phone. The support that Kristina would have needed during this time would have been particularly distressing to access online or on the phone because these forms of communication limit the human interaction and connection between clinician and patient.

During a segment of our interview, when Kristina explained the lingering effects of being assaulted in a motel, she explained that she is not good in relationships and does not feel ready for further relationships whilst in emergency housing. Kristina revealed that she had found company with a younger man who wanted to stay with her at the motel in the Waikato. However, I noted a feeling of shame when she explained ending the newly founded relationship with the man due to her not wanting him to have to stay in a motel, stating he deserved more than what she would be able to provide. This feeling of shame was again suggested when talking about some of her children's choice to stay with their grandparents rather than being in the emergency accommodation with Kristina. Kristina explained:

> **Kristina:** "My younger two fully have ditched me for their Nana and Granddad anyway, and their beautiful unicorn room out there. Yeah, well… and how can I take them away from their nana and koroua, I mean… Yeah, I don't know. I am not going to make them come here [to the emergency motel] when they can have… yeah, yeah, they got to go. They have the whole homestead farm thing with some chickens and that."

Kristina displays an aspect of fatalism as she describes her children choosing to be with their grandmother and grandfather. She justifies and accepts the choices made by her tamariki, believing that she could not provide them with a better lifestyle from within the emergency housing motel system. It was obvious by her tone of voice that she cared deeply for her children and the decision made to be apart from her tamariki echoed both fatalism and neo-liberal themes of responsibilisation and delegitimization as her feelings of inadequacy to be able to provide were outside her locus of control.

Kristina showed genuine concern as she spoke about the generation of children growing up in emergency housing during the Covid-19 lockdowns. She named these children "Covid-kids" and included her own children in this narrative explaining the difficulties she experienced in raising children in emergency housing. It was clear that Kristina had spent time thinking about the role the Covid-19 pandemic had played in the development of children and how the restrictions affected the day-to-day development of the youth living inside emergency motel accommodations.

> **Kristina:** "I quite often look at these people here as well [at the emergency motels]. These people here now. How long you fellows have been here for? And a lot of them being like, two years, a year, eight months, six months. It was hard for them you know? See the ones with their little babies. It's a whole generation of kids. My five-

year-old if I look at it is a 'Covid-kid'. My three-year-old is. Yeah, that's all she knew, she didn't even know playgrounds."

Kristina commented on the Covid-19 pandemic restrictions that were placed on emergency motel accommodations, which limited both the children interacting with other adults or children in their wider friend and whānau groups. Kristina then gave an example of these interactions and explained that motel management had approached Kristina when the family turned up to check on her well-being. The motel management then advised that due to the Covid-19 pandemic Level 4 restrictions, her whānau members would need to leave immediately. Kristina believed that the Covid-19 restrictions on whānau and friends visiting her motel were negatively impacting people's mental health at the motels who were physically disconnected from their whānau and friendship support for a period of time. Kristina went on to describe a scenario where a couple and a baby were evicted from their motel room after management had found the couple had allowed their mother to stay with them at the motel room because they felt they needed the additional support of the child's grandparent at the time. Being a mother herself and watching a small family being asked to leave the motel saddened Kristina. Kristina reinforced her feeling that emergency housing motels were not appropriate nor safe for children insinuating heavy alcohol and drug use happening weekly on "pay-day" when strangers would turn up at the motels and party with others at the motel with disregard for the families and their children who lived in the emergency motel accommodations.

Kristina explained that there was verbal and physical violence occurring in the emergency housing motels at which she stayed over the time of the Covid-19 pandemic. She described having to cope with ongoing verbal or physical altercations between residences, couples, and visitors. Kristina expressed that these motel conflict experiences impacted her mental wellness, which in turn lowered her distress tolerance. Kristina explained that this led to her becoming more reactive towards others living or visiting the establishments, adding to

the already volatile living situation. Kristina explained that she became upset and reactive when hearing the sounds of upset children who, as Kristina had already discussed, should not have lived in these emergency motels.

Her use of the colloquial phrase 'you know what I mean?' shows an attempt to gen normalise and generalise the severity and abnormality of her experience. Kristina used the pragmatic device "you know" frequently throughout the interview process. The statement "you know" is a phrase that emphasises "solidarity and implicit shared understanding" and reduces social distance between the speaker and addressee (Stubbe & Holmes, 1995). However, "you know" is used at the end of sentences that do not represent shared knowledge and instead are attempts to normalise and humanise an experience (Macaulay, 2002). The behavioural vocalised response of "you know" was a way for Kristina to connect and to provide context for the experiences she was processing and sharing in real time. This way of using "you know" was not specific to Kristina and others interviewed as part of this research shared "you know" statements as a way of sharing private unique experience as generalised everyday experiences.

In summary, Kristina's narrative of her experiences during the Covid-19 lockdowns had an undertone of feeling unsupported. Kristina experienced trauma during one of the Covid-19 lockdowns and struggled to access counselling or psychological support services, a struggle which she directly attributed to the restrictions placed on the provision of these services as a result of the pandemic. The Covid-19 restrictions also meant that Kristina was unable to have her own support system of friends and family around her in her time of need, which caused a further deterioration in her well-being. Kristina's experiences were also underpinned by a narrative of distrust in authority. This was particularly evident in how she expressed her distrust of the Covid-19 vaccine, giving examples of others who had more vaccinations and become ill more frequently. Finally, Kristina showed aspects of positive fatalism regarding her children's decisions to go live with their grandparents rather than living with her in emergency housing.

## 4.3 Analysis: Jeremy

The following section recounts Jeremy's experiences during the Covid-19 pandemic. Jeremy is a New Zealand European male who has worked in New Zealand and Australia. Jeremy describes himself as a doer, an assertive, problem-solving individual who has a strong work ethic and a heart of wanderlust. I was provided with Jeremy's contact details by a colleague who met Jeremy in her practice and introduced him to the research project. Jeremy's narrative was distinct from the other homeless participants in this research as he managed to maintain a full-time job throughout the Covid-19 pandemic. His job as a truck driver was classified as essential by the New Zealand Government and he talked about completing over 70 hours of work per week. However, Jeremy also found himself homeless, stranded, and without government support. Jeremy's homeless experience displays a part of the Covid-19 pandemic and homelessness which is not widely considered as his experiences are quite unique and not the most visible manifestations of homelessness.

Jeremy started his narrative by discussing his experiences just before the March 25th lockdown.

> **Jeremy:** "I was working full time and stuff, and I had just come over to Hamilton from out of town. And so, I was boarding, and at the time, I was seeing a girl, and she ended up getting kicked out [of her home] just before the lockdown hit. And then so I said to her "oh well you can come stay with me then". Yeah, we didn't; she didn't really get along with a couple of the other flatmates where I was, so we ended up getting kicked out of there… It just made everything really hard, and so we had nowhere to go after getting kicked out, and like my family were like, 'You know we can't take you out where you are and whatnot,' and yeah... we got kicked out. Yeah, like, ahh, about a week into the lockdown, I suppose. In the first week."

Jeremy was a full-time employee and had not been reliant on any social support before the Covid-19 pandemic and associated lockdowns. Jeremy found himself homeless at a time when moving around or finding new accommodations in the private market was unavailable due to the Covid-19 lockdown restrictions implemented on March 25th, 2020. Jeremy had enquired with the Ministry of Social Development (MSD) about help finding accommodation. The Ministry of Social Development representative had explained that they could not assist him with accommodation or housing at this time because his income was over the threshold for community assistance. Jeremy had sought accommodation with family who lived in the Waikato area. Unfortunately, at the time, family members in the area advised that they couldn't help him right now. Jeremy was not from the Waikato and had no friends currently in the Hamilton area, where he was with his partner as the community went into lockdown. Having pursued accommodation with The Ministry of Social Development, family links and friends, Jeremy was still without a home. Jeremy and his partner sought to seek shelter at local motels around Hamilton.

Jeremy discovered that finding availability at motels for casual customers during the Covid-19 pandemic was challenging. The decrease in motel room availability was due to a government initiative to get people off the streets pre-Covid-19 lockdown named 'Emergency Housing'. This emergency housing policy offered any individuals, partnerships or families who fit the criteria for homelessness (including overcrowding) to be given shelter in motels in their local community across New Zealand (Le Dé et al., 2023). This emergency housing initiative was welcomed wholeheartedly by the public and immediately utilised by people within the community. Social services, housing and healthcare workers began advising possible applicants to apply and move into these sheltered emergency motel units. One of the effects of this new emergency housing strategy was a reduction of people living on the streets or in overcrowded accommodations as a surge of people entered and filled motels throughout New

Zealand. Unfortunately, Jeremy found it hard to secure a motel room for himself and his partner due to the lack of availability of rooms. Once Jeremy had secured a motel room for the night, he explained that he was also paying a premium rate per night for a room due to scarcity. In addition to the difficulties Jeremy had finding available rooms at motels, he could not secure a motel room for longer than a day or two. Jeremy explained that he was told by motel management that this was due to motel bookings and obligations made to the Ministry of Social Development. Consequently, Jeremy stated that he was moving in and out of motels approximately every second day for weeks. After several weeks of finding and securing accommodation and paying each night to stay at a motel, Jeremy began to feel the strain of his precarious housing predicament. Jeremy explained that the housing situation and being homeless manifested into high levels of mental stress and body fatigue and started to become a financial issue. Jeremy reminisced later on in the interview that he did, in fact, spend some nights on a park bench. He concluded that, at the time, a park bench was sometimes "easier" than finding a motel that had space that night. There was anger in his voice when he remembered being locked out of public toilets as part of the lockdown. Le Dé et al. (2023) found that the closure of public toilets and water taps appeared to have been put in place to "force rough sleepers into emergency housing" (p. 6) with one key worker reflecting that "no one stopped to think about what it would mean to those that rely on those public taps" concluding that those relying on public toilets and taps "would have been doomed" (p. 4). Jeremy's experience of being locked out of public toilets as part of the lockdown measures echoed this sentiment and made his life much harder living in a situation where he relied heavily on these usually publicly available amenities.

Jeremy decided he needed to find somewhere to stay outside the motels and park benches and remembered the family beach house.

> **Jeremy:** "Yeah, yeah, we've got a beach house over at Whangamatā which I was trying to get to as well. And well, I got turned around at Waihi [by border patrol]. Yeah, and then I went around to go around the back road, and then I got stopped around there too, and they said, "You've already been warned". And then they put another thing on me to say that if [I am] pulled up and your licence plate or names run again, that they would arrest us."

Jeremy had explained to the police at the border leading from Waikato to the Thames-Coromandel area that he had been given consent to use the beach house by his family, and that he had no other place to go at the time. Jeremy went on to explain that the officers said it did not matter and that they could not let him pass due to Covid-19 pandemic lockdown restrictions. There were strict guidelines around movement under the New Zealand Covid-19 Level 4 restrictions around travel between regions (New Zealand Government, 2020b). Travel between regions was only allowed for 'essential' purposes. Some examples of what was considered 'essential' were workers travelling to and from essential work, relocating a home or business, or emergency services (New Zealand Government, 2020b). Because Jeremy's travel to the beach house was not considered 'essential', he was forced to return to Hamilton and pay nightly for motel rooms. This went on for several weeks until his sister offered to let him, and his partner stay on her farm in a shipping container they had sitting on the property. However, this was hardly a convenient location in which to live and did not provide some of the basic amenities you would expect in a home.

> **Jeremy:** "… Yeah. But in the end, we ended up going out to my sister's and they got a shipping container out there. So, I just ended up putting the bed and shit out of that and staying in that for the rest of the lockdown."

**Researcher:** "Wow, living in a shipping container. Yeah? Was it like modified? Or something?"

**Jeremy:** "Ooh, it's got a ranch slider in it, but apart from that nothing else, like it hasn't got lined walls or anything like that, so it got really hot and that… and like you come home at the day and stuff and like, cause the doors are shut, keep flies out. Yeah, like the thing's hot in here. And it's just, you know, like at least I wasn't sleeping on the street at the end of the day."

Having a private abode was better than sleeping on the streets, and Jeremy was fortunate that his sister happened to have a slightly modified shipping container with the bare minimum of luxuries. Jeremy explained that the shipping container did contain a ranch slider and was still very much in the early stages of modification into a temporary home. They had to traverse to the main farmhouse for toilet and bathroom functions. While structurally better than a tent and providing some protection from weather elements such as rain, this shipping container would be classified as 'sheltered' homelessness and "…a place not meant for human habitation" (Le Dé et al., 2023, p. 139). Jeremy's story continued with a narrative of his workplace circumstances and environment, and how the Covid-19 pandemic affected this part of his life.

Jeremy's profession as a truck driver was deemed 'essential' and required long trips to and from cities across the North Island of New Zealand. The mandate for essential workers was very stringent regarding the vaccination policy (New Zealand Government, 2021). Jeremy was required to have Covid-19 vaccination, which did not sit well with him. He described the reasons why he did not want to get vaccinated:

**Researcher:** "What about their vaccinations? Tell me about that. What makes you not want to get vaccinated?"

> **Jeremy:** "So I'm just not really into that sort of stuff because at the end of the day, like it, it's common flu, and you know, just the flu goes around every year. It's not, know you, they're trying to scare you into stuff, and I don't really… I don't believe in being bullied into shit like that. I think everyone has their own choice and for the fact they were trying to push everybody, and that was yeah. Yeah. And that was the thing that sort of pissed me off, and I was like, yea, nah."

Jeremy was apprehensive and distrustful of the government-mandated Covid-19 vaccination programme for essential workers like himself. Like Kristina and Maraea in the previous narratives, Jeremy was not fond of being told that he must become vaccinated for Covid-19 and, as such, resisted for the most part. This meant that Jeremy had the bare minimum number of vaccinations to be able to traverse the regions while travel restrictions were in place. It was not long before Jeremy's narrative returned to the events surrounding his partner and living in a shipping container.

Jeremy explained that his relationship started to break down with his partner because of being confined to a shipping container all day and all night. Jeremy explains,

> **Jeremy:** "She started going crazy man. Yeah, and we just started arguing, and them, you know, like she was wanting to come to work and stuff. And I was like, a couple of days I did [let her come with me]. But like a lot of places, you can't you know? Like, we pull up to the gates and [she was] not inducted [and therefore were not allowed inside the premises]. And so, you know and they' like, oh, you got to wait out on the street… So, then the relationship started really falling apart."

Because Jeremy was working extended and unpredictable hours, his partner was left alone in the shipping container accommodation for long periods of time. Jeremy attempted to address the problem by bringing the partner with him to work on his journeys in the truck. However,

this led to further problems, including logistic access problems, and complaints from management of services and border staff along the way to or during travel between locations throughout the Waikato and lower North Island. This was not a perfect situation for any couple to be in, and eventually, it led to the couple coming into conflict. In his moments of reflection on these stressful moments, Jeremy did not seem to begrudge his partner for feeling this isolation. Jeremy made it clear that he had attempted to adapt his world to have her more included in his daily activities. However, the end result was that the partner would have to stay in the shipping container while he ventured to and from work which elevated her discontent. An additional stress was the development of the Covid-19 'bubble' system.

The Covid-19 'bubble' system that was disseminated to the New Zealand public was created to reduce people's movement during lockdowns and other restriction levels (Long et al., 2020). The term 'bubble' referred to an "exclusive social network" in which members could only have physical contact with each other in order to limit potential exposure to the Covid-19 virus (Long et al., 2020, p. 6). The 'bubble' system suggested that face-to-face socialisation outside your household or 'bubble' was highly discouraged. Jeremy explained scenarios about the 'bubble' system that caused stressors to both his relationship with his family and partner. Jeremy's sister was extremely vigilant in upholding Covid-19 mandated restrictions and public healthcare suggestions such as the 'bubble' system. Jeremy's movement in and out of their family bubble was an ongoing issue for his sister. Being alone in a shipping container for long periods of time disconnected from family and friends, Jeremy's partner became restless to do something different, to talk to and be around others, so she eventually decided to leave the farm and go to a friend's place. This caused a conflict episode between Jeremy, his partner and his sister.

> **Jeremy:** "… and then she was just like, 'I'm going to go out to my friend's place', and I was, well if you do that, you can't come back because my sister's like… Know

you cannot break bubbles and all this shit, and you know… It was bad enough that I was going in and out of the bubbles to go to work."

Jeremy and his partner ended their relationship and separated shortly after, unable to resolve their issues. The conflict between Jeremy and his sister about his coming in and out of the family's 'bubble' for work continued, causing Jeremy to feel excluded and not wanted. Jeremy ended up leaving the shipping container home and returning to living on the road. This was towards the end of Jeremy's first Covid-19 lockdown experience, homeless and alone on the road, working long hours. This continued until he found a small place to stay in Wellington once lockdown restrictions were lifted and he could look for a room in the private market.

Jeremy engaged in normal work life for a period of time while the country came out of the Alert Level 4 lockdown and its associated restrictions and resumed a more routine lifestyle. However, this was not to last as, during a moment meeting a woman during his travels and agreeing to stay with her for a few days, the country again went into lockdown due to community transmission of the Covid-19 virus. Again, Jeremy was out of place and in a stranger's home.

**Jeremy:** "…got off the boat and gone to her place for the night, and then they locked everything down again. And so, I was like, oh, she's like, oh, just stay here with me, you know? And then, but then I couldn't go to work. And the same thing, I was in a stranger's house, you know, hadn't really known her long and feeling uncomfortable and a lot of mental pressure, really, you know? Like, cause everything's out of your control, you know? Not having a vehicle there that I could just jump in and leave if I want to go for a break…"

Eventually, under workplace pressure, the authorities provided Jeremy with a travel pass out of Wellington and back to Hamilton for work-related travel. Jeremy was given a pass to return

to Hamilton on the condition that he would then return to Wellington with his personal car and rejoin the now new 'bubble' with the woman he had only just met. This period was extremely stressful for Jeremy, and it did not make much sense to him to return to Wellington to live with a stranger simply because he initially went into lockdown with her. While enjoying the new company, he noted the tedium of the situation under the lockdown restrictions. Not moving, not working, and the numbing effect of the isolation. This social isolation played an integral role in the deterioration of his mental well-being. Jeremy explained that his personality, work, and private life traditionally involved the core concepts of being in motion and going on walkabouts. He mentioned that his life reminded him of the narratives surrounding the Gypsy culture in which constant movement was an integral part of their culture. With that in mind, Jeremy explained that the lockdowns really were having serious negative effects on his mental wellness, and he described started to have depressive-like thoughts, including images of him being restricted, penalised and forced to remain stationary, creating negative feelings about what the future may hold for him and his way of life. Globally, there were some targeted measures placed for groups of people with nomadic lifestyles, such as the Gypsy, Roma and Traveller populations (Armitage & Nellums, 2020; Lecerf, 2021). Some EU nations were found to have applied discriminatory measures, such as targeted roadblocks, drone surveillance and going so far as to build walls to enclose nomadic populations and discourage movement (Lecerf, 2021). Although nomadic populations experienced some discrimination, there were also urgent calls to action to ensure that these marginalised groups were considered when it came to putting in place certain restrictions on movement and access to public amenities, as well as the overall pandemic response (Armitage & Nellums, 2020). The research into the effects of the Covid-19 pandemic and restrictions does support Jeremy's quandary and concern for his way of living moving forward if further lockdown measures are imposed. The international studies suggest that there were harmful impacts for populations whose lifestyles

are inherently nomadic, and Jeremy experienced mental distress that was similar to that of people from these nomadic cultures, given his preference for staying on the move (Armitage & Nellums, 2020; Lecerf, 2021). Jeremy was aware that his psychological wellness was in decline due to the varying stressors he had experienced and not just the restrictive aspects of the lockdowns.

Jeremy's declining wellness was likely due to multiple stressor factors, including work, travel, motels, rough sleeping, relationship breakdowns, and family narratives with their structures and beliefs surrounding the pandemic and 'bubble' systems. Jeremy understood that he was declining rapidly into depression and as such sought help from his local GP for a referral to mental health specialists. There was an urgency in Jeremy's narrative when he described being unable to receive support for his deteriorating mental health status. Jeremy was not a particularly computer-savvy individual and was reliant on what support he could muster from within the community. During New Zealand's pandemic lockdowns, mental health and addiction services were provided via phone or online consultations.

> **Jeremy:** "You know, everything started falling apart, you know, like my mental health was getting pretty shit there for a bit too, you know."
>
> **Researcher:** "Did you have? Do you have any support with [with your mental health]?"
>
> **Jeremy:** "That or well, you couldn't get any hotlines or, everything was that jammed up. I even rang the doctors and talked to them and tried to get referred to somewhere so I could actually get in and everyone was just like, man, we've got no spaces, you know, even all helplines and stuff they setup and they were like we've got just too many people."

Face-to-face consultations in the community had to follow strict public health guidelines and were reserved for crisis services (Rodda et al., 2022). There were some positives to phone or online consultations, including increased access to services if mobility and travel were an issue. However, there were also disadvantages for people like Jeremy, who did not feel confident accessing healthcare services online or over the phone. Accessing mental health services, in particular, was also challenging for reasons such as privacy and the lack of support when recounting difficult emotions (Officer et al., 2022). Jeremy's narrative in this instance shows how social services, healthcare workers, clinicians and doctors were considerably hard to access at the time due to the volume of people who required support during the Covid-19 pandemic, as well as the restrictions placed on the provision of services.

In summary, Jeremy found the Covid-19 pandemic and associated lockdowns difficult to navigate comfortably. His experiences of being turned away at checkpoints trying to seek somewhere to sleep, sleeping rough, managing motel accommodations, and living with people he hardly knew, was stressful. Jeremy's narrative surrounding Covid-19 vaccinations was that of distrust and apprehension as he did not like to be told he had to take the vaccination to keep his job. The 'bubble' system disseminated to the public was challenging for Jeremy as his work role caused him to move in and out of many 'bubbles', which caused conflict between himself and his sister. Finally, Jeremy's difficulty in accessing counselling and psychology services for his deteriorating mental health is suggestive of the need for more comprehensive public training and awareness of the use of modern technological communications.

## 4.4 Analysis: Amelia

This section investigates the narrative of Amelia. Amelia is of New Zealand European descent, identifies as female and has primarily lived in New Zealand throughout her life. Amelia is an intelligent woman who goes above and beyond to craft her client-centred, genuine

approach to working with tangata whenua and other clientele within her service. Amelia was happy to be approached after learning about the research and agreeing to sit and talk about her experiences during the Covid-19 pandemic, both within her role as a case worker and inside her private lifeworld. Amelia's work role as a housing case worker was classified as 'essential' by the New Zealand government. Amelia worked with families who have become homeless and require specialised interventions and advocacy. Amelia worked throughout the Covid-19 pandemic the best she could with the resources she had access to, working both from home and within the community. Amelia sparkles when she discusses her interactions and experiences with her client base during our interview. It was clear that Amelia led by example when working with her tangata whaiora, promoting health-positive behaviours and strategies to both sustain tenancies and help prevent families from transmissions and infection during the Covid-19 pandemic.

Amelia's interview began with her explaining how she "looks to the science" around vaccination. Amelia expressed her belief in the importance of being up to date with the latest scientific evidence that has been made available to the public. She emphasised the importance of front-line workers being vaccinated. This included inoculations for all possible contagions that we are currently known and are available be to be vaccinated. Amelia commented on well-known vaccination programs that already existed pre-Covid-19 including MMR (measles, mumps and rubella). Amelia expressed her belief that healthcare workers need to be at the forefront of vaccination programs to decrease the potential spreading of illness throughout caseloads due to professional negligence on the part of the clinician. This statement is backed up by the New Zealand's government's stance when it came to enforcing vaccinations for front-line workers (New Zealand Government, 2021). The public health measures that were put in place effectively limited front-like workers' rights to personal autonomy by mandating the Covid-19 vaccination policy to protect the health of the New Zealand population (Sugimoto,

2021). Amelia presented a science-based health stance that is used by health workers in hospitals or aged-care facilities. This was reflective of her strong belief that community healthcare workers to keep themselves healthy and vaccinated to reduce viral transference in the community. This level of care and conscientiousness resonated throughout Amelia's narratives within both her own lifeworld and that of those persons she supports within the community.

Within a short period of time into Amelia's pre-Covid-19 narrative, it was clear that she had a sense of pride regarding the way she responded to the news of the incoming lockdown and restrictions that were to be implemented countrywide. Amelia animatedly explained what kind of preparatory actions she put in place within her own lifeworld. This including stocking up on essential household items such as dried food, UHT milk, fuel, tinned food, water, "… you know, that sort of stuff". Amelia shared her action-oriented preparedness mentality with her client base – "walking the talk".

> **Amelia:** "So I suppose I probably, unintentionally, or intentionally, I don't know, kind of put that [preparedness mentality] towards the people that I'm working with. You, 'well I got this, but have you got this?' you know, like, when you do your shopping… Obviously, there's things you can pick and choose you know, if you got a couple of extra dollars, can you know, what tinned foods could you get, or what, you know, that sort of stuff…
>
> **Researcher:** "So promoting more sustainable non-perishables [with your clients]?"
>
> **Amelia:** "Yeah, just making sure that they're getting what they can, or at least having a conversation about it?... You know? Hey, if you can get a big bag of rice then hey, chuck it in, you know?"

Amelia was positive about the "intentional or unintentional" dissemination of her Covid-19-informed preparatory mentality. However, while discussing the consequences of her preparedness mentality, a realisation seemed to have made her conflicted about her actions. Amelia realised that her Covid-19 preparedness mentality and associated idioms and phrases would have guided everyday actions with her clients and, as such, would have had an impact on their behaviours and thought formulation regarding Covid-19. Amelia clarified her thought process shortly afterwards, stating, "It's not panic buying, but it's that preparedness". Within a work role where you are seen as a figure of authority and knowledge, there are times when, as Amelia experienced, you second guess your actions in retrospect and either learn from or consolidate your actions. She recognised that her preparedness and leading by example would have encouraged her clients to take steps to prepare for the Covid-19 lockdown, which was positive. However, Amelia also felt a sense of powerlessness regarding the care she could provide for her clients during the Covid-19 pandemic.

Amelia understood that, due to factors such as finances, transport, and living space, there was a limit to what people in social housing, emergency housing, or the homeless could do to prepare for a lockdown situation.

> **Amelia:** "Like, when the actual lockdown came, I think we went out and got just fresh stuff, and kind of went 'ok, cool, if the supermarket closes, we're good. It doesn't matter.' The um… but in saying that I knew also that people that we were supporting didn't have that luxury, that um, and it is a luxury. You know, that sounds bad, but it is… you know, we had the space at home to store things, we, you know? All that sort of stuff. In a motel room, you don't. There's also limited things you can buy, store like, freezers, fridge space, space in a room, you know, neighbours, all that sort of stuff, you know? That very different kind of viewpoints of what you can prepare for and what you can't. Yeah."

Amelia reflected on her own level of agency, accessibility, and amenities at this point of her narrative. Amelia recognised her level of privilege living within the middle class of society, having greater access to information, finance, transport, and living space. Amelia shows genuine concern for those people who, in this instance, did not have access to transport vehicles, finance or access to credit, or space to store items such as a garage or a large freezer. This sense of concern developed into a feeling of a lack of control in her own work. Like Amelia, many healthcare workers have expressed feelings of powerlessness and tension between the care they were able to provide to their patients or clients within the realms of the pandemic regulations and the care they wished they could have offered (Hodwitz et al., 2022). Amelia understood the complex challenges people who were currently homeless in emergency housing or living on low-income benefits in social housing were about to face moving forward as the country went into lockdown.

On March 25th, 2020, New Zealand went into its Alert Level 4 Covid-19 pandemic lockdown, and with it, Amelia reminisced about how the lockdowns impacted her personal life and her ability to support her clientele, who are a large part of her daily events and interactions.

> **Amelia:** "I hated it. From day dot. The whole lockdown thing. I immediately felt like, because we had to work from home, you know, in my head, which I still believe… that I cannot do my job properly over the phone. Yeah, it just doesn't work, and everything got put on hold, so you know, all the KO (Kāinga Ora) stuff, all the agencies, and stuff that we could do proactively. There wasn't much to do because everything would be closed. Um, and even maintaining relationships…"

It was clear from "day dot" that Amelia really disliked the whole Covid-19 lockdown system. Her dislike of the lockdown system was not due to any concerns around the science behind the public-mandated restrictions but instead stemmed from her inability to provide the same level

of care she had been meeting pre-Covid-19. Amelia elaborated that maintaining relationships with clientele within the lockdown system was difficult and lacked interpersonal engagement. Amelia found that being unable to meet face-to-face with clients and engage in challenges proactively made it hard to do her everyday mahi. This was particularly difficult when fostering and developing newer relationships with clientele that had yet to establish defined roles and understandings of practice. Amelia discussed having trouble contacting other public sector organisations that were closed during the Level 4 lockdown restrictions. It was clear by Amelia's voice tone that she was having feelings of frustration when recounting her attempts to provide a high level of care to her tangata whaiora over this time period. Despite expressing frustration, Amelia's responses also evoked a fatalistic outlook, reflecting her feelings of powerlessness and acceptance of the litany of changes in her workplace role. She felt her position had deteriorated in breadth, with engagement mainly focusing on applications for food parcels and delivery of personal protection gear and other essential goods. Amelia felt her full housing case worker role was effectively put on hold for the most part over the months in Level 4 restrictions. This role restriction and powerlessness echoed the experiences of other healthcare workers worldwide who expressed feeling limited in their abilities to provide adequate care (Hodwitz et al., 2022). However, the restrictions did not stop her from staying committed to her tangata whaiora and workplace objectives of communicating and actioning assistance as effectively as possible.

Even the most basic level of community and housing support is valued and appreciated by many in need in the community, and those Amelia supported over this time showed resilience in the face of adversity. Amelia smiled recounting one instance of support when she shared a laugh with one of her people who thought "outside the box" and showed remarkable prowess. This occurred after one of Amelia's tangata whaiora contacted Amelia and

complained they had been denied access to a supermarket due to being unable to provide herself with the appropriate personal protective gear.

> **Researcher:** "Were things like food parcels common?"
>
> **Amelia:** "Yeah, yeah, hugely common. [Name removed] lived across the road from the supermarket, but she had no face masks. So, over the phone, I'd arranged to drop off [the face masks] to her, but she had gone and used like; she found a scarf to use as a face mask, you know, like, she'd come up with something, and we'd had a bit of a giggle about it…"
>
> **Researcher:** "A creative way of getting around the problem."
>
> **Amelia:** "Yeah, the um, but then talking about it, I was like, aw, I got some here, I'll drop them off when I'm out. Blah, Blah, Blah. So, then she was like, 'Sweet, I don't have to [drop the face masks off to her], but I will feel safer with a face actual mask rather than a scarf'. Also, it is a bit more socially acceptable, you know? Yeah, because people already, you know, judgemental and all that sort of stuff."

In this narrative, Amelia identifies the resilience factors and adaptability skills used to surmount a challenging circumstance. By using a scarf as a mask, she was granted access to the supermarket. However, there was a sense of shame and discrimination felt by her client for going into the supermarket wrapped in a scarf. As Covid-19 and lockdowns was a new phenomenon for New Zealand, it is understandable that the public, in fear of their own safety, desired that everyone follow the strict guidelines provided in the government mandates. Those persons who did not or could not follow these guidelines where perceived by others as ignorant and dangerous because of the increased risk of transmission of the Covid-19 virus. There is a sense of shame placed upon people who do not or cannot adhere to the mandated rules in the community, from people who do cooperate, particularly when it comes to potential harm due

to health risks (Sugimoto, 2021). This put Amelia's client in a vulnerable position, who at a time of need, had to shoulder the burden of her own felt transgression on top of the disapproving looks given by others while attending the supermarket in a scarf. During her recollection of her clients reaction of Amelia dropping off face masks to her client, I noted her clients response to be an expression of delegitimization. Amelia's client expressed an internalised notion of the 'underserving poor' in this statement where she offers Amelia to ignore her needs, stating, "Sweet, I don't have to [drop the face masks off to her], but I will feel safer with a face actual mask rather than a scarf". Delegitimization and the internalisation of the "undeserving poor" is a widely recognised phenomenon in modern homelessness literature (Leggatt-Cook & Chamberlain, 2010; Oak, 2015; Thorns, 1989).

Amelia described her client's experiences was not uncommon those she represented and went on to a narrative delving into other similarities experienced by people living in emergency housing.

> **Amelia:** "Stress, like having kids at home, she also had a child with a disability as well in the motel. So, trying to… like her biggest challenge was to… because in the motel there is no outside space you know? So, trying to keep her child in the room, and well children because she had three of them there with her… The stress of I think and not just her, but a lot of people that in that motel space, you kind of know there's a lot of distrust that the people next door are not sticking to the rules, you know, that sort of stuff, and a lot of people didn't [stick to the rules]. So again, If I go out there am I going to get sick? Are my kids going to get sick? Because I can hear them partying, I can see them, you know, like that sort of stuff. And it's like, do I put them at, you know, put myself at risk?"

Amelia's narrative identifies some stressors experienced by families within the emergency housing system. Adults and children living in small motel rooms. Safety and protection for families and their children in a compact motel environment amongst a viral outbreak. The ubiquitous distrust of the unknown persons living next door and the persons who refuse to adhere to public safety mandates and act accordingly to safety procedures and recommendations, i.e., facemasks, social distancing, and vaccination protocol. Amelia noted she would be told about groups of people partying, drinking, and, at times, fighting during the period of the lockdown system. The non-compliance to the mandated rules by some people within emergency housing was a shared experience throughout participant analyses.

During the periods in which no face-to-face contact meetings were allowed, Amelia and her colleagues had to use alternative methods of contact, which primarily meant using instant messaging platforms such as WhatsApp, cellular text messaging, and phone calls with their clients. While these were valuable tools to maintain a connection with people over this period, Amelia raised the concerns she had about having to provide support services in this way. Specifically, when it came to building a sense of whanaungatanga and completing needs assessments and discussing sensitive information.

> **Amelia:** "I went, 'no way, I am not doing assessments over the phone. I cannot build relationships with someone when I can't read them. I can't see their body language. I can't see a whole lot of things that, yes, it's the assessment and initial meetings. But it's what's not said, you know? I can't do that over the phone"
>
> **Researcher:** "The nuance…"
>
> **Amelia:** "Yeah. I also don't know who else is there [listening to the conversation]. That in all, also, a lot of people that we support have children and cannot spend an hour on the phone without interruption of children and all sorts of stuff… A motel

> room with four people, five people, whatever, is not an ideal space to be having some of those discussions, you know? Like, some of our assessments, we're talking about finances, we're talking about mental health and well-being, criminal history, that sort of bigger picture stuff. The person may not actually want to be talking about that in front of their kids, you know? Or anyone else that is in that space that we don't know and can't see."

Amelia was passionate about explaining the limitations of phone call appointments with clients who lived in emergency housing during the pandemic. She felt valid in her reasoning why she sometimes had to refrain from actioning assessment tools or discussing important client-sensitive information. The possible lack of privacy when providing support over the phone caused additional risks to service providers (Officer et al., 2022). There was no way of knowing if the phone conversation was truly private or whether other people were listening in on the conversations. The possible lack of privacy also meant that some clients may not have felt able to speak freely. On top of Amelia's concern for the possibility of a privacy breach by an unknown factor, she was mindful of the information that may be revealed during assessment tools that could undermine or create a vulnerability for exploitation. Apprehensions about phone consultation and privacy were shared by previous research participants Kristina and Jeremy, who reported feeling uncomfortable about or unable to share over the phone. The result of the restriction to only phone appointments during this period meant that client introduction, rapport building, assessment, and interventions were either delayed, cancelled, or put on hold until such a time as appropriate action could be taken.

In summary, Amelia's narrative is an example of the importance of the Māori concept of whanaungatanga as part of a functioning client-consultant pairing and highlights interpersonal strategies as of key importance to this objective. Amelia's ability to reflect on her own assumptions and internal discourse illustrates a high degree of agency and commitment to

humanistic workplace practices. A part of Amelia's narrative was the acknowledgment that those people she supports had ongoing challenges in their everyday life which were further heightened by the Covid-19 lockdowns. These challenges manifested in the form of financial instability, housing insecurity, lack of access to services, shame, stigma, and delegitimization. However, Amelia always portrayed the resilience of those in her care.

## 4.5 Analysis: Richard

The following section recounts Richard's experiences as a housing case worker during the Covid-19 pandemic. Richard is a European male and has lived in New Zealand for over ten years. As of our interview, Richard is a full-time worker and provider for his family, a homeowner and a father of young children. Richard has worked in multiple roles, ranging from handyman to construction, painting, and housing case worker. Richard amalgamates his diverse skillset into his practice as a housing case worker through relational methods, peer support, and empathy drawn from experience. Richard offered to participate and talk about his experiences living and working as a case worker during the Covid-19 pandemic after being introduced to the research by a peer. Richard's role as a housing case worker was classified as 'essential' by the New Zealand government, and he continued his practice throughout the Covid-19 pandemic, working alongside tangata whaiora in the community. Richard began his narrative at the onset of the Covid-19 pandemic in New Zealand when he began employment as a case worker. Richard started his account of his narrative by reflecting on the difficulty he experienced reaching out, introducing himself, and guiding people he had yet to meet in person.

> **Richard:** "… it was within days of the first lockdown. So, I was just getting used to the role. But then I had to start contacting my clients remotely, from where I was staying. I was staying with my in-laws with my infant son, and my partner, and so I had to juggle everybody living together and not leaving the house, but also trying to

> get to know new clients. So initially, it was hard to build rapport and relationships over the phone…
>
> **Researcher:** "Can you remember something that happened or maybe a feeling that you were getting when talking to this new set of clients that you've never met? And what was your first response to talking to them over the phone?"
>
> **Richard:** "So, fear of the unknown … because they are predominately people [who experience] mental health and addiction … [and] have been in the system for quite a long time … they're normally wary of new people in general. But then on top of that, with the added stress of being in a lockdown, you know? People were worried at the time because, you know, we didn't know where it was gonna go… but they wanted you to have the answers."

It was evident that starting new employment while working from home was extremely stressful for Richard. Juggling work responsibilities with an infant child within proximity added a level of complexity that was far from ideal for Richard, who was still conceptualising and learning his new role. Richard explained the difficulties communicating with and creating a trusting relationship with the tangata whaiora he had just been assigned as his caseload. Having had no formal interpersonal interaction with clients before calling via a cellular phone, Richard had to introduce himself and who he represented and then attempt to navigate and discuss personal and potentially sensitive information or complete assessments with someone who he had never met in person. Richard explained that his clients subsequently had a high level of distrust when speaking about their current life circumstances, needs and requirements with someone they had never met in person. This position was arduous for both parties, client and case worker, and is an example of how the process of relationship building was complicated by the advent of the

Covid-19 pandemic and associated restrictions. Richard had to continue working in this capacity until his workplace and role were given the 'essential' service designation.

Once the designation of 'essential service' was applied to Richard's work, he was provided access to the workplace, vehicles, and a bubble of team members, and was able to enter the community following strict guidelines of practice. This opportunity provided a way for Richard to strengthen the relationships he had begun over phone calls. However, this was still at a distance, as described in the following quote:

> **Richard:** "What was recommended to us at the time, which meant to educate our clients. [Particularly] the clients who were on the margins of society [who] weren't really in the loop of a lot of the information. So anytime we [would] see people, or we're on the phone, or, you know, we were social distancing, visiting with a social distance or whatever, we have to keep reminding, as you know, you need to social distance, you need to wear a mask, you need to continue to use hand sanitiser that was provided, and saying that you know, this isn't something that is just going away in a couple of days. It's something that we have to deal with for the immediate future…"

Richard was able to meet and interact with his clients while following public health guidelines. Social distancing and the use of personal protection equipment was a requirement for front-line staff inside the organisation where Richard worked. For Richard, this meant that he would be visiting people, sometimes for the first time, clad in personal protection equipment, including gloves, face masks, and shoe covers. The use of personal protective equipment did have some very noticeable limitations. Richard noted that the face masks are particularly challenging because they obscure the identity and view of the face, impeding non-verbal cues and reducing vocal clarity, leading to a communication breakdown or confusion. These identity and communication barriers due to personal protective equipment were experienced by other

healthcare professionals (Duan et al., 2021) and community workers (Ravenswood et al., 2022), and were also identified as barriers by patients receiving care in hospital settings (Pathan et al., 2022).

The personal protection narrative and masked interactions did, however, provide opportunities for Richard to offer direction and housing support to his clients and start the process of building working relationships. Richard reminisced on clients' resilience and adaptability during this stressful period. Richard spoke about clients who were proactive in their own personal safety, who wore masks and other personal protection gear, actively engaged in social distancing techniques, and would "go the extra mile, and they'll be washing the groceries that they received from the supermarket". However, not all people under his umbrella of care were happy to be approached or contacted in person over the period of the pandemic. Richard observed that some tangata whaiora were hesitant and fearful of being approached, stating that "Now other people [that I support] were more kind of paranoid, and this would increase at the start of the pandemic… And you could sense that nervousness with people when you're talking to them". This experience resonates with participant experiences described in Ravenswood et al. (2022) where it was suggested that in some cases, clients who had a mental health disability or dementia would become uncomfortable or fearful when a support worker would present with a face mask as "it would freak these guys out" (p. 37). During the lockdown periods, Richard explained that his work responsibilities changed and had become more focused on oversight of community housing placements within the service. These new responsibilities involved providing clients with guidance relating to the mandated restrictions, delivering personal protective equipment, and providing up-to-date information around support services that were operating over the lockdown periods, and how to access them correctly and safely.

In common with Amelia's experience described in this thesis in chapter 5.4, and many other healthcare workers mentioned by Hodwitz et al. (2022), Richard felt he could not perform his role comprehensively because of the restrictive measures put in place in response to the pandemic. Richard found that working alongside other services as part of a collaborative support network was difficult when the restrictions were first introduced. This was due to a break in the normal workplace events, and support workers, case workers, and clinicians clambered to become fluent in the applications of third-party software such as Zoom and Microsoft Teams, in addition to being displaced from their workplaces or working from home.

In summary, Richard's narrative of his experiences of working as a housing case worker during the Covid-19 lockdowns were underpinned by a sense of being hindered in his ability to perform his role well. The challenges he described were a direct result of the pandemic measures imposed by the New Zealand government. Richard spoke about the difficulties he faced in building relationships, as he was restricted to working from home and unable to meet the people, he was supporting in person. Richard's experiences are similar to those described by Amelia in the previous subsection of this chapter and are similar to experiences found in literature where healthcare workers share the challenges and frustrations of working within the strict health guidelines during the Covid-19 pandemic (Hodwitz et al., 2022). Finally, Richard described the resilience and adaptability of many he supported in response to the viral outbreak. He was surprised by the lengths some would go to feel safe during the Covid-19 lockdown period.

# 5 Chapter Five: Discussion

The current study aimed to provide a snapshot of the experiences of people who lived in emergency housing or were otherwise homeless, and those housing case workers who supported them during the Covid-19 pandemic lockdown periods starting in March 2020. I have had the privilege of meeting and discussing the journey of five participants who each shared a very different story of their experiences over the period of the Covid-19 pandemic in New Zealand. Their remarkable courage in sharing their daily events and challenges, success stories, learnings, and loss allowed me to take a snapshot of their lifeworld. The discussion will first give an overview of the thesis objectives. Then, I will reflect upon my cultural stratagem and analysis and discuss why this analysis was an appropriate approach in the creation of a more supportive, mana-enhancing, inclusive level of participatory research. Following this, I discuss the narratives that were found among participants and how they shaped their circumstances and perspectives during the Covid-19 pandemic.

In this thesis I aimed to explore how this experience of the Covid-19 pandemic had affected housing outcomes, mental health well-being, and the delivery and access to social services. There is existing academic literature exploring the impacts of the Covid-19 pandemic on people experiencing homelessness. However, these studies are often quantitative and do not explore the embedded nuance and subjectivity intertwined throughout the narrative experience (Carter, 1993). The present study has focused on the complex, human, and emotional side of the impacts of the pandemic and lockdowns, specifically for people experiencing homelessness and community case workers active in the local community. A multitude of factors influence an individual's journey into and through homelessness, including relationships, mental and physical health, and socioeconomic status (Johnson, 2009; New Zealand Government, 2019; Robinson, 2004). The wider sociocultural context and systemic barriers also shape this journey, and one person's experience of homelessness is unquestionably unique from anyone else's.

Regarding culturally appropriate research, I underpinned this research with cultural imperatives that promoted an inclusive and reciprocal relationship between researcher and participants, which sought to derive real lived experience without re-creating or exacerbating traumatic experience.

I believe that taking the time to introduce myself formally as a researcher and as a peer, being genuine, and sharing kai together, positively impacted participant engagement. I was honoured to be given the chance to sit alongside participants while they reminisced about their real-world experiences of homelessness and emergency housing during the Covid-19 pandemic. By underpinning my perceptions, analysis, and participant interactions using humanistic psychology in addition to the implementation of relational ethics on Māori principled practice, I was able to navigate a "genuine ethical relationship with community partners that enhanced reciprocal understanding, empathy, and support." (Hodgetts et al., 2021, p. 1983). Before, but particularly after the end of recorded interviews, it was common for participants to extend our time together by sharing a biscuit and having a korero around our lives before the Covid-19 pandemic, work stories and foretelling the future and what may be to come, both in our personal lives and the society we all shared. I consider these most welcome and cherished additional conversational experiences to be the reciprocal result of implementing the Māori aspect of whanaungatanga into engagement with participants. A part of creating this genuine, reciprocal, and meaningful relationship was the cultivation of a sense of manaakitanga, which advocates for respect, dignity, and indigeneity (Hudson, 2010) and avoidance of focusing on the negative (Hodgetts et al., 2021). The result was that participants found themselves invested in the research and had a strong desire to share their stories, highlighting the importance of our work and their trust in me. This trust is a cornerstone of ethical research and a testament to the responsibility we have as researchers to uphold the trust of our participants, and this relational mode of research keeps researchers accountable to the

communities and populations that which we engage in research. Through analysing the participants' narrative experiences, I uncovered and explored the challenges they have faced and the strategies they have utilised to cope with adversity.

## 5.1 Experiences of the Research Participants

The stories provided by the participants who experienced homelessness during the Covid-19 pandemic provided important insights into the lived experiences of this group. While each participant had unique experiences from one another during this time, some common themes emerged from the analysis. This section discusses and relates these shared narratives to the wider social context.

## 5.2 Lack of Access to Services

The accounts from the participants in this research highlight how the Covid-19 pandemic exacerbated existing barriers to healthcare faced by people experiencing homelessness. The lockdown measures and social distancing meant that healthcare services had to change the way in which they operate. Such changes included switching from in-person to online or telephone healthcare services, introducing social distancing, and restricting physical access to public spaces, i.e., public facilities such as public toilets and libraries and primary healthcare facilities such as hospitals and care facilities. These changes were important in reducing the transmission of the Covid-19 virus. However, they also created additional barriers to service access for some people.

Even before the Covid-19 pandemic, people experiencing homelessness were at higher risk of experiencing poor mental health due to the stress and uncertainty of homelessness. Kristina, who had been through a traumatic experience during the lockdown period (see page 65), described being unable to access both psychological support and medical care despite

going through a traumatic experience during the lockdown. The unavailability of in-person support for her experience caused significant distress and feelings of being let down by the system. Kristina believes that she experienced lingering mental health issues as a result. This highlights a broader problem in the provision of health services and the wider impact on mental health outcomes as a result of the Covid-19 pandemic measures (Hodwitz et al., 2022). The lack of access to in-person care during the lockdowns, particularly for sensitive cases such as Kristina's experience, made mental health care even more unattainable than it was prior to the Covid-19 pandemic.

The participant accounts of Maraea, Kristina and Jeremy indicate that the shift to online healthcare services during the lockdowns, which included mental health services, resulted in the exclusion of people without digital literacy, reliable access to the internet, and privacy. Homeless individuals tend to experience digital inequities, such as a lack of stable internet access or owning a device. For example, describing himself as not technologically savvy, Jeremy struggled to access mental health, psychology, or counselling during the period of the pandemic when mental health services were only permitted online or over the phone. This meant that he was unable to get the mental health support he needed, which worsened his condition. Jeremy's experience is an example of how the public health measures put in place during the pandemic may have inadvertently caused an exacerbation of mental health issues.

In addition to issues of digital literacy and inequitable digital access, the move to telephone consultations and counselling during the pandemic caused an additional barrier for people who did not have access to a private space for the duration of their healthcare appointments. The participants' accounts demonstrate how precarious living conditions in emergency motels restrict a person's ability to discuss private aspects of their lifeworld that they do not wish to share with their children or other adults within proximity. Sensitive topics, such as mental health, are more suitably discussed in a private setting for the sake of both

patient and provider. People without privacy, such as homeless individuals or those in emergency motels, may have been left without adequate support.

Intertwined in the participants' narratives was the theme of a shared sense of being let down during a crisis when it mattered the most. Their experiences illustrate how the measures put in place during the Covid-19 pandemic inadvertently intensified the inequities that already existed in access to healthcare for people experiencing homelessness. The lack of in-person mental health care resulted in the worsening of mental health for a group that is already vulnerable. The move to online health services also displayed how the digital divide that already existed within marginalised populations caused an increase in the barriers to healthcare.

## 5.3 Lack of Access to Information

A further challenge for participants who did not have ready access to digital devices was the way in which important public health messages were disseminated during the pandemic. Government-imposed lockdowns and social isolation restrictions during the Covid-19 pandemic resulted in a heavy reliance on digital platforms to disseminate public health information. The internet has become a vital tool for communicating updates about viral outbreaks, providing guidance on restrictions, and ensuring the presentation of the availability of services to the public. Information about the virus evolved rapidly in the early stages of the Covid-19 pandemic. This included details of the symptoms, how it was transmitted, and how to avoid exposure. During this time, information about potential exposure events was also communicated frequently, and there was an expectation to keep up to date on "locations of interest" (places or events where there was potential exposure to the virus) and comply with isolation requirements if these places had been visited. All this important health information was communicated online, and via radio and the daily 1pm television update, which meant that

internet access, digital literacy or access to a television or radio became necessary to stay informed.

The reliance on online communication during the Covid-19 pandemic exposed these digital inequities as a significant public health issue. The inability to access crucial health information was a barrier to health and well-being, both in terms of the virus and general health and mental wellness. The absence of information about this new virus and a new way of life, namely the lockdown and associated restrictions, was a source of stress and uncertainty for many. Maraea recalled that her lack of internet access meant that she was unaware of restrictions such as the limit on the number of people able to enter supermarkets. Maraea's family learned of this information from the police, who warned them about travelling with too many people while going to the supermarket. This situation shows the disparity between those with internet access and those without, as Maraea and her family were completely unaware of this crucial health guidance due to lack of digital access. Digital inequity can hinder access to health information and add to existing barriers to compliance with government mandates. During the Covid-19 pandemic, some of the isolation requirements and restrictions were mandated, and breaking these rules could result in fines or punishments. People experiencing digital inequity who could not access the health guidance would have struggled to comply with the regulations, which creates further vulnerability for this group. The participants' experiences of lack of access to information were pervasive, whether due to digital illiteracy or lack of internet access. These experiences highlight how the pandemic responses magnified the existing digital inequities experienced by people in insecure housing and the flow-on effect this had on mental health and compliance with regulations.

## 5.4 Autonomy and Public Health Policies

The Covid-19 pandemic brought about unprecedented public health mandates and restrictions on the everyday movements of New Zealanders. These restrictions were imposed rapidly, and the shift to complete lockdown and isolation was sudden. The way in which individuals responded to these restrictions on personal freedom varied significantly. The participants' experiences in this study demonstrate how differently some people experienced the effects of the restrictions. While the experiences in this study were specific to the context of New Zealand's public health response to the Covid-19 pandemic, the narratives are underscored by the individuals' general worldviews.

One of New Zealand's main public health responses to the virus was the COVID-19 Public Health Response (Vaccinations) Order (New Zealand Government, 2021). On several occasions, the New Zealand government reassured the public that there would not be a mandatory vaccination policy (Sugimoto, 2021). Despite this, some front-line and essential workers were later required to receive a Covid-19 vaccine to keep their jobs. Some workers shared stories of feeling pressured to be vaccinated even though they were not required to by any mandates (Lock, 2021). The exclusion from some public spaces and the potential of job loss created a sense of pressure and feelings of being 'forced' into becoming vaccinated to participate in society. As a result, many people felt that the vaccination program was overriding their right to autonomy.

One underlying theme that emerged from these narratives was one of personal autonomy. Personal autonomy in the context of the narratives in this study is related to the right of individuals to make choices about their health and their bodies, namely their choice to take the Covid-19 vaccination. Joel Feinberg's explanation of personal autonomy is relevant in this context. Joel describes personal autonomy as:

> "The right to make choices and decisions – what to put in my body, what contacts with my body to permit, where and how to move my body through public space…" (Feinberg, 1986, p. 54)

The participants in this study all had strong views about the vaccination program concerning their personal autonomy. Maraea's vaccine hesitancy was mainly driven by the scepticism of the vaccine's contents and effects, reflecting a worldwide discourse of conspiracy theories and speculations regarding the Covid-19 vaccine. Kristina shared Maraea's concerns about the vaccine mandate and their efficacy. Her already well-established resistance to authority and authoritative figures further exacerbated this untrusting discourse. Kristina was strongly encouraged to get vaccinated due to pre-existing health conditions. Despite the recommendations by doctors who stated it would protect her health and well-being, she ultimately felt she was being coerced into taking the Covid-19 vaccine. While she did eventually take the vaccine, the perception of losing her personal autonomy caused significant mental anguish. Jeremy was part of the group classified as essential workers and, as such, required to take the vaccine per the government's mandates. While he did comply, Jeremy also felt a strong sense of injustice at the thought of being 'forced' into taking the vaccine. He felt he had no choice, as non-compliance with the requirements would have resulted in Jeremy losing his job. These experiences highlight one side of the intersection between balancing public health mandates and personal autonomy. An alternate narrative presented by Amelia was the acceptance of losing some level of personal autonomy for the 'greater good'. For example, Amelia believed that it was vital for front-line workers to be vaccinated to ensure the protection of the greater population.

The narratives in this study provide a complex interaction between personal autonomy and public health policy. These experiences exemplify how societal narratives around distrust and resistance to authority are shaped by many factors, such as Maraea's personal beliefs,

Kristina's childhood trauma, and Jeremy's livelihood concerns. Their stories show the relevance of understanding personal beliefs, psychological dispositions and socioeconomic situations when considering the population's actions in response to stressful circumstances such as the vaccine program.

## 5.5 Social Isolation

The New Zealand government's lockdown response and 'bubble' system resulted in months of social isolation for many people. The lockdown approach meant that people were expected to stay at home to isolate and reduce the risk of transmission of the Covid-19 virus. Social gatherings on a large scale were prohibited, and the 'bubble' system was rapidly implemented. Some of my participants found the social isolation that came about due to the lockdowns was detrimental to their mental health and well-being.

The restrictions on social gatherings were applied to all gatherings at Alert Level 4 (New Zealand Government, 2020b). At Alert Level 3, funeral and wedding services were permitted, with strict rules for physical distancing and the number of people attending. Maraea's experience highlighted the impact of the restrictions on cultural traditions, such as large family gatherings for the birth of a child. Maraea talked about the unease and sadness her family felt when they were unable to celebrate the birth of her sister's child according to their traditions. These traditions are important to feeling connected and supported during significant life events. Maraea's experience is an example of the emotional impact of the restrictions on these life events.

Kristina spoke about the impact of the restrictions and bubble system on her mental health. After experiencing trauma during the lockdown, the isolation rules meant that she was unable to be surrounded by family and friends for emotional support at a time when she would have needed it the most. This compounded the lack of access to counselling and mental health

help that she was already experiencing. Kristina's experience shows how the pandemic restrictions had the potential to cause exponential harm to the mental health of vulnerable people.

Jeremy's experiences as a result of the social isolation rules caused significant distress for several reasons. During the lockdowns, in which social contacts were limited to 'bubbles', Jeremy was contained in circumstances that were less than ideal. During this time, he experienced a relationship breakdown, which he attributed partly to the interpersonal conflict that arose from being confined in close quarters with his partner. Later, during another lockdown period, Jeremy's 'bubble' included a woman he had just met a week prior. This was stressful for Jeremy, as he described her as a stranger at the time. Jeremy also described himself as preferring a nomadic lifestyle. The restrictions placed on travel between New Zealand's regions were a significant source of anxiety for Jeremy, as staying in one place felt uneasy. Overall, the participants' experiences show different elements that contributed to their feelings of social isolation during the time when New Zealand placed heavy restrictions on social contact. For a group already vulnerable to isolation due to insecure housing, these restrictions caused further isolation during a difficult and uncertain time.

## 5.6 Feelings of Powerlessness

The Covid-19 pandemic measures impacted the delivery of healthcare services in New Zealand. Due to stricter physical distancing and gathering restrictions, most support services were only permitted to be provided online or over the phone. Workers could not visit their clients in the community at this time. Previous studies have emphasised the importance of rapport-building for effective care delivery to vulnerable groups, such as people experiencing homelessness (Butt, 2021). The Covid-19 pandemic measures limited in-person visits,

hindering establishing and maintaining these important relationships between case workers and their client base.

Amelia's experience is an example of the impact that physical distancing restrictions had on the provision of care in the field of homelessness. Because of the move to online or telephone services, healthcare workers described a sense of powerlessness in their inability to provide the level of care they normally would be able to provide in person (Hodwitz et al., 2022). Amelia expressed her concern that she could not perform her duties effectively over the phone. The shift from in-person interaction resulted in fewer opportunities to develop trust and rapport with her newer clients. She felt uncomfortable discussing sensitive topics over phone calls, which was a central part of her role. The inability to observe non-verbal communication resulted in a level of disconnect which posed a significant challenge.

Richard's experience further highlighted the impact of the social distancing measures on his relationships with the people he was tasked to support. Richard began his role shortly before the first Covid-19 lockdown in March 2020. This meant that most of his initial contact with his clients was over the phone, and Richard described his struggles to build rapport. Personal connections and trust-building are crucial to providing effective care in this role, and the inability to meet in person in person hindered this process. Without these established connections, healthcare workers could not assess needs accurately and provide the right support.

Amelia and Richard's experiences express a narrative of having to navigate powerlessness in the field of providing support services to people experiencing homelessness. The Covid-19 pandemic measures ultimately resulted in the provision of fragmented services for the homeless population. However, the impact of reduced in-person support extended beyond housing providers. These restrictions also impacted social services such as the Ministry

of Social Development, mental health and addiction services, and employment services. These are all critical elements in supporting people experiencing homelessness to achieve sustainable housing, and the reduction in these services has a significant impact on the health and well-being of an already vulnerable group of people.

## 5.7 Discussion Summary

This thesis aimed to delve into the multifaceted effects of the Covid-19 pandemic on individuals in social housing or experiencing homelessness, as well as the community case workers supporting them. Through the narratives of five diverse participants, I have gained invaluable insights into their experiences during this challenging period in New Zealand. The participants' stories highlighted the exacerbation of pre-existing barriers, such as limited access to healthcare and digital inequities, as well as the heightened sense of social isolation and feelings of powerlessness. The analysis revealed common themes, including the struggle to access essential services, the challenge of staying informed amidst digital divides, the tension between personal autonomy and public health policies, and the profound impact of social isolation. These narratives emphasised participants' resilience and adaptability while shedding light on the systemic issues that need addressing to support their communities in future crises better. This study has emphasised the importance of understanding the lived experiences of individuals facing homelessness and those supporting them, particularly during unprecedented events like the Covid-19 pandemic. By focusing on the participants' voices and adopting a culturally sensitive and ethical research approach, this thesis contributes to a more nuanced and empathetic understanding of homelessness. As argued by Scanlen (2009), policy reforms need to consider the diverse needs and challenges of vulnerable populations, ensuring that no one is left behind in times of crisis.

# 6 Chapter Six: Conclusion

This conclusion chapter will summarise the key findings of this thesis and reflect on their significance. First, I will review the present research findings. Second, I will look at the significance of the study's findings, their implications, and recommendations for research on homelessness and government responses to public health crises. Finally, I will provide a short ending statement to summarise.

## 6.1 Research Review

The primary aim of this research was to explore the lived experiences of people in emergency housing or otherwise homeless, and the experiences of housing case workers who supported them during the Covid-19 pandemic. The study focused on the impacts of the Covid-19 pandemic measures and restrictions, specifically the lockdowns occurring in New Zealand from March 2020. A secondary aim was to understand how individuals experienced the Covid-19 pandemic within their individual sociocultural contexts, incorporating the perspectives of those experiencing homelessness and that of housing case workers working alongside people experiencing homelessness. The study utilised narrative analysis, an approach chosen for its ability to provide a deeper understanding of the intricacies of homelessness, when compared to a quantitative research approach. This study offered a nuanced understanding of the diverse effects of the Covid-19 pandemic and associated restrictions in New Zealand and offers insights into the lives of those experiencing homelessness during the pandemic.

## 6.2 Research Recommendations

The present study captured some of the immediate impacts of the Covid-19 pandemic and associated restrictions but also explored how these events intersected with the existing challenges faced by people experiencing homelessness and the professionals who support

them. Homelessness is often the result of intersecting societal and systemic issues such as lack of affordable housing, economic inequality and barriers to healthcare. These issues were amplified when the Covid-19 pandemic hit. For people experiencing homelessness, the Covid-19 pandemic caused further barriers to accessing essential services such as healthcare and social support networks, which caused increased vulnerabilities. Through the use of narrative analysis, the present study uncovered how homeless individuals handled these increased challenges, the coping strategies they used, and the barriers they faced in navigating access to essential services during the Covid-19 pandemic.

Implementing humanistic psychology principles alongside Māori principal practice within semi-structured interviews allowed for building rapport rapidly between the researcher and participants. Through approaching the interviews in a friendly, non-coercive or directing manner, the participants reciprocated; the conversation flowed naturally, and the participants became the lead actors in their own stories. This created the atmosphere for the participants to recount more vivid, unincumbered recollections of their story. Building these relationships is important in the context of homelessness research because there is already some distrust of authority and support services. When participants feel respected and heard, they are more likely to share the realities of their lived experiences, which provides researchers with more accurate information (Hodgetts et al., 2007). Through strengthening the lived experiences of the people directly affected by homelessness, narrative research can help inform policies driven by the realities and needs of these individuals and communities. It would be beneficial for further narrative research to explore how this community can best be supported during health crises like the Covid-19 pandemic.

## 6.3 Clinical Recommendations

The experiences evoked in this thesis underscore the urgent need for policies and interventions that ensure equitable access for homeless individuals during health crises such as the Covid-19 pandemic. The existing barriers to healthcare for people experiencing homelessness intensified because of the Covid-19 pandemic restrictions. The closure of in-person services and the shift to online platforms described by participants within this thesis were an example of the increased barriers to healthcare experienced during the Covid-19 pandemic. These underscore existing systemic inequalities in healthcare delivery, where people experiencing homelessness already face additional barriers to accessing healthcare (Scanlen, 2009). While the reliance on digital platforms for healthcare services was crucial for safety reasons during the height of the Covid-19 outbreak, this further widened the gap in access to care. Moving forward, addressing the existing issues requires a comprehensive approach. A more comprehensive approach could include increased funding for tailored healthcare services and initiatives that bridge the digital divide between social groups. Addressing digital access inequities would promote more equitable access to care for all individuals, especially those experiencing homelessness or living in social housing.

## 6.4 Final Comments

In conclusion, this thesis provides insights into the lived experiences of the Covid-19 pandemic for people experiencing homelessness or living in social housing and the case workers who support this community. I conducted semi-constructed interviews with participants about their experiences of the Covid-19 pandemic and its associated restrictions. The experiences participants shared in their interviews were analysed through a narrative lens and allowed for the acquisition of an understanding into the struggles and lived realities of

people living in emergency housing, homelessness, and those case workers who supported them during the Covid-19 pandemic.

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# Appendix A: Research Ethics Application

## *Research Ethics Application*

*Human Research Ethics Committee*
**TE WĀNANGA O NGĀ KETE**
**Division of Arts, Law, Psychology & Social Sciences**

Private Bag 3105
Hamilton 3240
Phone: +64 7 838 4080

E-mail: alpss-ethics@waikato.ac.nz

THE UNIVERSITY OF WAIKATO
*Te Whare Wānanga o Waikato*

***Before applying for approval applicants must familiarise themselves with the Ethical Conduct in Human Research and Related Activities Regulations in the University Calendar***
*http://calendar.waikato.ac.nz/assessment/ethicalConduct.html*.

Use this application if your research project involves the collection, use, and/or reuse of human data. This form is to be completed by staff and students doing research **prior to** the collection of any data from human participants.

Upon completion of this form please submit to/or email to your Faculty/School Human Research Ethics Committee [HREC]. Health Research and Health, Sport & Human Performance applications should be submitted to the central HREC (humanresearch@waikato.ac.nz).

## *Checklist*

**A positive answer to one or more of the questions below indicates the need for review by the HRC accredited Human Research Ethics Committee. Health Applications should be submitted by email to humanethics@waikato.ac.nz.**

☑ Are you investigating a topic that concerns health, disability or well-being?

☒ Are you using an instrument intended to assess health, disability or well-being?

☑ Is referral to a health service provider a potential outcome of participation?

☒ Are participants being recruited in their capacity as DHB employees?

☒ Is the researcher intending to collect tissue samples (e.g. bloods, saliva, urine) from healthy individuals?

☒ Is the researcher intending to utilize interventions related to exercise and nutrition?

**Submit this application form when the checklist and the Application Cover Sheet is complete and has been signed.**

☑ Personal details (on Application Cover Sheet)
☑ Academic Details (on Cover Sheet)
☑ Consent Form (attached)
☑ Signatures (where required)
☑ Information Sheet (attached)
☑ Research Instruments (attached)

# *Application Cover Sheet*

*Human Research Ethics Committee*
**TE WĀNANGA O NGĀ KETE**
**Division of Arts, Law, Psychology & Social Sciences**

Private Bag 3105
Hamilton 3240
Phone: +64 7 838 4080

E-mail: alpss-ethics@waikato.ac.nz

THE UNIVERSITY OF WAIKATO
*Te Whare Wānanga o Waikato*

| | |
|---|---|
| **Name of Principal Investigator**: | **Anthony Hall** |
| School / Faculty / Institute: | School of Psychology |
| Email address: | ash30@students.waikato.ac.nz |
| Phone number: | 021822977 |
| Office: | **N/A** |
| Student ID (if applicable): | 1241562 |
| Proposed start date of field research / data collection: | 1st August 2022 |
| This is an application for approval of: (please tick as many as apply) | ☒ Staff research project involving human participants<br>☑ Master's degree research<br>☒ PhD research<br>☒ Other |
| Name of degree / paper (if applicable): | Master of Social Sciences in Psychology |
| Supervisor's name (if applicable): | **Dr Ottilie Stolte** |
| Supervisor's approval (signature): |  |
| Funding sources: | **N/A** |
| Project sponsors (e.g. equipment sponsors): | **N/A** |
| Associated Applications (record the associated application code and title): | **N/A** |

☑ I request approval for this research or related activity and attach all relevant documentation necessary for evaluation under the Ethical Conduct in Human Research and Related Activities Regulations.
http://calendar.waikato.ac.nz/assessment/ethicalConduct.html

☑ I have read and complied with the University's Ethical Conduct in Human Research and Related Activities Regulations.

**Principal Investigator's signature:** 

**Date:** **04/05/2022**

# *Project Overview*

**Please provide us with basic information about your project.**

1. **Project Title:** Exploring the psychological impact of Covid-19 on whānau and individuals in social housing or experiencing homelessness

2. **Briefly state the research topic, research questions and/or research objectives.**

   The central aim of this research is to explore how the Covid-19 pandemic and associated lockdown measures in New Zealand have affected whānau and individuals living in social housing or experiencing homelessness.

   The following research questions will be explored to provide a holistic account of the experiences that whānau and individuals have had since the onset of the Covid-19 pandemic:
   - Exploring everyday experiences in social housing or homelessness before Covid-19 and associated lockdown measures (Pre-March 2020)
   - How life has changed with the onset of the Covid-19 lockdown measures for those living in social housing, motels or homeless.
   - An exploration of how whānau and individuals navigate social services, and what challenges may have risen under Covid-19 pandemic and associated lockdown measures.
   - Exploring personal experiences and accounts of how the Covid-19 pandemic and associated lockdown have impacted psychological wellbeing.
   - What does the future look like two years later with Covid-19 still within the community, and what are the implications of the pandemic on the psychological wellbeing of members of the community who are living in social housing or experiencing homelessness.

   To explore the research questions, interview participants will include both whānau and individuals who are either homeless or are living in social housing and keyworkers from social housing organisations who are working alongside clients who are experiencing homelessness or live in social housing. The purpose of interviewing these two differing positions of participants is to gain a wider perspective through gaining first-hand accounts of lived experiences, challenges and impacts that the Covid-19 pandemic has had on whānau and individuals living in social housing or experiencing homelessness, as well as gaining the perspectives of social housing keyworkers, their observations and understanding of the challenges experienced by their clients in social housing or experiencing homelessness during the Covid-19 pandemic.

   This masters thesis research is aligned with the objectives of a 5-year cross-institution MBIE-funded research project titled, 'Working to End Racial Oppression (WERO).' Although this thesis research is not being funded by WERO, I am being connected to the broader scholarly relationships that exist in the WERO project. This will allow for knowledge exchange, mentoring and collegial networks with other thesis students and scholars who have expertise on issues relevant to my research.

3. **What research activities are you planning to undertake?**

   Part 1
   - The Covid-19 pandemic is a recent and ongoing phenomenon worldwide. This researcher will be exploring current literature regarding Covid-19 and its effects on individuals and communities both nationally, and internationally.

   Part 2

- Keeping a private record of personal experiences and epiphanies relevant to the research topic as part of a critical reflexive methodological approach.

Part 3

- Conducting 3-4 semi structured interviews with participants who meet the criteria of 'living in social housing or currently homeless during the Covid-19 pandemic'.

- Conducting 3-4 semi structured interviews with participants who meet the criteria of 'working alongside clients who live in social housing or currently homeless during the Covid-19 pandemic'.

**4. To justify your project, provide a summary of the research, its methods, anticipated benefits, value and/or its contribution to the field.**

Secure housing for whānau and individuals is widely recognised in literature as being fundamental to healthy communities and provides a foundation for people to achieve citizen engagement, cooperation, and wellbeing. This premise is acknowledged worldwide with Evan Siddall, president of Canada's Mortgage and Housing Corporation succinctly stating:

> "Safe, adequate and affordable housing is a catalyst that enables Canadians to achieve other goals – from raising healthy children to pursuing education, jobs and opportunity. When affordable housing is in short supply, Canada's whole economy suffers"

Access to secure housing not only affects the health and wellbeing of citizens, but may also have an impact on a nation's economy. The housing and health guidelines explain that poor health outcomes, due to people living in insecure housing, often results in financial difficulty. Contextually, when communities have a significant number of citizens without secure housing: "This creates a cycle between poor health and household, local and national economic outcomes" (World Health Organization, 2018, p. 11)

In the context of Aotearoa New Zealand, one indicator of the prevalence of individuals and whānau struggling with housing insecurity is the number of applicants on the New Zealand Social Housing Register. As of January 2022, the Government Housing Dashboard showed an increase of 9,578 applicants on the register since March 2020, with more than half of these applicants added to the register in the period of March 2020 and September 2020. A possible contributor to the increase in individuals and whānau requiring social housing and/or experiencing homelessness in New Zealand is the Covid-19 pandemic, and the associated lockdown measures first implemented in March 2020.

The Labour government re-elected in 2020 took immediate action to restrict the spread of Covid-19 implementing the first lockdown level measures, which at its highest level (four), greatly restricted a community member's ability to find and move into housing. These new governmental restrictions included a prohibition of non-essential travel and business activities including heavy restrictions on private accommodation, social housing, and other tenancy movements (New Zealand Government, 2022b). The lockdown restrictions affected stakeholders in the housing and rental space with tenants not being able to move from, to, or between homes. NGOs and social housing providers working within lockdown restrictions had to get special authority from the government. In most cases, citizens housed, or homeless, had to wait for those measures to be lifted or modified to allow movement under the lockdown protocols. A study on the impacts of Covid-19 on Māori in Tāmaki Makarau (Auckland) found that not only were Māori disproportionately impacted by Covid-19 lockdowns in the areas of labour constraints and job losses, but Māori were also overrepresented in data for Emergency Housing Special Needs Grants (Independent Māori Statutory Board, 2021). Such studies have shown that Covid-19 has impacted movement in housing markets, and economic effects for populations including Māori. However, the effects of Covid-19 on the mental health and wellbeing of people in social housing, or those who are homeless, is less well known

An argument can be made that there is a need to address and understand the effects of the Covid-19 pandemic on vulnerable or marginalised populations here in Aotearoa New Zealand.

As there is only a small amount of research on the effects of the Covid-19 pandemic on vulnerable populations here in New Zealand, it would be appropriate to investigate how this pandemic has affected whānau or individuals in social housing and/or are homeless in New Zealand. As such, an in-depth investigation into the psychological effects of Covid-19 on whānau and individuals in social housing or experiencing homelessness will be completed.

Methodology

A case study approach will be implemented conducting 3-4 semi-structured interviews with 4-8 participants to cover a range of research questions. Case studies have been a useful methodology in researching homelessness and other minority populations. A case study can provide a deeper level of understanding and meaning by studying a small number of individuals' experiences, as opposed to studying a larger number of individuals, with less depth. As Gerring (2007) summarises, "sometimes, in-depth knowledge of an individual example is more helpful than fleeting knowledge about a larger number of examples. We gain better understanding of the whole by focusing on a key part." (p.1). Participants who could be included in this study will be between the ages of 18-65 years and be either in social housing or currently homeless. A second group of participants will include social housing service providers frontline staff/keyworkers working alongside whānau and individuals who are either homeless or in social housing. The potential study participants will be approached through social housing organisations throughout Hamilton, New Zealand. These include and are not limited to, LinkPeople - Ahikaroa, The People's Project, Emerge Aotearoa, and Te Rūnanga o Kirikiriroa, Kāinga Ora, and the Ministry of Social Development. Statistics suggest that 50% of the population in social housing self-identify as Māori with the other 50% being made up of either NZ European, Pacifica, or other (Ministry of Social Development, 2021). The recruitment process will endeavour to take into consideration these demographical statistics and seek to adopt recruitment strategies to ensure the inclusion of relevant demographics in this research. To further complement the research gathered through case studies on whānau and individuals within social housing or homeless, a critical reflexivity section will be provided within the methodology. This will draw on my own working experiences and observations having been involved in the field as a housing case worker.

Benefits and Implications of Research

The potential future implications for this research are the development of knowledge, ideas, and processes around how frontline staff and clinicians from social services and health providers can better respond to the needs of whānau and individuals who are either homeless or in social housing during this Covid-19 pandemic. By understanding the needs of whānau and individuals, services can develop more robust levels of support toward flourishing. The outcomes of this research could potentially be used to inform processes in workplaces, governmental or NGO, that are involved in social housing, or work with homeless populations which might improve the psychological wellbeing and outcomes for whānau in social housing, and those experiencing homelessness in Aotearoa New Zealand.

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# *The Researcher(s)*

**Please tell us about your research team.**

5. **List all members of the research team and briefly describe their roles within the research project:**

    - Anthony Hall – principal investigator.
        - Role: Complete the research project. This includes planning, research, data collection, and analysis of the results.
    - Dr Ottilie Stolte – supervisor.
        - Role: To supervise and provide guidance for the research project and share knowledge and expertise in the field of community psychology.
    - Dr Mohi Rua – supervisor.
        - Role: To supervise and provide guidance for the research project and share knowledge and expertise in the field of community psychology.

6. **Outline your qualifications to undertake this research. Include such things as prior experience, training in relevant research methods, and/or personal knowledge of the subject.**

    Anthony Hall is a post graduate student undertaking a master's degree in social sciences in psychology at the University of Waikato. Previously, Anthony has completed an undergraduate degree in psychology, and subsequent honour's degree in psychology researching Stigma & Whakamā: Perceptions of Mental Health Barriers at University & How This Affects Disability Support Services. Additionally, Anthony has completed a level 4 Tikanga Māori paper through Te Wānanga o Aotearoa and volunteered at Lifeline as a phone counselor. Anthony currently works within the social housing and homelessness sector supporting whānau and individuals in accessing social housing and supporting sustainment of tenancy. Prior to this role, Anthony worked at the University of Waikato as a disability advisor providing support services to students presenting with both mental and physical disability.

7. **What, if any, discipline-specific codes of ethics or professional standards will guide your research?**

    This research project will be guided by the Code of Ethics for Psychologists Working in Aotearoa/New Zealand (reference: https://www.psychology.org.nz/journal-archive/code-of-ethics.pdf) and the University of Waikato Ethical Conduct in Human Research and Related Activities Regulations 2008 (reference: https://calendar.waikato.ac.nz/research-assessment-graduation/ethical-conduct).

# *The Participants*

**Please provide the following information about your participants:**

8. **Broadly, who will they be? (Indicate the population, not the names of participants)**

    - Persons aged 18 years to 65 years who are either currently homeless, or live in social housing during, and current, in the Covid-19 pandemic.
    - Social housing keyworkers who were working alongside whānau and individuals experiencing homeless or are in social housing during the Covid-19 pandemic.

9. **How many participants will there be? Provide an estimate if you are unsure of exact numbers.**

    An estimate of 4-8 participants will be preferred for this case study approach.

10. **How will you recruit participants? Summarise your process.**

    I intend to approach organisations in Hamilton, New Zealand, who work alongside individuals and whānau either currently homeless or living within social housing. After receiving consent from those organisations, I will approach key workers who support potential participants. I will enquire with keyworkers to identify persons who fit the criteria of experiencing homelessness and/or living in social housing during the Covid-19 pandemic and associated lockdown measures. Once potential participants are identified, the keyworker can approach and offer the opportunity to participate in the research, and with that gain consent for those potential participants to be contacted. Additionally, keyworkers will also be asked whether they would be a participant themselves in a case study.

    **How will you inform them about the project and their part in it? Summarise your process.**

    The attached information sheet will be supplied to each participant. The research project and the participant's part in it will be discussed in detail in an initial hui before formal interviewing would occur. The participant will have many opportunities to ask questions about the project, the process, and their involvement, and the researcher will seek to provide clarification where required. Sufficient time will be provided to each participant to consider their involvement in the project.

    See Appendix #1 for participant information sheet.

    ***Attach** a copy of the information sheets for participants. Ensure that the content of the information sheet is written in language suited to the relevant participants. See a sample information sheet and guidelines **here**.*

    ***Attach** a copy of any recruitment emails, posts, posters or similar.*

    **Are the participants vulnerable?**
    [See *Section 2.3 Vulnerable Participants*, *Section 8.3 Ethical considerations when working with children*, and *Section 8.5 Ethical considerations around the disclosure of illegal behaviours through research* for guidance].
    **If yes, then**
        **In what ways are they vulnerable?**
        **Why do you need to involve them in your research?**
        **How will you protect them from harm?**

    There is a possibility that some participants may be considered 'vulnerable' under Section 2.3 Vulnerable Participants, as some participants may present with mental illness. This is not a

prerequisite for participation in the research but may be a coincidental occurrence within the target research group. The University of Waikato HREC Guidelines for Researchers will be used to protect participants from harm, by adhering to disclosure requirements for immediate threats to the public or individuals. The researcher will seek advice from the research supervisors if any such situation arises.

**11. Will you select participants on the basis of their ethnicity, iwi, culture, gender, sexuality, religion, ethical belief or disability?**
**If YES, then specify the basis for selection, and state how you will tell participants about the selection criteria.**

Not specifically. The participants will be selected based on their suitability within the research context.

**Are your participants likely to be from a particular ethnic group or other distinct population even if you are not selecting them on that basis?**

Yes. Statistics released by the Ministry of Social Development 2021 suggests that 50% of the applicants on the New Zealand Housing Register are of Māori ethnicity. Therefore, the likelihood of potential participants being of Māori ethnicity is higher than other ethnic groups as they are over-represented in the homeless population.

**What cultural and other competencies do you have to work with your selected participant group (e.g. language, membership, professional training)?**

As Māori are represented as having the highest number of applicants on the New Zealand housing register, it will be likely that at least one of the participants may be of Māori heritage. This researcher has worked alongside Māori as a disability advisor at the University of Waikato, and a housing case worker in current employment with [redacted] This researcher has completed papers such as PSYCH575 – Indigenous Psychologies and a level 4 Tikanga Māori paper through the Te Wānanga o Aotearoa and understands the importance of whakawhānaungatanga in relationship building, and its sustainment. My experience and ongoing training in how to work with ethnicities in a culturally competent manner have led to the development of cultural competency when working both with Māori and other vulnerable populations in New Zealand.

**12. Do you have any type of relationship with your participants already (e.g. employer/employee, supervisor/worker, personal relationship)?**
**If yes, then you will have a dual role in the research, both as researcher and, for example, as friend or family member. How will your pre-existing relationship affect your role as a researcher? Consider potential ethical issues associated with your pre-existing relationship. How will you address these issues in your project?**

No. As an employee of an NGO working with whānau and individuals who are either currently homeless, or in social housing, there may be a small overlap where potential participants may have met the researcher briefly as part of their journey to secure housing with [redacted]

**13. Will participants receive any form of compensation or incentive for participation? (See guidelines on compensation, and note that reimbursement for travel expenses can be stated, but does not need justification.)**
**If yes, what will they receive? (e.g. vouchers, prizes, shared refreshments, course credits etc.)**

Yes. Food and beverages will be offered during huis as part of being the host of the event and building whakawhānaungatanga through respectful inclusive actions. A small Koha in the form of a gift voucher will be offered to participants as a thank you at the end of the interview sessions.

# *Consent*

**Please provide the following information about consent processes**

14. **How will you gain informed consent from your participants?**
    **Who will gain consent from participants? Note that where dual roles exist (Q.12 above), coercion to participate may be avoided by asking a third party to undertake the informed consent process.**
    **When will participants give their consent?**
    **How will you record their consent?**

    Each participant will be provided with an information sheet outlining the details of the research project. Prior to any research taking place, the researcher will meet with the participant to discuss the research project and the participant's role in it and answer any questions they may have. The participant will have the opportunity to consider their involvement and either agree or decline. A consent form will be provided and completed by the participant.

    See Appendix #2 for participant consent form.

    ***Attach** a copy of the consent forms for participants. If you intend to seek oral consent, include a procedure sheet to describe the process by which consent will be negotiated.*

    **If vulnerable, are your participants able to give informed consent?** [See Section 2.3 Vulnerable Participants *for guidance*.]
    **If no, then:**
    **How will you obtain consent from their proxy?**
    **What steps will you take to ensure that their participation is voluntary at all times?**

    Yes. The participants will be over the age of 18 years old and able to give their own informed consent.

15. **With the exception of participants who are anonymous to the researcher, participants have the right to withdraw entirely or in part from the research. Please provide the following information:**
    **How long will participants have to withdraw? (e.g. three weeks after data collection, or receipt of a transcript)**

    A participant can withdraw from the research project at any time up to three weeks after the final interview has taken place. If the participant wishes to withdraw from the project, they will be asked whether they will allow the researcher to use the data already collected prior to withdrawal.

    **How will they withdraw? (e.g. by informing the researcher)**

    Participants may withdraw from the research by contacting the researcher (or the supervisors) through the contact details provided on the information sheet and communicating their desire to cease participation.

16. **Data collection activities may be planned for off-campus locations. Please list all off-campus location where you will engage in data collection.**

    All locations for interviews with participants will be agreed upon prior to the interview. This will be a location that provides privacy and is safe and comfortable for both the researcher and the participant. Such locations may include the home of the participant, public spaces with

quiet, private areas such as libraries, or bookable rooms within organisations providing relevant support services.

17. **Do you need consent or permission from any organisation, community representative, or anyone other than the individual participants?**
**If yes, list all the required permissions, consents, or approvals.**
**How and when will you gain these?**

Recruitment of participants from within the [redacted] has been approved [redacted]

***Attach*** *any statements, letters, or emails of permission or approval that have been secured in advance of your application to the Human Research Ethics Committee.*

## *Research design*

**Please tell us about what you will be asking your participants to do.**

18. **What will participants be doing?**
**How long will each activity take?**
**Please provide these details for all of the items on your list in Q.3.**

Participants will be asked to have a series of hui being interviewed qualitatively using semi-structured interviews over approximately 3-4 sessions. During these sessions, participants will be asked to discuss their lived and observed experiences of the effects of the Covid-19 pandemic when living in social housing or experiencing homelessness. Each interview will be scheduled to take around 60-90 minutes This time will be appropriately flexible depending on the participants' needs and breaks are able to happen over this time with a debrief at the end if required.

See Appendix #3 for researcher interview guide.

***Attach*** *all research instruments that you intend to use to collect data. (e.g. interview schedules, questionnaire/survey items). Indicate whether the research instruments are drafts or final versions. The final versions of research instruments must be lodged with the committee prior to data collection.*

19. **How will participants benefit from their involvement in the research?**

Participants may benefit from the discussion aspect of the research. For example, the therapeutic implication of feeling like you are being heard and acknowledged, that their experiences and stories matter.

The research may also help in the application of, and decisions made as policy by governmental agencies as well as NGOs, which would impact participants' opportunities and possibilities moving forward in the social housing and tenancy sector.

20. **Could participants be harmed in your research? [see Section 2 for guidance.]**
**If YES, please describe all potential harms to your participants.**

Potential emotional distress when discussing difficult subjects, such as the negative impacts of the Covid-19 pandemic.

**How will you minimize the risk of these harms occurring?**

- Participants will be made fully aware of the topics of discussion before each interview. Having time to prepare for discussion topics prior to the interviews will allow participants to reflect on their experiences in their own time. This method will reduce distress when discussing potentially negative experiences which occurred since the March 2020 New Zealand Covid-19 outbreak and associated lockdowns.
- Participants will also be reminded of confidentiality during the research period and research findings using pseudonyms. Reducing the risk of them being identified may reduce potential distress.
- During the interview process, participants will have the option of bringing a suitable support person, as well as pausing or ending the session at any time if needed.
- Throughout the interview process, the researcher will be aware of and evaluate the participant's affect and respond accordingly to any emotional distress that may occur – appropriate responses to distress might include taking a break from the interview, ending the session completely, or getting in touch with their key supports.
- The researcher will also avoid engagement with participants who present severely unwell to minimise risk of causing additional distress and harm to participants' mental health. This may include rescheduling hui, ending current hui by excusing oneself, or ending communication permanently.

**What will you do if a participant is harmed?**

If a participant is harmed in any way, the interview will end, and the researcher will take appropriate steps to support the participant. This may include taking a break before resuming the interview (if possible), ending the current interview and rescheduling another time, or ending research participation completely. Other steps may include encouraging the participant to access support services or their current keyworkers if participant if supported by the DHB. Additionally, encouraging reaching out to their personal support systems, such as family and friends would help limit potential harm.

**Is it likely that concerns could arise regarding the health and wellbeing of your participants, through their participation in your project? How will this be managed?**

If the researcher becomes concerned about the health and wellbeing of a participant during the interview process, I will be guided by the University of Waikato HREC Guidelines for Researchers. This legally requires a researcher to disclose any immediate threats either to the public or participant to an appropriate regulatory service.

**21. How will you analyse the data that you collect from your participants?**

Data will be collected through interviews with participants, and these interviews will be analysed using a case study analytical approach. Case study analysis has been a widely used method of inquiry in similar research projects on vulnerable populations. This type of analysis highlights each participant's unique experiences within the larger societal phenomena of the Covid-19 Pandemic

**22. Will your research involve comparing one group to another? [suggest moving up to Q.11]**
**If yes, then, explain how the comparison will be done.**
**How are the participants categorized into specific groups?**
**Why is it important to do this?**

No.

**23. Does your research involve any deception of participants?**
**If yes, then describe the deception.**

**Why is it necessary to deceive participants? How and when will participants be told of the deception?**

No.

24. **Will the true identity of the researcher(s) be concealed from participants at any time during the researcher? (Such research is called 'covert research'.)**
**If yes, then describe the concealment.**
**Why is it necessary?**
**How and when will participants be told of the concealment?**
**If never, then, explain why the concealment will not be disclosed to participants.**

No.

## *Cultural safety*

Te Whare Wānanga o Waikato, the University of Waikato, through its official *Charter,* has an explicit commitment to partnership with Māori, to kaupapa and tikanga Māori, and to the interests of New Zealand-born and Island-born Pacific people.

Through the *Ethical Conduct and Human Research and Related Activities Regulations*, researchers are required to respect the **cultural, social** and **language preferences** and **sensitivities** of participants. When applying for ethical approval, researchers should demonstrate an awareness of social and cultural difference, consult advisors regarding the appropriate conduct of their research, and present the outcome of consultation in their ethics application.

Two resources that are particularly relevant to research at the University of Waikato are *Te Ara Tika – Guidelines for Māori Research Ethics* and the *Pacific Health Research Guidelines.*

25. **Does the research project have particular relevance or potential implications for Māori, or for other social and cultural groups?**
**If YES, then please provide the following information about your consultation processes.**
**Who are the stakeholders? (That is, whom do you have to consult?)**
**What are the results of your consultation with them so far? (e.g. advice taken on appropriate procedures and approaches to research, decisions made about appropriate ways to return research findings)**
**Do you have at least one cultural advisor for this project? Please provide their name(s) and specific role(s).**

Yes. Statistics released by the Ministry of Social Development 2021 suggests that 50% of the applicants on the New Zealand Housing Register are of Māori ethnicity. The potential implications for Māori are unknown at this stage, as we cannot accurately predict participant demographics, and the outcomes of the research. However, if implications do arise and a further level of cultural competency is required, I can draw from the expertise of one of the supervisors Dr Mohi Rua as a cultural advisor in the application of kaupapa and tikanga Māori. Additionally, Dr Waikaremoana Waitoki who is Principal Investigator for the Working to End Racial Oppression (WERO) project will also act as a cultural advisor.

26. **Describe how you will show respect and sensitivity towards participants (e.g. having support persons present during interviews, having an interpreter if you are not fluent**

**in the language, being vouched for by elders, using appropriate gestures, dressing inoffensively, or participating in cultural ceremonies or rituals).**

The hui and information collected as part of the interview process will be conducted in such a manner where a particular focus on participant wellness is prioritised. Each participant will have a role in determining meeting times and locations to ensure they feel as relaxed, comfortable, and safe.

The researcher will ensure that the participant is able to voice any concerns throughout the interview process regarding unsettling content, or elicited distress due to the discussion topics or relived memories. Participants will have the option to not answer questions they are uncomfortable in sharing or end the session if their distress is becoming unmanageable.

The option of a support person being present will also be made available and discussed as part of the initial hui and information resources. Additionally, the option of having a support person join them in the hui will be reminded before each interview time as being a genuine option they can consider.

**27. How will the identities of participants (and their communities and/or organisations where relevant) be represented in the research?**

During the first hui participants will have the opportunity to choose a pseudonym to be used to represent them in the research. Additionally, identifiers such as family, friends, and key workers, will not have their names used to preserve confidentiality. Birthmarks, scars or identifying tattoos will not be detailed in a way that may jeopardise the participants' confidentiality.

Any organisations involved in the research will not be specifically named unless they choose so as part of an agreement, but the research will describe the scope of services they provide and how this is relevant to the research.

**28. Is it important to maintain the confidentiality of participants (and their communities/organisations where relevant) in the research reporting?**

Yes

**If YES, how will you preserve confidentiality?**

All participant names will likely be changed to pseudonyms, chosen either by the participant or the researcher. Participants will have the opportunity to decide what, if any, other details they are comfortable with sharing in the research, such as age (specific or approximate), gender, and ethnicity. Other identifying information will be eliminated or appropriately modified to ensure that participants cannot be identified. Names and identifying details of specific organisations involved will not be stated unless agreed upon as part of an agreement. If any participants request the inclusion of any identifying information, the implications will be clearly explained. The researcher will enact caution with such requests and consult with the supervisors.

All collected data and any associated documents, such as transcripts, will be stored securely on a password-protected computer and backup system only accessible by the researcher.

**29. In addition to the lead researcher(s), who else will see information provided by the participants? Will any of the shared information be linked to the participants' names, or will it be anonymised before sharing?**

***It may be appropriate to ask additional parties (e.g. student researchers, transcribers) to sign a confidentiality agreement. Attach the confidentiality agreement that you intend to use.***

In addition to myself as the lead researcher, only the supervisors Dr Ottilie Stolte and Dr Mohi Rua may have access to information provided by participants. Any information shared will be anonymised and identifying information will not be included.
No additional parties, such as student researchers or transcribers, will be involved in this research project.

**30. How and where will the data be stored and protected during the research project?**

The data will be stored on the researcher's password-protected and physically secure computer and backed up on the Google Drive facility provided by the University of Waikato.

## *Research Reporting*

**31. List all the anticipated research outputs for the project (e.g. thesis, conference papers, journal articles, other sorts of presentation, book, media release, pedagogic materials).**

- A Master's thesis for submission to the University of Waikato
- Potential journal publication
- Presentation of findings to stakeholders and/or at conferences

**32. What provision is there to provide participants with information about the outcomes of the research?**

The participants will be informed that they are able to request a copy of the research findings if desired, which will be provided at the completion of the research project. Alternatively, participants will be notified that the completed thesis will be available on the Waikato Research Commons website.

**33. Research data must be stored for a minimum of 5 years after the completion of a research project.**
**Where and how will you store your data after the project has been completed? (Supervisors are responsible for storing research data on behalf of their students.)**
**If archiving is appropriate for your project data, where will you archive the data and under what conditions?**
**If you do not intend to store your data indefinitely, how will you ensure that your data is safely destroyed?**

The primary supervisor, Dr Ottilie Stolte, will be responsible for storing the data in a secure server at the University of Waikato, after the project has been completed. No physical data will be stored by either the researcher or supervisor, with any physical data left after completion of research being disposed of via confidential shredding. Dr Ottilie Stolte will be responsible for deleting stored data from the secure server five years after project completion.

## *Legal Issues*

**34. Ownership of Human Research Data**
**It is usual to state that participants own the data that they provide, and that the researcher will use the data for the specified purposes, with the consent of participants. Please explain any variation from this arrangement.**

No variation from this arrangement.

35. **Copyright**
**The researcher's ownership of scholarly publications and other forms of research outputs is governed by the University of Waikato's Intellectual Property Rights Policy. Crucially the policy states in Clause 8 that*, "the University recognises and endorses the traditional academic freedom of staff to publish research and scholarly documents and to produce creative and artistic works without restriction; the University does not assert ownership of copyright of such works (e.g. books, journal articles, conference papers, art works and musical recordings) unless specified in clauses 12-18 of [the] policy."***
**Please explain any variation from this policy.**

No variation from this policy.

**Clause 9 states that, *"When dealing with intellectual property that includes Mātauranga Māori, and in the context of the WAI262 claim report, the principles of Te Tiriti o Waitangi will be applied by the University".* Please indicate if intellectual property is subject to the principles of Te Tiriti o Waitangi.**

No.

36. **Other legal or ethical issues**
**Describe any other legal or ethical issues related to this project. Consider particularly relationships between members of the research team, and project funders, sponsors, or other stakeholders.**

No other legal or ethical issues.

# Appendix B: Participant Interview Information Sheet

*Appendix #1*

**Participant Interview Information Sheet**

**Project title:** Exploring the psychological impact of Covid-19 on whānau and individuals in social housing or experiencing homelessness.

**Purpose and outcome**: The purpose of this research project is to gain a holistic view of how the Covid-19 pandemic and associated lockdown measures in New Zealand have affected whānau and individuals living in social housing or otherwise homeless. This research will be used in producing a Masters thesis.

**Participant's role:** Each research participant will take part in approximately 3 interviews, which will be held at private, safe and comfortable locations. Each interview will be recorded by the researcher and may take up to 60 to 90 minutes; however, the length of interviews can be flexible to suit the participants' needs. A range of topics will be discussed throughout the interviews, and the participants will be made aware of upcoming topics to have time to consider their responses. All participants' identities will remain confidential and no identifying information will be included in the thesis.

**Interview topics:** The interviews will explore a range of topics related to the Covid-19 pandemic. This may include:

- Exploring everyday experiences in social housing or homelessness before Covid-19 and associated lockdown measures (Pre-March 2020)
- How life changed with the onset of the Covid-19 lockdown measures for those living in social housing, motels or homeless.
- An exploration of how whānau and individuals navigated social services, and what challenges may have risen under Covid-19 pandemic and associated lockdown measures.
- Exploring individual experiences and beliefs of how Covid-19 and associated lockdown have impacted psychological wellbeing.
- What does the future look like two years later with Covid-19 still within the community, and what does moving forward look like to members of the community either in social housing or homeless.

**Your rights:**

1. The right to decline to answer any question(s).
2. The right to end the interview at any time.
3. The right to withdraw from the research process up to three weeks after the final interview.
4. The right to ask questions about the research during participation.
5. The right to have your identity remain confidential.

**Information collection procedure:** All information collected during the interview process will be securely stored on password-protected servers at the University of Waikato after completion of the project and will be destroyed after 5 years.

**Support contacts:**

- Lifeline – 0800 543 354 or TEXT 4357 (HELP)
- Depression Helpline (24/7) – 0800 111 757
- Adult Community Mental Health Services – 07 834 6902
- Crisis Assessment and Home Treatment Team (CAHT Team) – 0800 50 50 50
- Need to Talk? – Free call or TEXT 1737

**If you have any questions or concerns, please contact:**

Anthony Hall (Principal Researcher): ash30@waikato.students.ac.nz
Dr Ottilie Stolte (Supervisor): ottilie@waikato.ac.nz

*This research project has been approved by the Human Research Ethics Committee of the Division of Arts, Law, Psychology & Social Sciences. Any questions about the ethical conduct of this research may be sent to the Secretary of the Committee, email alpss-ethics@waikato.ac.nz , postal address, Division of Arts, Law, Psychology and Social Sciences , University of Waikato, Te Whare Wananga o Waikato, Private Bag 3105, Hamilton 3240.*

# Appendix C: Participant Consent Form

*Appendix #2*

UNIVERSITY OF WAIKATO
Division of Arts, Law, Psychology & Social Sciences

**PARTICIPANT CONSENT FORM**

**Name of person interviewed:** _____

I have received a copy of the Information Sheet describing the research project. Any questions that I have, relating to the research, have been answered to my satisfaction. I understand that I can ask further questions about the research at any time during my participation, and that I can withdraw my participation at any time up to three weeks after the final interview.

During the interview(s), I understand that I do not have to answer questions unless I am happy to talk about the topic. I can stop the interview at any time, and I can ask to have the recording device turned off at any time.

When I sign this consent form, I will retain ownership of my interview, but I give consent for the researcher to use the interview for the purposes of the research outlined in the Information Sheet. I understand that my identity will remain confidential in the presentation of the research findings.

| **Please complete the following checklist. Tick [✓] the appropriate box for each point.** | **YES** | **NO** |
|---|---|---|
| I consent to have interviews recorded for the purposes of this research | | |
| I wish to view a transcript of the interview(s). | | |
| I wish to receive a copy of the findings after completion of the research project. | | |
| I wish to have a support person present at each interview. | | |
| I would like to use a pseudonym to have my identity remain confidential in the presentation of the research findings.<br>If yes, I would like to use the name: _____ | | |

| | | | |
|---|---|---|---|
| Participant : | _____ | Researcher : | _____ |
| Signature : | _____ | Signature : | _____ |
| Date : | _____ | Date : | _____ |
| Contact Details : | _____ | Contact Details : | _____ |
| | _____ | | _____ |
| | _____ | | _____ |

# Appendix D: Interview Guide - Draft

*Appendix #3*

**Interview Guide - Draft**

**Interview 1**
The main objective of the first interview will be to introduce the research project and its purpose to the participant and ensure they are fully aware of the nature of their participation. The participant will be able to ask questions or clarification around any concerns they may have. There will be a discussion outlining the general topics that will be covered throughout the interviews.
Topics to be covered in interview 1 include:

- Life and experiences of the participants before the pandemic and lockdowns
- The impacts of the first lockdown measures implemented in March 2020

**Interview 2**
Following on from interview 1, the topics of interview 2 will include:

- The ongoing effects of the pandemic and repeated lockdowns and isolation requirements
- How whānau and individuals navigated social services, and what challenges may have risen because of the health measures imposed to prevent the spread of Covid-19 (lockdowns, isolation, mask requirements, vaccine passes etc.)
- Exploring individual experiences and beliefs of how Covid-19 and associated lockdowns have impacted psychological wellbeing

**Interview 3**
This may be final interview, depending on how the previous interviews have progressed. Topics will likely conclude with the following:
What does the future look like two years later with Covid-19 still within the community, and what does moving forward look like to members of the community either in social housing or homeless.

- Any other topics the participant may wish to discuss

**The overall structure of each interview will be as follows:**

- Casual greetings and/or small talk to help both researcher and participant ease into the environment and situation. This will include making sure the participant is comfortable, feels safe and feels able to take part in the interview at that time.
- An overview of the topics to be discussed during this interview will be briefly outlined.
- Each topic will be discussed, with a semi-structured approach to questions being utilised. This will involve asking open-ended questions and allowing the participant to elaborate at their discretion. Follow up questions may be asked, and these will flow organically from the participant's answers.
- At the conclusion of the interview, the researcher will 'check in' with the participant to discuss how the interview went, ask for any feedback or further questions, and ensure the wellbeing of the participant.
- The researcher will ask if the participant is willing to continue in the process. If they are, then the researcher will briefly discuss the topics that will be included in the next interview.