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**Lost Points of Intervention in Pathways to
Single Adult Homelessness in Hamilton, New Zealand.**

A thesis
submitted in fulfilment
of the requirements for the degree
of
Doctor of Philosophy in Social Science
at
The University of Waikato
by
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THE UNIVERSITY OF
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Abstract

Homelessness is a serious problem in New Zealand, with many social, health, human rights, and economic ramifications. Despite a broad consensus in international literature about contributing factors which raise the risk of homelessness, many misconceptions still remain about which specific factors contribute to homelessness in New Zealand. This is in part because of limited research in this context. Many policy responses to homelessness in New Zealand focus on a person's need for adequate housing as this is the prime presenting issue. However, people often have complex existing background issues that also contributed, and these are equally important targets for policy responses to homelessness.

Those who are single adults, without dependent children and homeless are often those found living in the most precarious circumstances. This cohort were the focus of this research. The objectives of this research were to determine pathways to single adult homelessness in Hamilton, New Zealand and to consider what other contributing factors and trigger events raised the risk of single adult homelessness. Robust objective quantitative and qualitative research into these contributors and triggers of homelessness is necessary to improve homelessness intervention. Further, recommendations about points of intervention were sought from those with the most knowledge about homelessness, those with lived experience.

This research included structured questionnaires completed with 100 participants who were program participants engaged with a homeless service in Hamilton, New Zealand. Additional detailed qualitative narrative was collected by semi-structured interviews with 11 participants. One-on-one feedback interviews were conducted with six participants. A mixed method approach netted a rich and diverse body of data about single adult homelessness in Hamilton and provided for the collection of robust evidence about important points and means of intervention and prevention.

Although everyone's circumstances were unique, results revealed a series of commonly occurring disruptive events throughout participants' lifetimes. A very high prevalence of adverse childhood events had resulted in an early exit from home for most participants, and time spent in state care. Instability in childhood had led to disruption, or exclusion, from schooling. Early disruption of social networks resulted in participants being isolated from natural familial and kinship support at critical points. Problematic substance use and mental health issues were common, often resulting in early institutionalization. These health and wellbeing issues had lifelong effects.

Structural issues exacerbated circumstances for people. Participants lacked access to safe, affordable single-person private rental and public housing. Additionally, people experienced discrimination in

their efforts to find housing. Participants had constrained incomes, most receiving welfare support, which further limited housing options in time of crisis. Many had high debt, particularly owed to government departments. Participants who sustained active relationships with government agencies and other organizations did not find these relationships to be a protective factor against homelessness. People sought the help of a homeless service because they felt they had nowhere else to turn.

Participants' recommendations provided important implications for policy responses to homelessness. A targeted reduction in family violence was advocated as a prevention opportunity. Detecting, and supporting, those who have survived adverse childhood events was also seen as a critical point of intervention. Trauma-informed approaches to social sector support would help reduce negative assumptions and victim blaming. Social sectors were also described as needing to be supported to eliminate discrimination.

Additional measures were advocated to prevent formerly homeless individuals returning to homelessness. This included support to facilitate access to a home (not a room), with comprehensive support to help people maintain this tenancy. Support to attend to background issues was also advocated. Facilitated access to work (where desired) was recommended as one mechanism to help reduce high levels of debt, particularly institutional debt. The absence of important familial and kinship networks to help provide support to access housing and other resources at critical points was a key factor participants identified as raising the risk of them becoming homeless. Therefore, alternative support mechanisms, such as homeless services like The People's Project, were advocated.

Statement of intellectual ownership

This thesis is an original work by Carole McMinn. Ethics approval was granted from the University of Waikato Human Research Ethics Committee on the 29th of January 2019 (ref: UoW HREC (Health) 2018#73).

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With heartfelt thanks I acknowledge the 100 men and women connected with The People's Project; Hamilton, who willingly shared their stories with me. Most did so to help others avoid this wholly unsafe, unhealthy, and dehumanising experience.

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Lastly, this research is dedicated to David, Neha, Paul, Betty, Rangitahi, and Buddy, six participants who have since died. It is for them, for the other 94 participants in this research, and for the over 3000 men and women who find themselves rough sleeping, living in cars or places not meant for human habitation each night in New Zealand, that this research needs to count for something.

Self-care note: This research includes discussion about physical, sexual, and emotional abuse, neglect, domestic violence, suicidality, self-harming, and other adverse and traumatic life experiences. If you are struggling with any of these issues, please consider if reading this thesis is right for you at this time.

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Abbreviations

ACC	Accident Compensation Corporation
ACE	Adverse Childhood Experience
AS	Accommodation Supplement
CYFS	Child, Youth and Family Service (former name for child protection services, now OT)
DHB	District Health Board
HCC	Hamilton City Council
HNZ	Housing New Zealand Corporation – Now known as Kāinga Ora – Homes and Communities
HF	Housing First
IRRS	Income Related Rent Subsidy
KO	Kāinga Ora – Homes and Communities (formerly Housing New Zealand Corporation)
MEH	Multiple Exclusion Homelessness
MHUD	Ministry of Housing and Urban Development
MoJ	Ministry of Justice
MSD	Ministry of Social Development
OT	Oranga Tamariki/Ministry of Children
TPP	The People’s Project
TAS	Temporary Additional Support
WINZ	Work and Income New Zealand (note – this acronym is no longer used by this government department, but its clients still commonly refer to this organisation by this abbreviation).

Glossary

Definitions were obtained via Te Aka Online Māori Dictionary (Moorfield, 2003).

Te Reo/Indigenous Language Used

Aotearoa	New Zealand
Aroha	Love, affection, compassion
Hapū	Kinship group, sub-tribe. A social unit made up of whānau
Iwi	Tribe, extended kinship group. A social unit made up of several hapū
Koha	Gift, present, offering, donation or contribution
Mahi	Work or an activity
Mana	Authority, status, personal and collective strength, pride, and identity
Marae	The open area in front of a traditional Indigenous communal meeting house Also often used to refer to the complex of buildings around a marae
Māori	The Indigenous people of Aotearoa/New Zealand
Pākehā	A collective term for New Zealanders primarily of European descent Non-Māori fair-skinned persons
Te Ao Māori	The Māori worldview
Te Reo Māori	Māori language
Tūrangawaewae	A place to stand and belong. Traditional ancestral land. One's home. A place where one feels empowered and connected
Whakamā	Shame or embarrassment
Whānau	Family, including extended family. Familial members belonging to a kinship group

Terminology

The following terms are used throughout this thesis. For this research, they have been defined in the following manner:

Co-living	Studio apartments often in complexes with communal spaces and amenities that are shared by tenants. Individual rooms often have own kitchenette, shower, and toilet. Communal areas can include shared laundries, full kitchen, and lounge. Tenancies are often similar to a boarding house tenancy.
Couch surfing	Staying temporarily with others, normally in a series of other people's homes. Non-permanent sleeping arrangements in other's homes. Board may or may not be paid for this arrangement.
Chronically homeless	People who are sleeping rough, or in other places not designed for habitation (for example, cars) for a total of 12 months or more in the previous three years and have high and complex needs. High and complex needs are defined as two or more coexisting conditions such as a mental health disorder, substance use disorder, acute or chronic health problem or involvement in the criminal justice system (MHUD, 2020).
Emergency Housing	Short-term accommodation provided by social sector agencies for people with an urgent and immediate housing need.
Episodically homeless	People who have experienced four or more episodes of homelessness within the previous 36 months where the combined duration of these episodes equals 12 months or more and where these episodes were separated by periods of no less than seven days (MHUD, 2020).
Doubled-up	Shared living arrangements, often in severely overcrowded circumstances
Hidden homeless	People who have no fixed abode who may be couch surfing and doubled up. Precarious living circumstances not easily detected by others.
Homeless	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, 2014). Lacking access to minimally adequate housing or severely housing deprived (K. Amore, Viggers, H, Baker, M, Howden-Chapman, P, , 2016).

Housing First	A housing intervention for chronically and episodically homeless persons based on a model pioneered in the United States of America (USA) and Canada. Housing First interventions offer access to permanent housing without mental health and substance use preconditions. The intervention includes support to maintain tenancies and attain a self-determined level of wellbeing and social inclusion (Tsemberis, 2015). This intervention has been funded by the New Zealand government in 10 centres throughout the country since 2018.
Hustling	Begging. Asking passers-by for food, money, or other items as charity. The term hustling is preferred by participants to the term begging.
Private housing	Includes private rentals, boarding, or flatting.
Public housing	Properties which are owned or leased by the state, or other community housing providers. These are tenanted to people who are eligible for public housing. Rent is often subsidized by public funds. This type of housing is also called social, state or community housing.
Rapid Rehousing	Part of the Housing First suite of homeless program provision aimed at supporting program participants with less complex ongoing support needs once housed than other Housing First participants. Support once housed is required for a shorter term, normally less than 12 months (Tsemberis, 2015).
Rough sleeping	Sleeping or bedding down outside, on the streets, in doorways, parks, bus shelters, abandoned buildings, garages, sheds, under bridges and in other places not meant for human habitation.
Single adult homeless	An unaccompanied adult individual (18 years old plus) who is homeless. Single adult person without dependent children with them while homeless. (Suzanne Fitzpatrick et al., 2000; A. Jones & Pleace, 2010).
Severe housing deprivation	Lacking access to minimally adequate housing or homeless (K. Amore, Viggers, H, Baker, M, Howden-Chapman, P, , 2016)
Social housing register	A register of people assessed as having a serious and urgent housing need who are in need of public housing. This list is administered by the Ministry of Social Development and the Ministry of Housing and Urban Development. Clients are assessed as at risk (priority A) or as having a serious housing need

(priority B) and placed on the register until suitable public house becomes available. Also known as the Social or Public Housing Waitlist (Ministry of Housing and Urban Development, 2018).

Streeties	People who live on the street (rough sleeping), who are often part of a community of people who are homeless at the same time (Ravenhill, 2008). Also a term applied to someone who has been rough sleeping for longer periods of time.
Transitional housing	Short-term housing for people with an immediate housing need. Housing is often for a maximum of 12 weeks. Sometimes accompanied by 12 weeks support from an agency or service. This housing can be owned by the state, by non-profit or other organisations (e.g. faith-based organisations).
Visible homeless	Rough sleepers. People seen by others to be living rough or in places not designed for habitation, such as cars.

“Everyone thinks...homelessness is because a person wants to be,
when it’s not really. The last thing anyone wants to be is homeless.”
(Sarah, in-depth interview, 2019)

Chapter 1. Introduction

Homelessness is a serious problem in New Zealand, with many social, health, human rights, and economic ramifications. Based on census and operational provider data from 2018, 41,644 people were considered severely housing deprived, which is another term for homelessness used in New Zealand, lacking access to minimally adequate housing in our country (K. Amore et al., 2020). This is a rate of 886 people per 100,000. The 2018 total was an increase of approximately 4,400 people from the previous census in 2013, and a 45% increase from the first Population and Dwellings census count in 2001 (K. Amore, Viggers, H, Baker, M, Howden-Chapman, P, , 2016). In New Zealand, homelessness is defined as “living situations 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, 2014, p. 5).

Most New Zealanders experiencing severe housing deprivation in 2018 (65% of 41,644) were sharing accommodation, as temporary residents in severely overcrowded private dwellings. This type of homelessness is sometimes called “hidden homelessness” (Tsemberis, 2015), due to its less overt nature. A much smaller portion of all of those homeless (n= 3,522) were recorded as being without shelter, sleeping rough outside and unsheltered (n=195), in improvised dwellings (n=1,311), or living in mobile dwellings such as cars (n=2,016) (K. Amore et al., 2020). More than half of all of those living without shelter were single men (54.7%). The most common age group for those without shelter was between 45-64 years of age (n=1,380). Māori, the Indigenous people of New Zealand, were over-represented, making up 25% of the unsheltered cohort, while making up only 16.5% of total population at that time (Statistics New Zealand, 2019).

These common demographic characteristics of the specific homeless cohort living without shelter in New Zealand, namely mostly single adult (18 years or older¹), male, middle-aged, and Indigenous, bear similarities to the characteristics of many people living unsheltered in other countries. Indigenous people are overrepresented in unsheltered populations in countries such as Canada, Australia, and the United States of America (USA) (Andrew et al., 2016). Rough sleepers in these and other countries such as the United Kingdom (UK) are mostly single men and women, without dependent children

¹ For this study “Adult” is defined as 18 years or older as per the Minors’ Contract Act 1969, as, subject to a few exceptions, this is the age a person can legally sign a tenancy contract in New Zealand. It is also the minimum age criteria for entry into service with The People’s Project, the case study homeless service research participants were registered with.

(Chamberlain & Johnson, 2013; Suzanne Fitzpatrick et al., 2000; Goering et al., 2014; A. Jones & Pleace, 2010). This group have been called “single adult homeless” and are the focus of this study.

Single adults sleeping rough, often in plain view, epitomise the image many people have of those who are homeless (K. Amore et al., 2020; Clapham, 2007). This cohort often garner the most public and media attention (often negative) due to the overt, public nature of sleeping outside (Collins, 2010). Additionally, those visibly homeless may be framed as disruptors of urban social order by governance bodies such as city councils seeking to promote clean, safe community spaces (Baker & Evans, 2016). A lack of understanding about people’s background issues and their complex journeys into homelessness means this cohort are often highly stigmatised (Kate Amore, 2019). It is easy to forget that many have not always been homeless, nor perhaps alone. People have often been parents, a spouse or long-term partner, and many have held down jobs (J. T. Anderson, 2016; Suzanne Fitzpatrick et al., 2013; Goering et al., 2014). The portion of time people are observed rough sleeping is, therefore, often merely one small, rather public, window into people’s lives and must be viewed in that context.

Despite a large volume of international literature about single adult homelessness, including broad areas of consensus about contributing factors, (Andrew, Aubry, Belanger, Bird, Peters, et al., 2016; Chamberlain & Johnson, 2013; Clapham, 2007; Collins, 2010; Suzanne Fitzpatrick et al., 2013; Goering et al., 2014; G. Johnson & Chamberlain, 2008; A. Jones & Pleace, 2010; Kim et al., 2010; Mejia-Lancheros et al., 2021; Montgomery et al., 2013; Patterson et al., 2014; Ravenhill, 2008; Roos et al., 2013; Shinn et al., 2007; Woodhall-Melnik et al., 2018), and a steadily increasing volume of literature about homelessness more generally from within New Zealand (Atatoa Carr et al., 2018; Shiloh. Groot et al., 2011; Hodgetts et al., 2014; D. Johnson et al., 2013; Lawson-Te Aho et al., 2019; N. Pierse et al., 2019; Rua et al., 2019; Shum, 2021), there remain many misconceptions about factors that have contributed to people finding themselves single as adults, and with nowhere to live in New Zealand. These misconceptions are common among the general public, who’s knowledge of contributing factors to homelessness may rely on information gleaned from limited sources, such as from social media or news reporting. Among policy makers, misconceptions can relate to reliance on data gathered from government departments, and other organisations which is collected for funding and compliance purposes, not specifically for the purpose of understanding contributing factors which raise the risk of homelessness in this country. Additionally, while there is some research from New Zealand about homelessness, there may be an inability among local academics to translate and mobilise knowledge generated through academic research to policy and public contexts. Overall, these inadequacies highlight a need for more specific local research aimed at creating knowledge based on data collected for the purpose of arriving at a genuine understanding of local contributing factors (Rua et al., 2019), that can be mobilised to counter these misconceptions.

Compared to homeless families, and youth who are homeless, single adult homeless suffer additional stigmatisation. Their homeless circumstance is often viewed as a personal shortcoming because it is assumed single adults are less encumbered, and more readily able to take responsibility for themselves (Clapham, 2007; Gowan, 2010; Ravenhill, 2008). In addition, once the immediate problem of lack of housing is alleviated for this group, policy responses and homeless prevention and intervention programs and resources, often focus on changing people's behaviour, or supporting people to find work or an occupation (Clapham, 2007). Although this approach may work for some, it fails to take into account the complex accumulation of factors that may have lead someone to an episode of homelessness (Suzanne Fitzpatrick et al., 2013; Ravenhill, 2008). Providing housing and work alone, without additional support that specifically targets broader determinants and contributing factors, may be setting people up for further failure (Padgett et al., 2016; Tsemberis, 2015).

It is often assumed that those who are single adult homeless are unwell, particularly mentally unwell or suffering with substance use disorders. These co-existing health issues, and other acute or chronic medical health disorders, are often held to be prime contributing factors to single adult homelessness. Medicalised framing of homelessness, focusing on people's health issues as prime contributors, has been referred to as the "disability ethos" in homelessness discourse (Padgett et al., 2016; Tsemberis, 2015). This lens has contributed to an emphasis on a medical approach to supporting those homeless in some countries. In the USA and Canada for example, a person must have an existing mental health diagnosis to be assisted by some homeless services (Padgett et al., 2016).

While research shows many single adult homeless do suffer with mental health issues and problematic substance use, it also tells us most people who suffer with these health issues do not become homeless (Suzanne Fitzpatrick, 2005). Therefore, medical issues such as these cannot be considered the prime contributors to homelessness. Additionally, studies have shown these wellbeing issues have often been part of people's lives long before they became homeless (Suzanne Fitzpatrick, 2005; Ravenhill, 2008). People often lived housed with these wellbeing issues, and well as homeless. These comorbid health issues have, therefore, only been shown to be contributing factors for some single adults who are homelessness, not the cause.

Single adult homeless are often stigmatised in relation to misconceptions about problematic substance use. This issue is prevalent among many single adult homeless in other countries and can be both a contributing factor to people's homeless episodes and an existing issue exacerbated by extended episodes of homelessness (Padgett et al., 2016; Piat et al., 2015; Roos et al., 2013). Substance use is often framed as a coping mechanism by those homeless (Watson et al., 2016). Such

use acts as a foil against the biopsychosocial harshness of homelessness, which beyond the physical challenges of, for example rough sleeping, includes factors such as social isolation, discrimination and systemic abandonment (Shiloh Groot & Peters, 2016; Lawson-Te Aho et al., 2019; Nevil Pierse et al., 2019; Rua et al., 2019).

Other biopsychosocial issues are also commonly attributed to single adult homelessness, such as the prevalence of those suffering from the impacts of traumatic brain injuries (Mejia-Lancheros et al., 2020; Oddy et al., 2012), sometimes acquired during time spent in prison (Durand et al., 2017; Mitchell et al., 2017). Additionally, problem gambling is also associated with homelessness (Matheson et al., 2014).

Many policy responses to single adult homelessness focus heavily on providing people with increased access to adequate housing (Chamberlain & Johnson, 2013; A. Jones & Pleace, 2010). Technically, providing everyone with a house should solve the “houseless” part of homelessness. However, focusing solely on providing housing ignores a large body of research showing single adult homeless often have complex existing biopsychosocial issues (Nooe & Patterson, 2010) that have accumulated over many years and often long before people found themselves with nowhere to live (Suzanne Fitzpatrick et al., 2013; Goering et al., 2014; A. Jones & Pleace, 2010). The word “homeless” focuses on people’s lack of access to accommodation. However, equal focus should be given to addressing other contributing factors and drivers of homelessness once they are known.

Despite many decades of research, mostly in other countries, single adult homeless remain a highly misunderstood cohort (Clapham, 2007; Parsell & Parsell, 2012; Ravenhill, 2008). This misunderstanding exacerbates public stigmatisation of this group. It can also lead to misguided government policy, and potential misallocation of public funding. There is still limited research in the New Zealand context (Nevil Pierse et al., 2019) about homelessness in general, as well as about this specific cohort. Further exploration is needed to confirm if the broad consensus about contributing factors from other countries applies in this context, and to understand what other local issues exacerbate people’s circumstances when in housing crisis. For these reasons, this research seeks to explore the factors that have raised the risk of someone being a single adult who is homeless in New Zealand. This will include an equal focus on factors other than a lack of supply of housing, as research from other countries has shown that rooflessness is but one of many issues people face at crisis point (Ravenhill, 2008; Rua et al., 2019).

1.1 Homelessness in New Zealand

To follow is a discussion giving context to homelessness in New Zealand and an overview of government and community response.

1.1.1 Framing the national homeless crisis

Based on census and operational provider data, homelessness is steadily increasing (K. Amore et al., 2020, p. 4). The highest rates of severe housing deprivation were found among Māori and Pacific people, even though coverage of census 2018 was low for these populations. Māori had a homeless prevalence rate close to four times that of New Zealanders of European descent. Pacific people were six times more likely to be homeless than European New Zealanders.

Consensus holds that increasing rates of homelessness in New Zealand are exacerbated by declining access to housing, with the demand for affordable private rental and state housing² outstripping supply (A. Johnson et al., 2018; Nevil Pierse et al., 2019). There are rapidly increasing public registers or wait lists for state housing (Ministry of Social Development, 2020b), and rapidly inflating private rental prices, resulting in a sharp increase in the number of rental applicants for more affordable properties.

At a macro level, declining access to state provided housing has its roots in neoliberalism and austerity movements that began in 1970-1980's in New Zealand (Barnett & Bagshaw, 2020; Hope & Scott, 2017; Howden-Chapman, 2015). Neoliberalism is an economic and political philosophy based on a government's role in society being focused on keeping order, protecting property, and creating environments where economic markets act as the primary mechanism determining public access to most societal resources and capitals. The approach includes the following three elements:

- privatisation of traditionally state-run activities (such as telecommunications, prisons, roading, water and energy infrastructure and supply)
- pronounced reduction in public expenditure (sometimes referred to as fiscal austerity) on infrastructure and social services such as health, housing, and welfare provision
- deregulation to encourage economic activity and consumer freedom of choice (such as deregulation of labour markets, allowing for individual employment contracting)

As a result of this approach, in a bid to partially withdraw from the provision of social housing, successive New Zealand governments have sold off portions of state-owned housing, sometimes to

² The term 'state housing' is synonymous with 'social' and 'public' housing and these terms are often used interchangeably by New Zealanders.

private individuals and organisations, and also to non-government community housing providers (Howden-Chapman, 2015; A. Johnson et al., 2018). For example, in 1950, the National government sold 30% (13,300 homes) of the state housing stock at that time. By June 2017, the number of social housing dwellings owned and managed by the government had reduced from a peak of 69,717 units in 2011, to 60,301 dwellings, which was the lowest level of government provided housing stock since 2000. The current Labour government ceased all sales of state housing in 2017.

Some local governments have also divested of social housing. For example, the Hamilton City Council divested of 344 pensioner housing units selling them to non-government social housing provider Accessible Properties Limited in March 2016 (A. Johnson et al., 2018). This housing still forms part of the social housing pool in Hamilton. However, while tenants are now rarely evicted from state-provided social housing (A. Smith, 2021), community housing providers have more agency over managing tenants perceived as difficult. Ever since selloffs of social housing began, there has been sluggish attempts by successive governments at catching up on supply.

Along with a reduction in state provided social housing stocks, the demand for private rental properties has outstripped supply (A. Johnson et al., 2018). Census data from 2018 showed rental vacancy rates were low at 10% across New Zealand in 2018, and even lower in some centres. In Hamilton, for example, vacancy rates were 5%. A downward trend in tenancy bond lodgements also suggested existing renters were staying longer in properties.

Other factors have also contributed to a lack of affordable housing. In a report from 2018, population growth was inflated by large net increases in migration, that had particularly impacted Auckland (A. Johnson et al., 2018). There were an additional 40,000 people per year needing housing in this city. Landlords have therefore been able to be selective when seeking tenants, and tenants have been disempowered by this highly competitive environment.

Various recent tax and other policy and legislative changes that have also affected the supply of rental properties. For example, a change in bank lending loan to property value ratios has acted as a barrier for first home buyers (A. Johnson et al., 2018). This cohort have been relegated to renting for longer periods to save larger amounts as deposits on housing purchases.

Declines in first home purchases has also contributed to a general decline in home ownership rates, which is experienced disproportionately among various populations. For example, in 2013, Māori home ownership rates were 28%, and Pacific people 19%, compared to New Zealand Europeans at 57%. Home ownership has traditionally been something most New Zealanders aspire to (Perkins & Thorns, 1999). Security of tenure provides an individual with many benefits including contributing to

a person's ontological security. Ontological security can be defined as a state of wellbeing and a positive view of self, and the meaning of life, derived from a sense of continuity, order, and stability, of which housing stability is one element (Dupuis & Thorns, 1998; Giddens, 1991).

There have been various other recent policy and legislative changes which have been intentionally designed to act as a disincentive to private rental property investment. This includes changes to tax law abolishing income tax deductibility of depreciation on buildings and phasing out loan interest deductibility for rental income tax purposes (A. Johnson et al., 2018). Recent changes to tenancy laws have also made it harder for landlords to evict tenants without providing a reason for eviction (90 days' notices). The Healthy Homes initiative requires landlords to bring insulation and heating in rental properties up to mandated standards within strict timeframes (Howden-Chapman, 2015). This can be a costly exercise for landlords. Higher housing prices have also meant lower rental returns for rental property investors (A. Johnson et al., 2018). As a result of these and other factors, many rental property investors have divested of rental portfolios, further reducing supply.

Along with a diminishing supplies of affordable housing, income levels have not kept pace with rent rises, particularly for those receiving welfare income (Boston, 2013; Tanielu et al., 2020). This disparity also has its roots in neoliberalism. Severe cuts were made to basic benefit rates during Welfare Reforms in 1991 (Barnett & Bagshaw, 2020). Since then, welfare income levels have remained low. A recent review of the adequacy of welfare income in New Zealand concluded that many people were living desperate lives due to seriously inadequate incomes while on a benefit (Kiro et al., 2019). Reduced benefit rates created financial pressure for families with children living on welfare income, resulting in a rise in child poverty. In 2015, 28% of children were considered to be living in poverty, 20% of those in severe poverty (Barnett & Bagshaw, 2020). Successive governments have attempted to bridge the gap between rental costs and welfare levels by providing additional welfare supports. For example, Accommodation Supplement is paid as a top up to beneficiaries by the Ministry of Social Development (MSD) to support rents paid to private landlords. By 2018, the net result of this approach was that up to 40% of all private rental tenancies were being supported by some level of state or public funding. Additionally, Income-Related Rent Subsidies are paid toward rents of those living in government and non-government owned social housing (Howden-Chapman, 2015; A. Johnson et al., 2018).

Consensus holds that housing supply and affordability issues, and constrained financial means, particularly among those receiving welfare income, are accepted contributing factors to homelessness in New Zealand (A. Johnson et al., 2018; Rua et al., 2019; Tanielu et al., 2020). Despite these housing and income constraints however, policy responses to homelessness continue to focus on improving

people's access to an inadequate supply of state and other community housing, and to a limited and diminishing supply of affordable private rental properties (Howden-Chapman, 2015; A. Johnson et al., 2018; Ministry of Housing and Urban Development, 2020).

Other systems failures have contributed to single adult homelessness. Existing research showed a cohort of 390 single adult homeless were over-represented in government administrative and service-based data, reflecting poor social outcomes. This was at a rate of interaction vastly in excess of a control group representative of the general population (Nevil Pierse et al., 2019). Homeless people's most common interactions were with the health and justice systems. Additionally, as children, many had also recorded high rates of interaction with child protection services, vastly in excess of the control group. This suggests that homeless people had endured additionally disrupted early lives which may have contributed to later life housing instability. National administrative data about these adverse childhood events (ACE) has limitations. There is a data gap, for example, in accessible records of child protection services Oranga Tamariki – Ministry of Children (formerly known as Child, Youth and Family). Administrative data is only available for those born after 1986 (Nevil Pierse et al., 2019, p. 5). Therefore, the precise prevalence of ACEs among homeless cohort in New Zealand is not able to be determined based on these data alone. Overall, this research showed that despite prolific interaction over prolonged periods (sometimes up to 30 years), this cohort's active relationship with government agencies and services had not been a protective factor against homelessness.

As has been alluded to, homelessness is experienced inequitably between population groups in New Zealand. Māori and Pacific people are disproportionately over-represented, including among those single and homeless (K. Amore et al., 2020; Atatoa Carr et al., 2018; Lawson-Te Aho et al., 2019). Racism is often the basis for people's inequitable access to resources, including housing (Pihama et al., 2014; Rua et al., 2019; Walters et al., 2010). Over-representation of Māori among homeless counts has been attributed in part to the ongoing effects of colonisation (Shiloh Groot & Peters, 2016; Lawson-Te Aho et al., 2019). Being displaced from ancestral land and disconnected from kinship networks can contribute additional complexities for Māori who are homeless (Shiloh Groot & Peters, 2016; Hodgetts et al., 2014; Rua et al., 2019).

Beyond consensus about the contributing factors outlined, in comparison to other countries, there is still paltry research about the complexity of issues and unique contextual factors which may have raised the risk of single adult homelessness in New Zealand (Al-Nasrallah et al., 2005; Collins, 2010; Nevil Pierse et al., 2019). In this respect, this study sought to contribute to a fuller contextual understanding of factors which have contributed to people's circumstances when in housing crisis.

1.1.2 Responses to homelessness in New Zealand

New Zealand has social safety nets that are designed to protect people from becoming homeless (J. T. Anderson & Collins, 2014; Collins, 2010). Successive governments have centred their role in preventing housing insecurity on providing adequate permanent housing for low-income New Zealanders. To achieve this goal, a national state housing program was established in the mid-1930's. This was mostly aimed at supporting families on low incomes. As at the end of November 2020, there were 72,807 state houses available for people. At the same time, there were over 21,000 households on a state housing register waiting for housing (Ministry of Housing and Urban Development, 2020). Under the New Zealand definition of homelessness, all on the state housing register are homeless (Statistics New Zealand, 2014). Demand for social housing has not keep pace with supply (A. Johnson et al., 2018). Most of those waiting for housing were requesting either a one bedroom (n=10,400) or a two-bedroom property (n=6,949) (Ministry of Social Development, 2020a). This would suggest that the highest demand for state housing is likely from single adults, and couples or small families, who are on low incomes and have a serious housing need.

New Zealand's social safety net includes government provision of welfare support, also called benefit payments or benefits. Single adults who do not have work may be eligible for income support (Job Seekers Benefit) through MSD (Ministry of Social Development, 2020a). Benefit receipt is conditional on fulfilment of many administrative and other mostly work-focused requirements. MSD also administers the payment of income support for those who have a non-accident-related health condition or disability which affects their ability to work (Supported Living Payment). Other financial supports administered by MSD include additional allowances to support with living costs such as the Temporary Additional Support allowance, financial support with rent costs (Accommodation Supplement) and other essential expenses (such as Special Needs Grants, the Disability Allowance for support with medical costs, and non-recoverable Food Allowances). Benefit levels have not kept paced with the cost of living, however (Boston, 2013). This has contributed to beneficiaries having fewer options in a housing crisis.

People who are homeless may attempt to secure emergency housing (EH), temporary housing (provided for stays of mostly 12 weeks) (TH) or state housing, which are low-cost housing options designed to support people with many barriers to renting in the private rental market (Ministry of Housing and Urban Development). These types of accommodation are provided by an array of both government and non-government organisation. Access to this accommodation, and payment of rental costs thereon, is mostly co-ordinated by the Ministry of Social Development (MSD) and the Ministry of Housing and Urban Development (HUD). People who are homeless may also access some

emergency housing support directly from providers, who are mostly non-government or faith-based organisations. Table 1 summarises the main entry points and types of EH, TH, state housing and housing supports provided to those in urgent need of housing.

There are many people currently precariously housed in emergency housing in New Zealand. Under the New Zealand definition of homelessness, these people are also considered homeless. For the quarter ended December 2019, 30,941 people had received a special needs grant for emergency housing from MSD (Ministry of Social Development, 2020b). The amount paid to support people in this accommodation was over \$48 million. This was a 97.4% increase from the December 2018 quarter, representing a significant increase in the amount of people needing emergency housing support.

In May 2019, the government adopted this country's first co-ordinated national homeless strategy. The Aotearoa New Zealand Homelessness Action Plan (2020-2023) is a multi-year, cross-government framework aimed at reducing homelessness in New Zealand. The plan has 18 immediate actions that were to be put in place in 2020, and a further 18 longer-term actions. The 18 immediate actions are aimed at various initiatives, including continuing to roll out Housing First homeless services throughout the country. Housing First is an evidence-based housing intervention for chronically and episodically homeless persons that facilitates people's access to permanent housing and provides support to help people maintain their tenancy, as well as support to achieve a desired level of wellbeing and social reintegration (Tsemberis, 2015). This program approach is hailed as a socially progressive response to alleviating homelessness (Baker & Evans, 2016).

Other action points include mitigating people's exit from institutions to homelessness, providing more housing options for people, providing more support for those already in emergency housing, partnering with iwi (local Māori tribes, the local Indigenous population) for housing and support options, improving homeless data, expanding initiatives aimed at sustaining people's existing tenancies and supporting various other initiatives. A total of \$300 million has been allocated to support 10,000 people at risk of or already experiencing homelessness over three years (Ministry of Housing and Urban Development, 2020).

The government has maintained a safety-net approach, by focusing on providing housing options for those homeless or providing support to sustain existing housing arrangements for those at risk of losing a tenancy, which is a preventative focus. There appears to be less focus on identifying and alleviating other drivers of homelessness in New Zealand, or on prevention and early intervention in pathways that may lead to homelessness. This may be because there is still limited evidence and information about other contributing factors, points of intervention or prevention options in this

context. It may also be that existing evidence has not been adequately mobilised to create more holistic solutions to known drivers of homelessness. Additionally, perhaps as a hang-over from neoliberalism, social systems perpetuate discriminatory misallocation of resources.

Other community-based support of those homeless includes the provision of free and low-cost food through food banks and community meals. These supports are mostly coordinated by faith-based organisation.

Table 1 Emergency, temporary and state housing support

Types of emergency, temporary and state housing	Ministry of Social Development (MSD)/Work and Income support	Ministry of Housing and Urban Development (HUD) support	Faith-based, Community, Iwi, or local government and support
Shelters	Work and Income may facilitate access to a shelter and support with Accommodation Supplement, an additional welfare payment, to help people afford accommodation costs.	Funds and contracts Housing First and Rapid Rehousing support for people to exit shelter to access and sustain permanent housing.	Shelter properties and support services mostly provided by non-government organisations.
Emergency Housing (EH)	Support to access and fund EH through non-recoverable Special Needs Grants, often in motels, back-packers, campgrounds, short-stay boarding houses and hostels. Person may be asked to pay 25% of benefit toward accommodation cost.	Funds and contracts Housing First and Rapid Rehousing support for people to exit EH to access and sustain permanent housing.	Specialist EH is provided by community and non-government organisation such as Women's Refuge.
Transitional Housing (TH)	Work and Income support access and refer people in EH to transitional housing providers.	HUD leases and builds transitional housing. Contracts support agencies for people in TH.	Faith-based and other non-government organisations provide property and support services, mostly for 12 weeks duration.
State, social, or public housing	Work and Income complete screening assessment and initial assessment for social housing. MSD maintain social housing register or waitlist. Work and Income deduct income related rent payment from benefits and pays to Kāinga Ora.	HUD co-ordinate property lease and building of property through crown entity Kāinga Ora. Kāinga Ora allocate social housing to people on MSD waitlist and maintain the tenancies and properties. Provide Intensive Case Managers for complex clients. Funding provided to Housing First providers and other organisations to support those in public housing if formerly homeless.	Non-government organisations, private developers, Iwi, local government councils, faith-based organisations and community housing providers contract property and services to HUD.

1.2 Homelessness in Hamilton

Hamilton is New Zealand's fourth largest urban centre, with a population of approximately 176,000 in 2020. It is home to 3.5% of the New Zealand population (Hamilton City Council, n.d.; Statistics New Zealand, n.d.). Located in the North Island, approximately 120 kilometres south of Auckland, Hamilton was initially an agricultural service centre. Now, the city has a diverse economy and is the third fastest growing urban area. The city has two major tertiary education providers, and before COVID-19 border restrictions were in place in New Zealand, approximately 40,000 tertiary students each year resided in Hamilton, including many overseas students. Based on the 2018 census, approximately 48% of the population were male and 52% female. The median age was 32 years old, the youngest of all territorial authorities in New Zealand. The ethnic makeup of the city in 2018 was 64% European, 24% Māori, 19% Asian, and 6% Pacific people. The median income was \$30,200, which was slightly lower than the median income for all of New Zealand (\$31,800), but much lower the income level earned by 17% of New Zealand's income earners (\$70,000). There was a 5.6% unemployment rate.

Reflecting national trends, homelessness in Hamilton is increasing. Between 2001 and 2018, census and administrative data showed the number of people lacking access to minimally adequate housing in Hamilton city rose from 939 people to 1458 (K. Amore et al., 2020; K. Amore, Viggers, H, Baker, M, Howden-Chapman, P, , 2016). Of those homeless in 2018, the majority (87%) were sharing accommodation in severely over-crowded private dwellings (n=1263). A further 153 were in temporary accommodation, including night shelters, Women's Refuge, and emergency accommodation provided through MSD. Only 39 people were recorded as being without shelter on census night.

The local register for state housing is over-subscribed. As at September 2020, there were 1,347 households waiting for access to public housing in Hamilton City, with people waiting many months to be housed (Ministry of Social Development, 2020a). The majority (n=1,187) were an A priority rating, denoting a serious and urgent housing need. Of the total waiting for state housing, 597 were waiting for a one-bedroom property. It is likely that these people were single adults or couples without dependent children who were homeless.

People homeless in Hamilton are served by a number of government, non-government, and faith-based organisations. The People's Project (TPP) is a government-funded Housing First homeless service supporting single adults (18 years or older) and couples without dependent children who are homeless in Hamilton city (TPP, 2020). The criteria for support by this service is generally defined by the service's funder, the Ministry of Housing and Urban Development (MHUD). These criteria have changed and evolved since the Ministry's inception in 2018 in response to contract changes. Initially,

government funding criteria were narrow, limited to supporting those who were considered chronically homeless, having been rough sleeping for one year or more. However, TPP initially chose to support all adults and families who were homeless according to the accepted New Zealand definition (Irvine & Sherson, 2021). Today, TPP predominately supports single adult homeless and homeless couples who have complex support needs, and who are finding it hard to exit homelessness without support (A. Jones & Pleace, 2010). The case study cohort for this research is made up of people registered with this service.

TPP has been operating in Hamilton since 2014. The program includes a collaborative governance group, made up of local government and non-government social sector organisations, local iwi, and business sector partners. This group provides strategic direction for the program and helps coordinate response across the community. The program's day-to-day operation is overseen by a parent organisation, the Wise Group, which specialises in supporting people with mental health and wellbeing issues (McMinn, 2017). TPP's program delivery is guided by Māori cultural advisors who are part of its staff and cultural competency is a critical component of service delivery.

When TPP began, local police and health authorities identified 80 rough sleepers in the central business district. These people had been frequent presenters at emergency services, such as the emergency department of the local area hospital and mental health crisis services. This group were also well known to local Council parks, and reserve security teams, and Police. Since opening, over 3,000 people have registered for help with this service (Irvine & Sherson, 2021).

Existing research involving data from this provider has revealed some information about characteristics of single adult homeless in Hamilton (Atatoa Carr et al., 2018; Nevil Pierse et al., 2019). Program participants are disproportionately Māori (73.7%) (Atatoa Carr et al., 2018). In one study where reasons for homelessness was asked, the most common trigger was a family relationship breakdown, followed by health issues (including mental health and problematic substance use issues) and tenancy issues, particularly people's inability to meet rental payments. Fifty-five percent of this cohort described having debt. Of the amount of debt disclosed, the average debt per person was \$10,000. Each of these factors have likely contributed to people's journey into homelessness in Hamilton.

Research involving TPP program participants has also explored people's interactions with government services by reviewing administrative data held in the New Zealand Integrated Data Infrastructure (IDI)³

³ The IDI is a large, linked research database of microdata collected from government and non-government organisations and administered by Statistics New Zealand. It includes data from the health, justice, welfare, tax, and education sectors (Pierse et al, 2019).

(Nevil Pierse et al., 2019). It was assumed that this cohort (n=390) of mostly single adult homeless would appear sparingly (if at all) in administrative data, validating the argument that people had not been helped by government services because they were “hard to reach”. However, the study found that this cohort had a high, sustained and rapidly increasing use of all government services in the time preceding presenting at TPP for assistance (Nevil Pierse et al., 2019). This service contact rate was at a level far in excess of a comparative cohort of non-homeless New Zealanders. The highest number of interactions for these program participants was with the health system. An example of people’s high interaction rate was that between 2005 and 2016, this small cohort had been dispensed over 88,000 individual medication items, most of which were categorised as antidepressants or antipsychotic medications. For one period (5 years before being housed by TPP) this cohort’s rate of prescription dispensing was 2.4 times that of the comparative cohort.

This cohort also had a high rate of interaction with other government departments. People’s mental health and justice sector interactions were over ten times the rate of interaction of the comparison group. The cohort had spent 10,440 bed nights in mental health facilities in the 5-year period before being housed. They were living in poor health, were socially disadvantaged (being on low income for long stretches of their lives), and highly connected with the justice system, often since youth. The researchers concluded that this high and sustained level of interaction with government departments represented systems failure by sectors and services that are intended to provide support. For this cohort, a high and sustained level of social sector contact was not a protective factor against homelessness.

While this research provided compelling and unique data about factors associated with homelessness and some potential contributors in Hamilton, it was unable to determine exactly when people’s trajectory to homelessness had first begun, nor whether their increased interaction with services was directly linked to events that specifically precipitated homelessness (Nevil Pierse et al., 2019). What is known is also limited to what has been reported to (and recorded by) authorities and agencies. Many who make up this cohort seek to avoid coming to the attention of authorities and divulge information sparingly (Ravenhill, 2008). Additionally, information, as recorded by organisations and agencies, is likely collected for compliance, operational, and funding purposes, not specifically for the purpose of understanding the drivers of homelessness. Therefore, to appropriately understand homelessness in this context, and to understand how to effectively lower people’s risk of becoming homeless across their lifespan, candid contributory research is required. This must involve trusted researchers, and methods that promote freedom of expression for participants involved in research processes.

1.3 Research objectives

This research therefore aims to add to existing knowledge by achieving the following objectives:

1. To determine what factors contributed to or raised the risk of single adult homelessness in Hamilton.
2. To determine if a pathway of common occurrences throughout people's lives raised the risk of homelessness, and what age any such pathway might have begun.
3. To consider critical points of intervention, where appropriate intervention may lower the risk of single adults becoming homeless.

This thesis focuses on a case study involving program participants of The People's Project.

1.4 Significance of this research

This research has advanced knowledge about contributing factors and pathways to single adult homelessness in New Zealand. It is an in-depth inquiry, a mixed method approach facilitating the collection of rich qualitative and quantitative data about single adult homelessness in Hamilton. Data gathered contributes to a place-based understanding about factors which have raised the risk of someone becoming homeless. Additionally, data includes evidence of systems failure across participants' life spans, specifically highlighting a failure to act at critical points. A participatory approach allowed for inclusion of participants in all aspects of this research, including validation of results and co-design of recommendations about solutions and interventions in homeless pathways. Including those who are homeless in the co-design of solutions is still relatively rare among homeless literature, both in New Zealand and in other countries, and is a unique feature of this study. First-hand knowledge of intervention opportunities is vital in policy formation. Critically, the voice of Māori who were homeless is also well represented among this data. Therefore, this research contributes to understanding Indigenous worldviews about contributing factors and solutions to homelessness in this country.

Situating the participant as an expert about homelessness in Hamilton is central to the critical realism approach taken. This worldview links with clearly articulated goals among all involved in this research, including participants, researcher, academic supervisors, and host homeless service, The People's Project, to mobilize learnings to create better outcomes for New Zealanders. There is therefore a practical focus which permeates this study, aimed at gathering specific local evidence with a view to applying findings to remedy both specific local issues, as well as to add to a national conversation about lost points of intervention.

Research tools employed include questions used in international research conducted with people who were homeless in America and Great Britain. Results from this study will therefore allow for international comparison. Fitzpatrick et al. (2013) conducted a survey of pathways into homelessness for people experiencing homelessness in seven UK cities. These researchers gave permission for use of their Multiple Exclusion Homelessness survey content in this study (Appendix H) and concluded that carrying out similar comparable studies with people experiencing homelessness in other countries would contribute to international research about social exclusion.

There is a growing body of international evidence linking an increased risk of homelessness in later life with adverse events and trauma experienced in childhood and adolescence (Suzanne Fitzpatrick et al., 2013; Larkin et al., 2012; Montgomery et al., 2013; Ravenhill, 2008). There is currently minimal empirical evidence confirming the prevalence of such experiences among people homeless in New Zealand. National administrative data about adverse childhood events (ACE) has limitations (Nevil Pierse et al., 2019, p. 5). Additionally, these data likely underreport the actual prevalence of family violence, much of which goes unreported to authorities. This research allowed for collection of a large body of data about these experiences from those with lived knowledge. A unique feature among the data collected for this research is the understanding of the age at which adverse events were first experienced. This data allows for a clear understanding of the chronology of ACE events, adding critical information about vital points of early intervention. Additionally, unique data is collected about how participants consider these experiences in relation to raising people's risk of becoming homeless later in life.

To prevent homelessness in a local context, we must first understand contributing factors and pathways in this context. This research seeks to do exactly that. This study is well-informed by those with lived experience. Meaningful and appropriate participant inclusion was achieved in all aspects of this research, including validation of final results (Hudson, 2010; Martin & Kunnen, 2008). This study therefore represents a consensus of views about homelessness in Hamilton, from the perspective of a cohort of those with lived experience.

1.5 Thesis overview

This chapter provided background information and some context about homelessness in New Zealand. It outlined the main elements of government and community response. An overview of prevalence and response in the case study city of Hamilton was presented, and some potential local contributing factors were explored. The study cohort was introduced. This sets the stage for this inquiry, which is aimed at determining the factors which raised people's risk of becoming homeless in Hamilton, and how those who have been homeless think we can lower these risks.

In Chapter Two, existing literature about factors that raise the risk of single adult homelessness is reviewed in detail. This includes academic and non-academic sources from both New Zealand and other countries. It also includes studies considering the links between colonisation, racism, and homelessness. A comparison is made of various pathways into homelessness that have been identified both locally and internationally.

Chapter Three details the methodology and methods used in this research and details the rationale for the theoretical approach adopted. The specific methods used are then defined, including a description of the participant selection protocols, recruitment and interview processes. The analysis process and implementation experiences are then explained. Validating results with participants was an important part of this study. Discussion about this experience is presented, outlining the specific insights gained through this process. Ethical considerations related to interviewing vulnerable cohort, particularly where some population groups are disproportionately represented, are reviewed.

In Chapter Four, the results of quantitative data collection are presented. This chapter looks at the prevalence of adverse and disruptive events participants experienced across their lifespan, starting with participants' earliest recollection of disruption in their childhood homes (if any) and finishing with experiences that may have happened in participants' most recent episode of homelessness. Local suspected drivers of homelessness are explored, including unsupported exit from local care and custodial institutions. The impact of health and wellbeing issues as contributing factors is considered, as well as the prevalence and level of debt participants were experiencing and its impact (if any) on the range of options available at crisis point. The findings are presented in the context of a pathway, made up of a series of commonly experienced disruptive event which had occurred across participants lives.

Chapter Five presents the results of a small amount of narrative data collected in quantitative surveying. Participants define what the word homeless means to them, which provides context about the effects of social isolation in people's lives, particularly at crisis point. Data are presented about episodes of discrimination, including racial discrimination throughout participants lives, if applicable. Where participants had lost contact with family, reasons provided about this disconnection are presented.

Chapter Six presents the results of interviews conducted with a selection of phase one participants. Participants discuss in more depth the contributing factors they consider influenced their trajectory into homelessness, identify some trigger events that had occurred. The effects of systems failure and discrimination in people's lives and as this relates to their homeless experience is considered.

Additionally, participants' experiences and opinions about resources and support they would have welcomed, both before becoming homeless and while homeless are detailed.

Chapter Six presents detailed discussion about the research findings and implications in relation to existing homeless literature, response, and policy. Potential points and types of intervention are presented. A conclusion to this thesis includes a review of the specific objectives of this research in relation to the findings. Policy implications are considered, as well as the contribution this research makes to broader literature about homelessness in New Zealand.

Chapter 2. Literature Review

2.1 Introduction

There are broad areas of consensus about contributing factors to single adult homelessness that have emerged in existing literature. Explanations of homelessness have traditionally been divided into two broad categories, individual and structural (Suzanne Fitzpatrick, 2005; Neale, 1997). Individual explanations consider personal pathologies, characteristics, and behaviours of homeless people, while structural explanations include considering broader macro-social and economic contributors such as adverse housing and labour market conditions, systems failure, and rising levels of poverty. There is a consensus among academic commentators that a combination of both categories contributes to homelessness. Structural factors create the conditions within which homelessness occurs and an accumulation of personal problems makes some more susceptible to adverse social and economic trends (Suzanne Fitzpatrick, 2005). There is also recent understanding that the effects of individual and structural contributing factors to homelessness can accumulate over time (Clapham, 2003), sometimes intergenerationally (Lawson-Te Aho et al., 2019; Metzler et al., 2017) with critical and sensitive influences at specific time periods that may be more amenable to preventative intervention. Therefore, a longitudinal lens is important in explaining homelessness and enhancing preventative strategies. This has given rise to approaches such as the pathways approach explained in section 2.4.

This chapter explores this understanding, which is presented under the following headings:

- Individual contributing factors.
- Structural contributing factors.
- Pathways to single adult homelessness.

New Zealand literature related to single adult homelessness is then reviewed. This section includes discussion about pathways to homelessness identified locally, and the contribution of systems failure and inequity to an increased risk of homelessness. Literature about the link between colonisation and an overrepresentation of Māori among those homeless is also presented. This section will conclude with discussion about homeless interventions that are recommended to reduce the risk of homelessness among single adults.

2.2 Individual contributing factors

Traditional explanations of single adult homelessness include considering the contribution individual proximal factors play in raising people's risk of homelessness (Suzanne Fitzpatrick et al., 2013; Suzanne Fitzpatrick et al., 2000; A. Jones & Pleace, 2010; Neale, 1997; Ravenhill, 2008; Shinn et al., 2007).

Literature often includes discussion about health and wellbeing issues, relationship issues, disruptive events in people's early lives and later-life traumatic personal events such as a house fire or job loss. In this section, discussion includes considering the impact the following factors can have on housing stability:

- Mental health issues and problematic substance use.
- Adverse childhood events
- Diminished social capital contributing to social exclusion.

The contribution of other health issues such as gambling, and traumatic brain injury are also considered, along with individual trigger events such relationship breakdown.

2.2.1 Mental health and problematic substance use

Single adult homeless often have multiple and complex health and wellbeing issues (Goering et al., 2014; Padgett et al., 2016; Tsemberis, 2015). Research has shown that the prevalence of mental health disorders and problematic substance use among people who are homeless is generally significantly higher than in the general population (Montgomery et al., 2013; Roos et al., 2013). For example, Roos et al. (2013, p. 279) showed that there was a significant relationship ($p < .001$, CI 95%) between mental health disorders such as paranoid schizophrenia, obsessive-compulsive disorder, major depression, social phobias and posttraumatic stress disorder and an increased risk of people experiencing an episode of homelessness. Additionally, mental health issues and problematic substance use disorders have often shown to be comorbid issues among people who are homeless (Goering et al., 2014; Padgett et al., 2016; Roos et al., 2013; Tsemberis, 2015). For example, about 80% of program participants connected with several Pathways Housing First programs in America have shown to have co-occurring mental health and substance use disorders (Tsemberis, 2015, p. 33).

Prevalence of these comorbid issues is also strongly associated with an increased risk of interaction with the justice system (A. Jones & Pleace, 2010). Interactions with the justice system have ramifications for housing stability as even short periods in prison can lead to tenancies being terminated (Nevil Pierse et al., 2019, p. 8), and discrimination when seeking accommodation post incarceration (J. T. Anderson, 2016). Individuals with a history of incarceration have shown to be 7.6 times more likely to experience adult homelessness (Montgomery et al., 2013, p. 21).

People's mental health issues and problematic substance use also exacerbate relationship issues and can result in a breakdown in family, spousal, kinship, and other household relationships. Relationship breakdown is often the most prevalent reason given for the loss of people's last tenancy (Isobel Anderson & Christian, 2003; Chamberlain & Johnson, 2013; Suzanne Fitzpatrick et al., 2013; Ravenhill,

2008). Therefore, these comorbid health issues have shown to have a far-reaching, inter-related and accumulative contribution to homeless episodes for people.

Once homeless, people's existing health and wellbeing issues often worsen. A lack of continuity of care, due in part to transience, means many single adult homeless have their health needs met through frequent interaction with emergency services, particularly emergency departments of hospitals (Padgett et al., 2016; Tsemberis, 2015). This care is more likely to be crisis management of acute issues, rather than preventative care for chronic medical conditions. Additionally, there is a cyclic nature to the influence of these co-morbid individual factors, as the biopsychosocial impacts of being homeless contribute to exacerbating people's existing health issues.

Recent New Zealand research involving a review of coroner's reports for 171 people identified as homeless at the time of their death showed that over three-quarters of this cohort died from conditions amenable to timely and effective healthcare interventions (Charvin-Fabre et al., 2020). This study identified that many of the patients had a record of cardiovascular disease and diabetes as well as mental health issues and problematic substance use. While the main cause of death for the cohort studied was from cardiovascular disease, one third of all deaths were as a result of suicide, mostly from hanging. The coroner's inquiries revealed that 73.4% of homeless people who committed suicide had been diagnosed with mental health issues, problematic substance use and depressive mood disorders. However, less than half of these people (49.9%) had been treated for a psychiatric disorder. This cohort had died over 30 years younger than housed New Zealanders. Their average age at death was 45 years, dropping to 38-years old in the case of suicide.

While an association has been proven between mental health issues, problematic substance use and single adult homelessness, evidence has shown that these issues often existed long before people found themselves with nowhere to live (Suzanne Fitzpatrick et al., 2000; Ravenhill, 2008). Additionally, research has shown there are many people who have a mental health issue and/or substance use issues housed successfully in communities, people who may not ever experience homelessness (Suzanne Fitzpatrick et al., 2000). These health issues are therefore considered existing background issues (Isobel Anderson, 2001), which may raise the risk of becoming homeless. Comorbid mental health and problematic substance use may be primary contributing factors for some. However, for others, these issues may merely exacerbate circumstances and events leading to crisis point.

2.2.2 Adverse childhood events

There is an increasing volume of literature exploring an association between adverse childhood events (ACE) and an increased risk of homelessness in people's later life (Boullier & Blair, 2018; Felitti & Anda, 2014; Suzanne Fitzpatrick et al., 2013; Goering et al., 2014; Hughes et al., 2017; Larkin & Park, 2012;

Montgomery et al., 2013; Narayan et al., 2017; Patterson et al., 2014; Ravenhill, 2008; Roos et al., 2013; Theodorou & Johnsen, 2017). Much of the research linking ACEs and homelessness has been carried out in the US, although there is an increasing interest in this association in the UK and Europe (Suzanne Fitzpatrick et al., 2013; Theodorou & Johnsen, 2017).

Adverse childhood events (ACE) are traumatic events that occurred within a person's childhood household before the age of 18 years (Felitti et al., 1998). Such events might include physical and emotional abuse and neglect of a child or adolescent, as well as vicarious traumatisation experienced by witnessing traumatic events taking place involving other household members.

A 10-question ACE test was developed by Felitti et al. (1998) to measure abuse, neglect and traumatisation in childhood. These questions have been adopted and adapted by the World Health Organisation and the Centre for Disease Control and Prevention in America (Boullier & Blair, 2018; Centers for Disease Control and Prevention, 2020). An ACE score is calculated from the number of yes or no answers to questions about 10 categories of abuse, neglect, and traumatisation. A "yes" response to one category nets a score of 1 point. A "no" response scores zero points. No additional points are allocated in relation to the number of incidents that may have occurred within each category. An overall ACE score ranges from zero, meaning no abuse or neglect occurred to ten, meaning a significant amount of abuse was sustained.

The 10 ACE categories relate to emotional, physical, and sexual abuse and neglect experienced as a child before age 18 years. It also measures incidents of respondents as children witnessing domestic violence between household members or care givers, growing up with mentally unwell household members, or with household members experiencing problematic substance use. The incidence of loss of a caregiver through separation, divorce or death or having a household member go to prison is also measured (Felitti et al., 1998; Larkin et al., 2012). These questions have been included in the data collection questionnaire in this study to explore the link between ACEs and homelessness in a local context. The various ACE categories are represented in Figure 1.

Exposure to traumatic conditions in childhood have been found to have pervasive biopsychosocial effects throughout someone's life (Felitti et al., 1998; Montgomery et al., 2013; Roos et al., 2013). Research has demonstrated that ACE exposure is strongly associated with an increased risk of poor and persistent health outcomes. This includes an increased risk of developing mental and physical health issues compared to those who had not experienced ACEs. Rates of later-life depression, obesity, cancer, heart disease, diabetes, and an increased risk of suicidality are higher among those who have experienced ACEs than those who have not (Boullier & Blair, 2018; Brown et al., 2009; Felitti et al., 1998; Roos et al., 2013). ACEs have also shown to increase susceptibility to problematic

substance use, and premature mortality. The more substantial the level of trauma sustained in childhood, the higher the risk of developing these health and wellbeing issues (Theodorou & Johnsen, 2017).

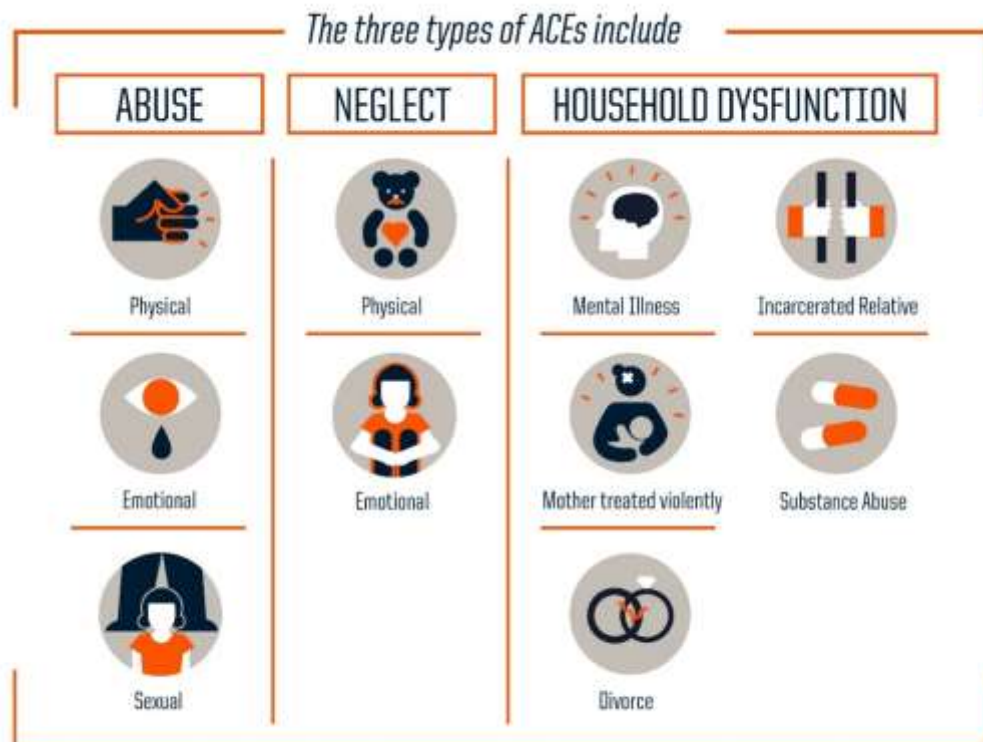


Figure 1 The 10 categories of Adverse Childhood Events⁴

While anyone can be at risk of experiencing ACEs (Merrick et al., 2019), there is a broad consensus that ACEs feature disproportionately in the life histories of people who experience homelessness (Theodorou & Johnsen, 2017). Sundin and Baguley (2015) conducted a review of 24 studies about the prevalence of childhood experience of physical and sexual abuse in homeless adults (18 years old or above) in three Western countries. It was estimated that the average prevalence of childhood physical abuse among cohort studied was 37%, compared to estimated rates of between 4 and 16% in the general populations in the USA, Australia, and the UK. The average prevalence of childhood sexual abuse amongst people homeless was 32% for females and 10% for males. This compared with an estimated rate of 7.5% of all children in the general populations studied (10% for females, 5% for males).

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Several large studies conducted in USA have used the 10-question ACE test to demonstrate the relationship between ACEs (and other factors) and homelessness. Using data from Washington State's annual Behavioural Risk Factor Surveillance System (BRFSS), a health-related telephone survey that collects state data in the USA (Montgomery et al., 2013), research was carried out to determine the association between ACEs and adult homelessness in a general population, as well as the prevalence of homelessness among people who had completed military service. Of the total respondent population (n=6,017), 5.6% had experienced homelessness, with 2.8% experiencing repeated adult homelessness. The mean ACE score for those experiencing homelessness in this study was 3.9/10 compared with 1.6/10 for the cohort who have never been homeless. When age, gender and ethnicity were adjusted for, ACE scores separately predicted increased odds of experiencing homelessness as an adult ($P < .001$), as well as increased odds of reported physical and mental health problems. Each additional ACE experience reported increased a person's risk of adult homelessness by 20%-49%. Additionally, this study showed other factors were also associated with an increased risk of homelessness, such as a history of incarceration (7.6 times more likely), being unemployed (3.9 times), experiencing mental health issues (2.7 times), and alcohol use problems (2.3 times). Many of these are adult manifestations of ACE exposure.

In a similarly large American study using elements of the 10-question ACE test, linking ACEs and homelessness, Roos et al. (2013) looked at data from the National Epidemiologic Survey of Alcohol and Related Conditions, which collected data between 2001-2002 and 2004-2005. The study involved information from 34,653 face-to-face interviews with participants who were non-institutionalised American citizens, 20 years old or older. The researchers were looking at the relationship between ACEs, homelessness, and significant diagnosed mental health disorders (including major depression, anxiety, social phobias, post-traumatic stress disorders, schizophrenia, and borderline personality disorders). This research concluded that the relationship between having a major mental health disorder and an experience of homelessness was significant ($p < .001$). Within this cohort, each ACE was significantly associated with increased odds of future homelessness, even after adjusting for mental health disorders. An accumulation of several ACEs therefore additionally increased people's risk of both developing a mental health disorder and of becoming homeless.

Of the total cohort, 3.3% (n=1103) had experienced homelessness in their lifetime. Of this group, 79.2% had experienced at least one ACE, compared with 51.3% of those never homeless. For women, childhood emotional abuse was most strongly related to an increased risk of experiencing homelessness and any significant mental health disorder. For men, emotional abuse and sexual abuse was most strongly related to an increased risk of experiencing homelessness, while emotional abuse alone was most strongly related to an increased risk of experiencing any significant mental health

disorder. It was noted by the researchers that the results were likely an underreport because the sample did not include people who were institutionalised, such as those in prison.

The researchers concluded with a recommendation that vulnerable populations be screened for ACEs because of the strong association between ACEs, an increased risk of homelessness, developing mental health disorders and many other health-related issues. This was also recommended because individuals might benefit from specifically tailored interventions related to traumatisation in childhood (Felitti & Anda, 2014; Roos et al., 2013).

There is very limited research linking ACEs with homelessness in New Zealand, although the prevalence of ACE among some homeless cohort has been detected incidentally, rather than intentionally (Al-Nasrallah et al., 2005; Nevil Pierse et al., 2019). For example, Pierse et al (2019, p. 4) examined administrative data from child protection agency Oranga Tamariki/Ministry of Children and showed that despite limited historical data on child abuse, there was a strong suggestion that the homeless cohort being studied (n = 390) had suffered an elevated level of abuse, compared with a large representative cohort of New Zealanders (n = 33,666). The mean occurrence of notifications of care and protection concerns from all data from 1991 to 2016 for the homeless cohort was 5.9 notifications, compared with 0.2 for the comparative cohort. Additionally, the mean occurrence of actual findings of abuse for the same period was 2.3 for the homeless cohort, compared to 0.2 for the comparative cohort. This comparison has limitations however, as we do not know how many of the representative comparative group in this study had ever experienced homelessness in their lives. Therefore, the results of this study do not represent the prevalence of ACEs among those ever homeless in a general population, as this was not the aim of this study. These results suggest, however, that ACEs and homelessness are linked in New Zealand, but to what extent is currently poorly understood.

Other New Zealand studies using the 10-question ACE test includes research involving participants of the Dunedin Study, a longitudinal investigation of health and behaviours in a cohort of 1,037 people born in 1973, in the South Island (Reuben et al., 2016). Most of the participants (95%) were aged 38 years at the time of ACE testing. Close to 42% of the cohort recorded no adverse experience on the ACE test. Approximately 33% scored 1/10, 12% scored 2/10, 7% scored 3/10, and 6% scored 4 or more. The South Island has lower ethnic diversity than other regions in New Zealand, particularly in the 1970's. This research provides us with ACE prevalence in a local context from the 1970's, but not a test of ACEs among a homeless cohort in New Zealand.

Another large study using 8 questions from the 10-question ACE test sort to measure the impact of ACEs on school readiness among children involved in the Growing Up in New Zealand (GUiNZ) study

cohort (Walsh et al., 2019a). The GUiNZ study is a longitudinal birth cohort of 6,000 children born between 2009 and 2010, and their parents. The study showed that by age 4 ½ years, 52.8% of the children in the study (n=5,562) had experienced at least one ACE and 2.6% had experienced 4 or more ACEs. The study did not include questions about sexual abuse the children may have experienced, or mental health issues experienced by the children's parents.

A recent New Zealand study using 8 questions from the 10-question ACE test sought to measure the prevalence of ACEs in a large sample of adults (n = 2,887), and to explore the associations between ACEs and experience of violence by intimate partners, and non-partners in adulthood (Fanslow et al., 2021). Data were drawn from the 2019 New Zealand Family Violence Survey, a population-based study conducted across three regions (Waikato, Northland, and Auckland) between March 2017 and March 2019. ACE prevalence results showed that 55% of participants had experienced one ACE and 11.6% reported at least four ACEs before the age of 18 years. Cumulative ACEs prevalence was higher among Māori participants (n=318, 11%), with 78% reporting at least one ACE and 27.4% reporting four or more ACEs.

Of particular concern to the authors was the high prevalence of Māori participants who reported having a childhood household member who was incarcerated (17%). The authors noted that existing New Zealand literature documents the adverse inter-generational impact of incarceration of Māori, who are disproportionately represented among prison populations (Stanley & Mihaere, 2018; Workman, 2019). Incarceration of a household member can have an immediate impact on housing security for a household (Suzanne Fitzpatrick et al., 2013; Nevil Piersse et al., 2019; Ravenhill, 2008), particularly if the member contributed financially toward rental payments.

Overall, this study showed that those participants who were younger, identified as Māori, were unemployed, were living in highly socioeconomically deprived areas, and had low food security, reported significantly higher prevalence of ACEs ($p < 0.001$). Exposure with any ACE type was significantly associated with later-life exposure to inter-partner violence and non-partner violence. Compared to those with no ACE exposure, those with exposure to 4 or more ACEs were between 4.3 and 9.5 times more likely to report exposure to various forms of intimate partner and non-partner violence as adults.

While providing useful information about ACE prevalence among various New Zealand populations, the results of the few studies using ACE testing represented do not test the prevalence of ACEs among those ever homeless, as this was not the aim of these studies. One study does, however, make associations between ACE and increased risk of later-life domestic violence, which is a contributing factor to relationship breakdowns, a factor well-recognised as a contributor to housing insecurity and

homelessness (Chamberlain & Johnson, 2013; Suzanne Fitzpatrick et al., 2013; Ravenhill, 2008; Shinn et al., 2007). The study involving data from the New Zealand Family Violence Survey also highlights a disproportionately high burden of ACEs among Māori participants, which the authors have linked with the intergenerational impacts of experiences of colonization, and historical and cumulative trauma (Pihama et al., 2014). These cultural complexities will be discussed in more detail in section 2.5.

2.2.3 Diminished social capital contributing to social exclusion

Single adult homelessness may be considered the epitome of social exclusion, and lack of access to social support networks and resources at crisis point is often a critical contributing factor (Clapham, 2007). Social networks form part of an individual's social capital (Kingi et al., 2013). Therefore, discussion about diminished social capital, social exclusion and homelessness intersect. To follow is a description of the capitals framework, situating discussion about social capital as it relates to homelessness. Discussion about social exclusion as it links with homelessness is then presented.

2.2.3.1 *Diminished social capital*

The ability to participate in economic, cultural, social and political aspects of society relies on an individual having access to reserves of resources or capabilities related to these aspect, which are also referred to as capitals (Clapham, 2007; Kingi et al., 2013; Ravenhill, 2008; Shinn et al., 2007). An individual's lack of access to capitals such as physical capital (for example, housing), economic capital (income and financial reserve), human capital (human capabilities such as educational attainment and work experience) (Shinn et al., 2007; The New Zealand Treasury, 2019) and cultural capital (for example, participation in cultural practices (Kingi et al., 2013)), having connections with one's whānau, hapū and iwi) can contribute to raising someone's risk of single adult homelessness (Clapham, 2007; Lawson-Te Aho et al., 2019; Ravenhill, 2008; Shinn et al., 2007). An individual's access to these capitals is often influenced by structural factors, including social policies and processes. Diminished social capital can also result from a lack of access to social networks made up of family, and kinship networks, friends, and colleagues. Loss of employment, for example, may mean an individual also loses contact with networks of work colleagues, which includes a loss of access to any goods and other resources these colleagues may have been willing to share (Kingi et al., 2013).

Other examples of factors resulting in an erosion of social capital includes an individual's experience of trauma in childhood and time spent in foster care, or other out-of-home placements. These experiences can result in later life dislocation from family and kinship networks (Suzanne Fitzpatrick et al., 2013; Lambie, 2018; Ravenhill, 2008; Shinn et al., 2007). As discussed in section 2.2.2, out-of-home placement has commonly been experienced by those who are homeless (Suzanne Fitzpatrick et al., 2013; Ravenhill, 2008; Tyler & Schmitz, 2013). For example, in research that was carried out across

seven cities in the UK in 2010, involving 452 people from 39 homeless services, nearly half of all the participants (48%) had been in local authority care as a child (Suzanne Fitzpatrick et al., 2013, p. 157).

Opinions about an individual's perceived lack of social capital is subjective. Individuals who are homeless may have differing views about the level of social capital to which they have access. Ravenhill (2008) notes that among homeless communities, problems and difficulties often viewed as negative social capital by the housed community (for example, being born into a gang related family network) may be seen as "badges of honour" by some who are homeless.

Social capital may also be understood differently between various population groups (Kingi et al., 2013). For example, some Māori and Samoan communities in New Zealand place high importance on community-based social capital, related to the extension of a sense of social security through resources and support shared among kinship groups in close-knit communities. Literature related to additional cultural complexities that arise from the impact of erosion of kinship networks among Māori who are homeless will be discussed in section 2.5.2.

Additionally, considering the importance of social capital among Indigenous groups, a recent article compared Maslow's hierarchy of human needs (Maslow, 1943) with an Indigenous worldview. Maslow's model highlights the importance of physical capitals, food, clothing, shelter, and safety, as primary human needs. Improving physical capitals is also the focus of many homeless responses, which gives primary importance to providing housing as a basic human right, along with facilitating access to food and clothing. However, an alternative First Nation perspective from the Blackfoot tribe highlights the importance of social capital, specifically belonging to a community (Ravilochan, n.d.). This is because basic needs such as food, clothing, and shelter, are extended to all tribal members by virtue of being a member of this community. Homeless policy and program provision taking this focus might concentrate on connecting people with a social network as a primary intervention.

A similar conceptual approach, highlighting the importance of belonging to a community is the 'Whānau Ora approach' or 'whānau-centred approach' which informs Government health and social services supporting Māori. Whānau Ora is a "culturally grounded, holistic approach focused on improving the wellbeing of whānau (families) and addressing individual needs within a whānau context" (Te Puni Kokiri, 2015, p.9). This approach was developed to refocus service delivery and policy related to health and social services supporting Māori away from a focus on individuals and single-issue problems, instead expanding support for the wellbeing of the family or extended family the individual was situated in.

In summary, diminished social capital contributes to social exclusion and raises an individual's risk of single adult homelessness. A lack of access to social networks made up of family, and kinship networks, friends, and colleagues means some face homelessness alone. The importance of social capital of this nature can be understood differently between various population groups, with some groups seeing a lack of connection with kinship networks as pivotal to homelessness. Among Māori, social capital is considered in relation to the collective wellbeing of an individual's family (whānau) and extended family. Loss of connection with family therefore has additional impact for some Māori who are homeless.

2.2.3.2 *Social exclusion*

Social inclusion is the ability of an individual to participate fully in economic, cultural, social and political aspects of society (Watson et al., 2016). Social exclusion therefore involves an individual having an inability to participate in these aspects. Socially excluded people are more likely to become homeless (Clapham, 2007). Individuals who are homeless often experience social exclusion as a diminished quantity and quality of social supports, or social capital. A lack of positive social support at critical moments often contributes to housing precarity (Ravenhill, 2008). An example would be having no one to turn to for help if issued with a 24-hour eviction notice.

Individuals who are highly socially excluded are also more likely to engage in high risk health behaviours such as problematic substance use, and are at a higher risk of compromised physical and psychological health (Watson et al., 2016). These issues can, in turn, act as contributors to discrimination, and to an increased risk of homelessness, illustrating the interrelated and cyclic nature of contributing factors.

Along with being a catalyst for fractured relationships among family, out-of-home placement in people's adolescence and youth has a high association with later-life social exclusion, as well as an increased risk of poor mental health outcomes throughout a person's life (Roos et al., 2013, p. 275). Mental health issues can contribute to a person being socially excluded (Mejia-Lancheros et al., 2021). For example, acute conditions may contribute to discrimination when applying for rental tenancies. This is yet another example of the cyclic and interrelated nature of contributing factors.

In summary, individuals who are homeless often have diminished social networks, social ties and social resources to call on in a crisis (Ravenhill, 2008). Social exclusion has shown to be a key contributing factor to homelessness (Clapham, 2007; Suzanne Fitzpatrick et al., 2013; Ravenhill, 2008; Straaten et al., 2018). Diminished social capital contributes to social exclusion (Shinn et al., 2007). Homelessness may be the ultimate expression of social exclusion and some authors believe that homelessness and

social exclusion must, therefore, be discussed in tandem (Clapham, 2007). Diminished social capital, social exclusion and homelessness are intricately intertwined concepts.

2.2.4 Crisis point - Individual trigger events

Homeless discourse sometimes includes discussion about individual trigger events which may precede episodes of single adult homelessness (Isobel Anderson, 2001; Suzanne Fitzpatrick et al., 2013; Ravenhill, 2008). These seemingly isolated events are often the final pain point in a string of events which have contributed to a raised risk of homelessness, and seldom the sole contributing factor.

Relationship breakdowns are one of the most prevalent trigger events cited for loss of an individual's last tenancy leading to homelessness (Chamberlain & Johnson, 2013; A. Jones & Pleace, 2010; Ravenhill, 2008). This includes relationship breakdowns between youth and their parents, resulting in individuals running away from home or leaving home completely (Chamberlain & Johnson, 2013; G. Johnson & Chamberlain, 2008; Ravenhill, 2008). Often this is an individual's first experience of homelessness (Rua et al., 2019). Later life relationship breakdowns including divorce, separation, or death of a long-term partner, can also contribute to a loss of tenancies. Loss of tenancy can also result from a breakdown in relationship between flatmates and other household members, including family. This breakdown may involve additional factors, such as problematic substance use, mental health issues, domestic violence (Padgett et al., 2016; Tsemberis, 2015). Homelessness can result from a household member being asked to leave, or a landlord evicting tenants for neighbourhood disturbance. Victims of domestic violence may need to swiftly exit a property for safety reasons (Shiloh Groot, 2010; Lambie, 2018; Padgett et al., 2016; Ravenhill, 2008). Additionally, if a household member is incarcerated, this may impact the financial viability of a tenancy for the remaining tenants.

Along with relationship breakdowns, economic disruption is another often cited trigger event resulting in loss of a tenancy and eventuating in an episode of homelessness (Chamberlain & Johnson, 2013; Shinn et al., 2007). Loss of employment, or an unexpected debt, for example, can mean people are unable to pay rents, which may lead to eviction. The effects of economic disruption can be more pronounced among single adults. For example, loss of employment for one partner in a relationship may not necessarily result in a loss of tenancy as the wage of an employed partner acts as a protective factor. A significant relationship has been shown to exist between increased rates of homelessness and increased proportions of single-person households in a community (Culhane et al., 2013).

While individual trigger events, such as relationship breakdowns or economic disruption, do contribute to immediate episodes of homelessness for some, they are seldom the sole contributing factor. Research has shown trigger events can predate homeless episodes by up to 9 years (Ravenhill, 2008). More latterly, trigger events are understood as additional contributing factors to homelessness,

not the cause. These events are, therefore, considered in context of the longitudinal and dynamic impact of such events across people's lives, which is the perspective taken in a pathways approach to understanding homelessness, described in section 2.4.

2.2.5 Problem gambling and traumatic brain injury

Problem gambling can contribute to housing insecurity (Matheson et al., 2014). Excessive portions of income spent on gambling are linked to relationship breakdowns, job loss and eviction due to rent arrears. Each of these issues is also associated with an increased risk of homelessness. Problematic gambling can take time to result in homelessness. For example, loss of employment and relationship breakdowns related to problematic gambling are often the result of an escalation of financial pressures over time. This understanding supports the need for a longitudinal approach to determining drivers of homelessness.

Research has shown gambling problems are more prevalent among those homeless than non-homeless, and gambling problems also increased risk of homelessness. Therefore, gambling can both contribute to homelessness and exacerbate circumstances for those who are already homeless. Gambling behaviours are also linked to other problematic addictions and mental illness, both of which have been previously demonstrated to contribute to homelessness.

Similarly, there is a high prevalence of traumatic brain injury (TBI) among those who are homeless (Mejia-Lancheros et al., 2020; Oddy et al., 2012). TBI's are associated with mental health disorders such as post-traumatic stress disorder, anxiety, depression, and cognitive disorders. TBI's are also associated with physical health disorders, such as neurological and endocrine dysfunction. Additionally, TBI's can contribute to social behaviour deficits, affecting a person's ability to communicate, adapt, to integrate into a community, and to interact with others. The high prevalence of those homeless with TBI's can be a result of a high level of violence experienced while homeless. TBI's may have been acquired during violent events in childhood (Atwool, 2019; Felitti & Anda, 2014). There is also an association between the high prevalence of TBI's among those who have been to prison (Durand et al., 2017; Mitchell et al., 2017), and a high prevalence among those homeless with imprisonment histories (Baldry et al., 2006; Montgomery et al., 2013). Overall, research has demonstrated that those with a TBI, however acquired, are at a greater risk of homelessness.

2.2.6 Summary of individual contributing factors

Many individual factors are associated with an increased risk of single adult homelessness. Mental health and problematic substance use are individual factors often prevalent among single adult homeless. These health issues can contribute directly to homelessness, for example contributing to a

breakdown in relationship with other household members leading to eviction. Additionally, these issues can contribute more indirectly, for example being a basis for discrimination when seeking employment. Employment is a protective factor against homelessness, with the potential for increased household income providing more options when a crisis (Mejia-Lancheros et al., 2021). Health issues are often accumulative. Problematic gambling, for example has been linked to mental health issues and other additive behaviours such as problematic substance use. Each of these elements has been linked separately to homelessness. However, their combined impact is associated with an even greater risk of homelessness (Montgomery et al., 2013).

A disproportionate number of single adult homeless have survived ACEs and therefore an association exists between being a survivor of ACE's and an increased risk of future homelessness. Family violence in people's childhood households contributes to a high number of ACE survivors experiencing out-of-home placements in youth, often due to state intervention. This experience can contribute to diminished social capital later in life. Additionally, physical violence experienced in childhood may result in a TBI, which can contribute to biopsychosocial complexities later in life and is associated with an increased risk of homelessness.

There is an association between diminished social capital, social exclusion, and an increased risk of single adult homelessness. Individuals who have diminished social capital have fewer avenues of support when in housing crisis. Equally, individuals who are socially excluded are at a much higher risk of homelessness than those with strong social supports. Single adult homelessness may indeed be the ultimate manifestation of social exclusion.

Many of the individual issues discussed are intricately interwoven and there is often a cyclic nature to the impact of these factors. In addition, individual factors are often influenced, and exacerbated by, structural issues, which have also increased people's risk of homelessness. Discourse relating to structural factors increasing the risk of single adult homelessness is now discussed.

2.3 Structural contributing factors

Traditional explanations of single adult homelessness also include considering the contribution structural issues have made to raising the risk of homelessness in a community (Isobel Anderson & Christian, 2003; Suzanne Fitzpatrick et al., 2000; Neale, 1997; Shinn, 2007). They are macro-socioeconomic factors out of the locus of control of an individual. Structural explanations for homelessness often focus on the contributions of housing market constraints, systems failure, inequity, employment constraints and poverty. Additionally, discrimination including racism, and

colonisation are also structural factors associated with an increased risk of homelessness in some countries. Each of these factors will now be discussed.

2.3.1 Lack of access to affordable, adequate housing

Lack of access to minimally adequate and affordable housing is the presenting issue for single adult homeless people (K. Amore et al., 2020). Policy responses therefore often focus on improving people's immediate access to accommodation. Government's responsibility to provide adequate housing is often framed from the perspective of housing as a human right (Human Rights Commission, n.d.), and adequate shelter as an essential element of basic human need (Maslow, 1943). Further, housing has been shown to be a determinant of health (National Health Committee, 1998), and an important element in helping aid recovery for individuals who have a complex range of health and other issues (Tsemberis, 2015). Having stable housing contributes to ontological security (Dupuis & Thorns, 1998; Giddens, 1991). A home provides an environment allowing for social and material constancy, a secure base around which identities form, a place where inhabitants may feel in control of some aspects of their lives, where they may go about daily routines of human existence, generally free from surveillance (Dupuis & Thorns, 1998, p. 29).

Homeless discourse related to housing normally involves each of the following elements:

- Housing supply issues.
- Costs of rental accommodation.
- Barriers to accessing accommodation.
- Landlord discrimination.
- Inadequacy of available affordable housing.

Each of these elements will now be discussed.

National housing shortages, particularly of affordable, often state-provided housing, has been noted as a prime exacerbating structural issue contributing to homelessness in many countries, including the UK, USA, Canada, Australia, and New Zealand (I Anderson & Tulloch, 2000; J. T. Anderson, 2016; Chamberlain & Johnson, 2013; Suzanne Fitzpatrick et al., 2000; Howden-Chapman, 2015; A. Johnson et al., 2018; MacKenzie & Chamberlain, 2003; Shinn, 2007). Housing supply issues can be additionally problematic for single adult homeless as there is often an even more pronounced shortage of single-person housing in communities (Brame, 2018; Culhane et al., 2013). People who have multiple barriers to accessing private rental accommodation are often relegated to state-provided and other social and community housing. Where there is also a shortage of these types of housing in a community, the risk of homelessness is further compounded.

Constrained housing markets contribute to a lack of affordable rental properties (J. T. Anderson, 2016; A. Johnson et al., 2018; Rua et al., 2019). Under these conditions, landlords often have many potential tenants vying for cheaper accommodation. This situation can be exacerbated if communities have large populations of people with limited income. Additionally, a subset of cheaper rental properties in a community will often include accommodation intended for shorter-term tenancies. Communities with large student populations will have additional pressure placed on supply of this type of housing. Students will be among those vying for these types of tenancies, along with those with lower incomes. This is the situation in Hamilton (Brame, 2018), where there is a large student population, limited affordable housing, limited social housing and oversubscribed housing with shorter-term tenancies.

People with multiple barriers to accessing scant offerings of affordable housing in a community are at greater risk of homelessness (J. T. Anderson, 2016; Chamberlain & Johnson, 2013; S. Fitzpatrick, 2012; MacKenzie & Chamberlain, 2003). Many barriers relate to individual factors such as people's criminal histories, poor credit ratings, health and wellbeing issues and a lack of social networks to draw on in a crisis. These issues have been discussed in section 2.2. However, structural factors such as inadequate support from social services at critical points, and racism add additional barriers.

When faced with a housing crisis, individuals may seek the support of social agencies to register for eligibility for public housing, to access emergency housing, or for financial support to be able to afford rental and utility bonds, among other things. Commenting on housing precarity among Māori, Rua et al (2019, p. 6), notes that many have found these interactions with social services "dehumanising and demoralising". Agencies' offices can be physically punitive environments characterised by security guards, cameras and a lack of private space to discuss sensitive issues (Rua et al., 2019). Further, some have experienced hostile, and humiliating exchanges with agency staff, exchanges laden with coercion, denial of entitlements, blaming and a high level of intrusion when seeking legitimate support. Past experience of this type of poor treatment often deters people from even attempting to access accommodation where these agencies need be involved. This barrier is simply the final pain-point in a long line of barriers to accessing accommodation. A recent report by the New Zealand Productivity Commission concluded that people with complex needs, such as some single adult homeless, need additional support to navigate social services equitably (New Zealand Productivity Commission, 2015). Additional support is particularly critical when people are in crisis. Therefore, inadequate support from social services increases people's risk of resorting to homelessness, rather than attempting to seek this type of support.

Having multiple barriers to accessing housing in the private rental market often relegates single adults to living in boarding circumstances or co-living style accommodation (Isobel Anderson & Christian,

2003; A. Jones & Pleace, 2010). This style of accommodation often has communal facilities, such as laundry or cooking facilities. Where groups of people with complex issues are congregated together, communal facilities can be problematic. Additionally, tenancy agreements for co-living facilities are often of a more precarious nature, being based on boarding house tenancy rules, with stricter conditions around visitors, low tolerance for problematic behaviours and shortened eviction notice periods (Howden-Chapman, 2015; A. Jones & Pleace, 2010; Ravenhill, 2008). A recent report from the UK reviewing a program aimed at reducing rough sleeping in Greater Manchester concluded that shared and congregate forms of accommodation were highly detrimental to some people's wellbeing (Watts, 2021). This was in part because shared accommodation can lead to daily fracas among residents and sometimes harm. These tenancies therefore often have a high turnover. Some individuals who exit co-living style accommodation due to additional biopsychosocial pressures of congregate living will have few alternative housing options. Some exit to homelessness. Therefore, not only is a shortage of housing a contributing factor, the type of housing available to single adults on a limited income is also a confounding structural issue raising the risk of adult homelessness.

2.3.2 Racism, inequity, and colonisation

Racism contributes to an increased risk of homelessness, both New Zealand and in other countries (Andrew, Aubry, Belanger, Bird, Birdsall-Jones, et al., 2016; Shiloh Groot & Peters, 2016; Lawson-Te Aho et al., 2019; Rua et al., 2019). Indigenous population groups in other countries report high rates of rental application rejection, as well as high rates of episodes of race-based eviction (J. T. Anderson, 2016; J. T. Anderson & Collins, 2014). Some of these actions represent personally mediated racism, which is race-based prejudice and discrimination levied by one individual toward another (Jones, 2000). In addition, where there are poor and inadequate mechanisms and policies in place to address the specific population needs of communities defined by race (or in the New Zealand context by ethnicity), this represents a societal failure to rectify institutional racism, which is race-based inequitable access to goods, services, and opportunities in a society, including housing. This also represents structural racism and the ongoing impacts of the hierarchical strategies of power and resource distribution established through the colonial experience. Therefore, racial discrimination experienced in attempts to access housing, exacerbated by both individual and structural factors, and supported by the racism enacted in legislation and at the systems level, contributes to a raised risk of homelessness.

Indigenous people are over-represented among those homeless in many countries which have been colonised in their past, including Canada, Australia, and New Zealand (J. T. Anderson & Collins, 2014; Andrew, Aubry, Belanger, Bird, Birdsall-Jones, et al., 2016; Lawson-Te Aho et al., 2019; Thistle, 2017;

Walters et al., 2010). The 2018 census in New Zealand showed that Māori were disproportionately represented among those lacking access to minimally adequate housing, or experiencing homelessness (K. Amore et al., 2020). Proportionally, Māori were close to four times more likely to be severely housing deprived than New Zealand European. It was noted by Amore et al that data collection issues meant that information for Māori in this census was an undercount. Accordingly, the disparity in prevalence between population groups is likely to be higher. Māori are also overrepresented among participants of the case study population working with TPP (Atatoa Carr et al., 2018). Therefore, homeless discourse focusing on additional complexities for this population group is relevant to this study.

There is a broad consensus of opinion that the over-representation of Māori among those homeless in New Zealand is linked to the enduring effects of colonisation (J. T. Anderson & Collins, 2014; Collins, 2010; Shiloh Groot & Peters, 2016; Hodgetts et al., 2014; Lawson-Te Aho et al., 2019; Nevil Piersé et al., 2019; Rua et al., 2019; L. T. Smith, 2013). Historically, colonisation resulted in displacement of Māori from their ancestral land and the consequential degradation of important kinship systems (Lawson-Te Aho et al., 2019; Rua et al., 2019). Displacement from ancestral land contributed to a loss of cultural and spiritual connectedness and identity for many Māori (Hodgetts et al., 2010; L. T. Smith, 2013). Ancestral land is of paramount importance to Māori (L. T. Smith, 2013). Tūrangawaewae in Māori culture means a sense of identity and independence associated with having a home base. Land affords spiritual and cultural links for people to a geographical place, where their ancestors have lived and their remains may still lay (S. A. M. Groot et al., 2012; Rua et al., 2019). Consequently, the relationship between the intergenerational sense of loss of connection with one's ancestral land is heightened for some Māori who are homelessness (Shiloh Groot & Peters, 2016). This is sometimes referred to as spiritual homelessness (Shiloh Groot & Peters, 2016; Rua et al., 2019; L. T. Smith, 2013; Thistle, 2017).

Along with feeling disconnected from ancestral land, being homeless for some Māori heightens their sense of loss of physical connection with whānau (family), hapū (subtribe), and iwi (tribe), important kinship networks integral to this culture's sense of identity (Shiloh Groot & Peters, 2016; S. A. M. Groot et al., 2012; Lawson-Te Aho et al., 2019). In research about Māori who are homeless, people expressed a profound sense of whakamā (shame and humiliation) at being disconnected from whānau (family) and hau kāinga (their ancestral homeland) (Shiloh Groot & Peters, 2016).

The deep destabilisation of Indigenous cultures, including Māori, by colonisation and the ongoing impact of brutal historic events, loss of power, autonomy and resources has caused intergenerational trauma (Pihama et al., 2014; L. T. Smith, 2013; Thistle, 2017), which some consider the root of Māori

homelessness (Lawson-Te Aho et al., 2019). Unresolved grief from historical trauma can manifest as disproportionate levels of mental, cognitive, behavioural, social, and physical challenges for Indigenous groups (Pihama et al., 2014; Walters et al., 2010). As detailed in section 2.2, such biopsychosocial factors are highly associated with an increased risk of homelessness.

There are additional cultural practices for Māori which can influence activity when family members have nowhere to live (Shiloh Groot & Peters, 2016). For example, for some Māori there is an expectation that family members without secure accommodation will be taken in by their kin (J. T. Anderson & Collins, 2014; Rua et al., 2019). This factor may have contributed to the high prevalence of Māori who were doubled-up, sharing accommodation as temporary residents in severely overcrowded private dwellings on census night (n=10,938) (K. Amore et al., 2020). This prevalence was higher than among any other ethnicity. This custom can be both a source of strength and stress for people, who may be experiencing their own precarity (Rua et al., 2019). For single adult homeless who are Māori and who may have been excluded or disconnected from such cultural and familial support, perhaps because they have worn out their welcome, research has shown their sense of whakamā (shame) is further compounded (Shiloh Groot & Peters, 2016).

Racism has shown to be deeply imbedded in many settler and colonial cultures and systems, including in New Zealand (Andrew, Aubry, Belanger, Bird, Birdsall-Jones, et al., 2016; Lawson-Te Aho et al., 2019; Pihama et al., 2014; Rua et al., 2019; L. T. Smith, 2013; Thistle, 2017). Racism is recognized as a major contributor to homelessness (J. T. Anderson, 2016; J. T. Anderson & Collins, 2014, p. 969; Andrew, Aubry, Belanger, Bird, Birdsall-Jones, et al., 2016; Shiloh Groot et al., 2008; Lawson-Te Aho et al., 2019; Rua et al., 2019). Imbedded racism creates additional race-based systemic barriers for many ethnicities within New Zealand. Institutionalised racism, for example, contributes to inequitable access to health, education, and housing opportunities for Indigenous and other communities (Barker et al., 2017; Harris et al., 2018; Lawson-Te Aho et al., 2019). Inequitable access to resources has contributed to Māori carrying a greater burden of ill-health, material poverty, poor educational achievement, and shortened life expectancy than other population groups. Decreased access to education and employment opportunities, and poor health are acknowledged contributors raising the risk of homelessness. Therefore, inequitable access to resources and discrimination are factors that contribute to Māori being disproportionately represented in homeless counts.

Institutionalised racism has also contributed to the overrepresentation of Māori in other poor social outcomes. In 2019, there were four times as many Māori children in state care as other population groups (Tanielu et al., 2020). Additionally, there were six times as many Māori in prison, and on the public housing wait list as other population groups. The practices of New Zealand's child protection

services have recently come under review due to public concern about practices involving Māori children in state care (Atwool, 2019; Radio New Zealand; Whānau Ora Commissioning Agency, 2020). Discussing the over-representation of Māori children in child protection services, Atwool (2019, p 28) referred to this prevalence as New Zealand’s “own stolen generation”, comparing the practice of excessive separation of Māori children from their family and cultural connections by child protection services to policies resulting in removal of Indigenous children from their families to residential schools in Canada. Experience of state care, and institutionalisation in prison are linked with an increased risk of homelessness. Therefore, these inequities, caused by institutionalised and other structural racism, have added further risks of homelessness for Māori. Racial discrimination also impacts other population groups in New Zealand (K. Amore et al., 2020; Tanielu et al., 2020). It is broadly acknowledged that Pacific people, for example, are also over-represented among data about homelessness, ill-health, and criminal justice outcomes.

Structural racism is the antecedent to a much more insidious form of racism. Internalised racism, an individual factor, involves an acceptance by members of stigmatised population groups of negative messages about their abilities and their intrinsic worth, which can result in self-imposed limitations on people’s right to self-determination and expression (C. P. Jones, 2000, p. 1213). Internalised racism can lead to individuals failing to recognise and report discrimination. While there is still limited research linking internalised racism to homelessness in New Zealand, this effect has been noted in research about racism in the health sector in this country (Harris et al., 2018). Internalised racism contributes to poorer health outcomes for some stigmatised population groups, who may not seek treatment for conditions based on various self-imposed limitations. Therefore, since increased prevalence of health issues can contribute to an increased risk of homelessness, it follows that this form of racism has probably also contributed to homelessness, although this has not been specifically measured.

From this discussion, it can be seen that additional race-based complexities contribute to an increased risk of homelessness for some population groups in New Zealand. Racism contributes to inequitable access to resources, over-representation in poor social outcomes for some population groups, and an increased risk of homelessness. Being homeless for some Māori is about more than being houseless: they feel shame (*whakamā*) about being disconnected from ancestral ties, from familial support and from a home base on their ancestral land from which to weather life’s adversities. Historic trauma caused by colonisation, that may manifest as complex biopsychosocial issues, adds additional complexities for some Māori. Additionally, some racism can remain internalised, unreported and undetected (C. P. Jones, 2000). The link between internalised racism and homelessness may, therefore, be the hardest to evidence.

2.3.3 Poverty

Constrained income levels restrict people's housing options further. Having access to adequate income means people can usually avoid homelessness, even if they are experiencing personal crisis (Suzanne Fitzpatrick et al., 2000). Therefore, structural issues that adversely impact people's income levels, also raise the risk of homelessness. A downturn in an economy can result in increased unemployment, for example. Sudden unexpected loss of regular income can result in the loss of a tenancy, particularly for single adults (Culhane et al., 2013; A. Jones & Pleace, 2010). Where there is a proliferation of people employed in more precarious work types, such as casual labour or short-term contracts, this may raise the risk of homelessness. There is a disparity in this effect between men and women in some countries, with women, particularly those who are single-parenting, at greater risk of employment precarity (Esping-Andersen, 2007; Rua et al., 2019). It follows this group is at greater risk of homelessness.

At a macro level, some US and European studies found evidence that where welfare provision is adequate and housing affordable, some forms of homelessness appeared lower (A. Jones & Pleace, 2010; Shinn et al., 2007; Tsemberis, 2015). Conversely, where welfare levels have not kept pace with inflation, particularly inflation in the cost of accommodation, this raises people's risk of homelessness. This is the case in New Zealand (Boston, 2013; A. Johnson et al., 2018), where benefit levels have not kept pace with the cost of living and rent levels have risen significantly in relation to people's incomes.

There is consensus that those living in poverty are at an increased risk of multiple poor social outcomes, including homelessness (Isobel Anderson & Christian, 2003; Suzanne Fitzpatrick et al., 2000; Hodgetts & Stolte, 2017; Ravenhill, 2008; Tanielu et al., 2020). However, authors such as Suzanne Fitzpatrick (2005) caution that there is also research to prove that the great majority of people living in poverty do not become homeless. This author suggests we need to ask what is it about poverty, as well as other factors, that could increase someone's risk of homelessness. Poverty is, for example, linked to social exclusion (Clapham, 2007; Straaten et al., 2018), including inequitable access to resources, such as health care, which is a form of discrimination, a structural issue (Hodgetts & Stolte, 2017; Watson et al., 2016). A decline in access to healthcare may mean that people's existing health issues go untreated. Untreated health issues such as mental health challenges and problematic substance use can exacerbate relationship issues. Relationship breakdown is a common trigger event for an episode of homelessness. Therefore, poverty has the potential to exacerbate many existing issues individuals face and impacts households in multiple ways, beyond increasing housing precarity.

There is also a link between poverty and an increased risk of childhood adversity (Allen & Donkin, 2015; Metzler et al., 2017). For example, measuring the impact of local deprivation in the UK between

2010 and 2015, research showed children who lived in the most deprived 10% of neighbourhoods had 11 times greater chance of being in child protection services than those living in the 10% least deprived areas (Bywaters et al., 2016).

Poverty can be experienced intergenerationally (Metzler et al., 2017). Adults who live in poverty have increased odds of experiencing inequitable access to education and employment opportunities. As a result, children of parents who live in poverty are themselves at a greater risk of unemployment or earning lower incomes as adults. In New Zealand, due to the long term inadequacy of welfare income levels (Kiro et al., 2019), families who are intergenerational recipients of welfare are considered to have lived multiple generations in relative poverty, and have been referred to as the “permanent poor” (Shiloh Groot & Peters, 2016). Māori are overrepresented among this cohort.

Debt contributes to poverty (Bramley et al., 2020; A. Jones & Pleace, 2010; Tanielu et al., 2020). There are many forms of debt⁵. Institutional debt in New Zealand can be incurred through court fines and reparations, student loans, income tax debt, child support debt, and advances in welfare payments. Poor co-ordination of the levying of institutional debt can leave people with even less money for rent. This is because these types of debt are often deducted directly from people’s benefits before they receive the remainder as a weekly or fortnightly payment. In a recent report about destitution in the UK, the authors recommended governments ensure that debt deductions from benefits were not a driver of hardship and destitution (Bramley et al., 2020). There is still limited evidence about how much institutional debt has contributed to homelessness in New Zealand.

2.3.4 Systems failure

There is a consensus that systems failure, meaning a failure of government-led public services to deliver effective service, has contributed to homelessness in New Zealand (Batterham, 2017; Nevil Pierse et al., 2019; Rua et al., 2019). Systems failure includes inadequate treatment and support when dealing with government and other social sector organisations (Rua et al., 2019), a lack of co-ordinated

⁵ Forms of Debt: Institutional debt includes advances from Work and Income for things like purchases of essential whiteware, emergency dentistry, and rental bonds. Other forms of institutional debt include courts fines and reparations, tenancy tribunal debts and student loans.

Consumer credit lending is another form of debt. The Ministry of Consumer Affairs categorises forms of consumer credit lending into three different tiers (Colmar Brunton Social Research Agency, 2011). First-tier lenders are registered banks. Debts to banks includes personal loans, overdraft fees, and credit card debt. Building societies, credit unions and public service investment societies make up second-tier lenders. Many beneficiaries in Hamilton bank with credit unions because they generally have less onerous joining criteria. Third-tier lenders are finance companies other than those who offer finance exclusively to businesses, such as pawn brokers and mobile lending trucks. These lenders often extend credit to people at a level unrelated to people’s ability to repay their debts. Their offerings are often at grossly inflated prices and repayment includes very high interest rates, sometimes as much as 400% per annum. This has been called predatory lending because unscrupulous lenders often target beneficiaries who are already living in poverty, some of whom have poor financial literacy (Salvation Army, 2019).

Other debt includes debts to gangs. Participants report that loans to gangs for drug debt carries the highest interest component of all. Unpaid debts double weekly until paid and can result in confiscation of one’s bank card, other forms of extortion and violent retribution if unpaid.

care and support between organisations (Nevil Pierse et al., 2019) and inadequate support when exiting care and custodial state-run institutions. It also includes failures in state-provided health, education, social housing, mental health, and disability services. Poorly supported exits from institutional care are recognised triggers of episodes of homelessness (Suzanne Fitzpatrick et al., 2000; A. Jones & Pleace, 2010; Ravenhill, 2008). This can include poorly supported exits from prison. Despite having long-standing relationships with often multiple state-run organisations, homelessness still ensues for many people (Nevil Pierse et al., 2019). These relationships have not therefore been a protective factor.

Former prisoners are at a higher risk of homelessness than the general population (Baldry et al., 2006). People's corrections histories can result in discrimination when attempting to secure accommodation. Therefore, additional support is needed to support this cohort find housing on exiting custodial care. Being sentenced to time in prison can also result in people losing tenancies (Clapham, 2007; Nevil Pierse et al., 2019). An example is when a person is sentenced to go directly to prison after a court hearing, without any possibility of finalising their tenancy.

Poorly supported exits from other institutions have also shown to increase people's risk of homelessness. This includes poorly supported exits from acute mental health facilities (Suzanne Fitzpatrick et al., 2000; Nielsen et al., 2018). Having spent time in out of home or state care through child-protection services has shown to increase the risk of someone becoming homeless (Batterham, 2017; Suzanne Fitzpatrick et al., 2013; Ravenhill, 2008). Being in foster care can disrupt people's relationships with supportive family, meaning people have fewer supporting relationships to draw on when ageing out of care. Additionally, poorly supported exits from state care in adolescence can result in episodes of homelessness.

2.3.5 Summary of structural contributing factors

Lack of access to affordable, appropriate housing is a prime presenting issue for single adult homeless. The pressure of an inadequate supply of affordable housing in a community is compounded where there is high demand for this housing. Contextual issues such as large student populations in a community and large populations of people living on low incomes can contribute additional housing pressure among those vying for this housing. Without access to a stable place to call home, an individual may have a reduced sense of ontological security. Stable housing is also shown to be a determinant of health and wellbeing.

Racism, inequity, and colonisation also contribute to homelessness. Personally mediated racism on the part of landlords contributes to various population groups being denied access to rental accommodation and being evicted more frequently. Structural racism has shown to contribute to

inequitable access to health, housing, and other opportunities in New Zealand. Inequitable access to health resources means medical conditions go untreated among various populations, contributing to people's ill-health issues worsening and accumulating. Untreated health issues contribute to a raised risk of homelessness. The overrepresentation of Māori among those homeless is also linked to the enduring effects of colonization. Historical trauma may manifest as complex biopsychosocial issues, adding additional complexities for some Māori who are homeless.

Having less income means people have fewer options in a housing crisis. Poverty therefore plays a part in an increased risk of homelessness. Poverty can be experienced intergenerationally. Employment precarity and debt, which includes institutional debt, also contributes to housing precarity.

Systems failure has shown to contribute to homelessness in New Zealand. A lack of appropriate and co-ordinated support of highly vulnerable service users has contributed to some avoiding asking these organisations for help when in crisis. A lack of adequate support when existing care and custodial institutions and settings has also contributed.

2.4 Pathways to single adult homelessness.

The individual/structural dichotomy is now considered an overly simplistic explanation of homelessness (Clapham, 2007). A consensus position holds that single adult homelessness is the result of a complex interplay of both individual and structural factors (Clapham, 2007; Suzanne Fitzpatrick et al., 2000; A. Jones & Pleace, 2010). There is ongoing argument however about a hierarchy of contributing factors, considering which factors are more important (Suzanne Fitzpatrick, 2005).

Research confirms that people's wellbeing issues have been existing issues that have been part of their lives long before they became homeless (Ravenhill, 2008). Structural factors merely exacerbate these and other existing individual issues for people (Piat et al., 2015), creating pressures and constraining their ability to resolve difficult housing situations (Isobel Anderson & Christian, 2003). Similarly, trigger events such as a relationship breakdown, a financial crisis or an eviction are seldom the sole cause of homelessness (Suzanne Fitzpatrick, 2005; Nooe & Patterson, 2010; Ravenhill, 2008). The pressure created by layering a trigger event on top of a lifetime of accumulative disadvantage and a severe lack of social, economic, and human capital does however increase an individual's risk of homelessness.

There are alternative approaches to explaining homelessness which encompasses the consensus view outlined in the preceding sections and are said to transcend many limitations. The pathways approach is one such method.

Although each person's life-journey and experience of homelessness is unique, generalisable clusters of factors and common sequences of events have been identified among homeless cohort studied in many countries (Isobel Anderson, 2001; Chamberlain & Johnson, 2013; Suzanne Fitzpatrick et al., 2013; Ravenhill, 2008). The pathways approach identifies these common factors and sequences. Pathways analysis often describes a person's journey from being previously housed, into episodes of homelessness and back to being housed, if appropriate. The longitudinal frame allows for considering the combined effect of an accumulation of contributing factors, that may have built up over time. The pathways explanation of homelessness is therefore viewed as an holistic approach (Clapham, 2007). Consequently, it is an approach that has been taken by many researching homelessness (Isobel Anderson, 2001; Chamberlain & Johnson, 2013; Clapham, 2003; Suzanne Fitzpatrick et al., 2013; T. M. Jones et al., 2018; MacKenzie & Chamberlain, 2003; Piat et al., 2015; Ravenhill, 2008; Tyler & Schmitz, 2013; Woodhall-Melnik et al., 2018).

In line with the broad consensus of understanding about contributors to homelessness, this approach recognises that people's homeless circumstances are rarely the result of a single factor. Both individual and structural factors are considered, as these factors often overlap. An example is where institutional debt, a structural factor, contributes to a person having insufficient funds to pay personal debts, which may result in a person having poor credit, an individual factor. Poor credit is a factor which is often a barrier to tenancing private rental accommodation, especially in periods of high demand for housing and low supply.

Much existing research using a pathways approach to understanding homelessness has been carried out in the US, Canada, and the UK (Theodorou & Johnsen, 2017). Therefore, literature identifies pathways into homelessness in these countries, which may or may not translate into the New Zealand context. Table 2 gives examples of a variety of pathways identified in studies involving single adult homeless in various countries. These examples demonstrate that there are various methods of categorising sequences of events and common clusters of contributing factors. For example, some pathways are stratified by age bands exhibiting common clusters of factors. Often age bands are grouped according to youth experiences of homelessness, adult experiences, and later-life homelessness, such as in the work of Anderson (2001). Other pathways identify clusters of factors around a main trigger event, such as exiting institutional care (Piat et al., 2015; Ravenhill, 2008) or family breakdown (Chamberlain & Johnson, 2013). Still other pathways are clustered around individual health factors, such as problematic substance use or mental health issues (Chamberlain & Johnson, 2013; Suzanne Fitzpatrick et al., 2013).

Fitzpatrick et al (2013, p 2) created a definition of a pathway to homelessness based on a group of commonly experienced contributing factors spanning three domains. Any experience within these domains had contributed to research participants experiencing a state of deep social exclusion while homeless. Multiple exclusion homelessness (MEH) describes people who have been homeless, who have also experienced time in institutional care, or substance misuse, or participation in “street culture activities” such as begging, drinking on the streets, and “survival” shop lifting and sex work, or any combination of these domains. Questions from the survey used in this MEH study have been included in quantitative surveying in this thesis.

What is evident from literature from a variety of countries is that many pathways start with ACEs as a precursor to lives characterised as highly unstable and chaotic. To illustrate this point, each of the studies in table 2 include ACEs as an important contributing factor.

Table 2 Examples of pathways to single adult homelessness

Authors	Country	Catchment cities	Number of participants	Participants	Pathways or clusters of factors relating to single adult homelessness
(Piat et al., 2015)	Canada	Moncton, Montreal, Winnipeg, Toronto, Vancouver	219	18 + years old, Housing First and Treatment-as-usual services users, housed, unhoused, in shelters and transitional housing	<p>Transitioning from foster care and institutional care - ACE, foster care or institutional care, transience as a child, disruptive youth, and adulthood</p> <p>Becoming entrenched - Substandard housing, unsafe and drug-involved neighbourhoods, poverty, lack of affordable housing, stigma, racism, violence</p> <p>Structural amplification of individual risk - Lack of access to housing, substandard housing, problematic communities, poverty, unemployment. These issues exacerbate accumulated individual risk factors and behaviours.</p> <p>Interplay among individual factors - ACE, family violence, later-life relationship problems, mental health issues and problematic substance use. Intergenerational problematic behaviours and factors.</p>
(Chamberlain & Johnson, 2013)	Australia	Melbourne	3941	Participants homeless and at risk of homelessness involved with two high volume homeless services.	<p>Housing crisis - Financial crisis, low incomes, often job loss</p> <p>Family breakdown - Relationship breakdown sometimes involving domestic violence, had to, or made to leave home.</p> <p>Substance abuse - Problematic substance use dominates activity. High prevalence of mental health issues. Early drug use at age 20 or before. Loss of job. High debt. Often evicted from last tenancy.</p> <p>Mental health issues - Loss of parental support among youth with mental health issues who are homeless. Caregiver death or incapacitated caring for adults with mental health issues. Includes those with intellectual disabilities.</p> <p>Youth to Adult - First homeless occurrence before age 18 years. Traumatic childhood and adolescence. Left home young. Often stepparents.</p>

Authors	Country	Catchment cities	Number of participants	Participants	Pathways or clusters of factors relating to single adult homelessness
(Suzanne Fitzpatrick et al., 2013)	United Kingdom	Belfast, Birmingham, Bristol, Cardiff, Glasgow, London, Leeds	452	Participants of low-threshold services, day centres, soup kitchens, outreach	<p>Mainly homeless - Less complex, mostly male. Often migrants. Mostly in London. High transience</p> <p>Homeless and mental health - Moderate complexity, ACE, anxiety, and depression common, high incidence of suicidality</p> <p>Homeless, mental health and victimisation - High prevalence of institutional care as a child. Most thrown out of family home by parents or care givers. Much higher prevalence of anxiety, depression, and suicidality. Acute inpatient experience. Self-harmed. High prevalence of being victim of violent crime and sexual assault as an adult. Most been to prison.</p> <p>Homeless and Street Drinking - Complex. All are street drinkers. Most have problematic alcohol use. Most have anxiety and depression. Most engaged in begging and shoplifting behaviours. Many have been divorced or separated.</p> <p>Homeless, hard drugs, high complexity - Complex. Most under 50 years old. Most thrown out by parents. All have problematic substance use. Nearly all have anxiety and depression. High prevalence of suicidality. Most have been to prison. Nearly half were evicted from their last rental accommodation.</p>
(Ravenhill, 2008)	United Kingdom	London, Bedford, Exeter, Wimbledon, Reigate	146 adults 256 youth	Unhoused, housed formerly homeless	<p>Child abuse pathway - High prevalence of ACE, post-traumatic stress, disrupted social networks, time in state care. As youth and adults - prison, low self-esteem, self-harming, problematic substance use, and domestic violence.</p> <p>Adults over 19 years - High prevalence of ACE, later-life relationship breakdown, traumatic life events, problematic substance use, mental health issues, high debt</p> <p>Exiting care - ACE, childhood family breakdown, asked to leave, institutionalised, loss of social networks, transience, mental health issues, problematic substance use.</p>

Authors	Country	Catchment cities	Number of participants	Participants	Pathways or clusters of factors relating to single adult homelessness
(Woodhall-Melnik et al., 2018)	Canada	Ontario	25	In homeless shelters and working with homeless services	<p>Youth pathway - ACE, ran away from childhood home or kicked out, multiple institutions, left school, mental health and problematic substance use, criminal justice involvement.</p> <p>Emerging or early adulthood pathway - ACE, formerly housed, relationship breakdown, mental health issues, problematic substance use, criminal justice involvement.</p> <p>Middle adulthood pathway - ACE, mental health issues, extreme poverty, caregivers/parents of those with intellectual and physical disabilities die or incapacitated.</p>
(Isobel Anderson, 2001)	Various	Meta-analysis – UK and International literature			<p>Youth pathway (age 16-24) -ACE, left home early, state care, problems at school, transient with caregivers, family dynamic change (stepparents). Youth homelessness often resulting in extended and repeated patterns of homelessness.</p> <p>Adult pathways (age 25-55) -Households forming, changing, and dissolving. Structural factors such as employment changes play a part. An inability to access suitable alternative house exacerbated by relationship breakdowns, often involving domestic violence.</p> <p>Later-life pathways (age 50+) -Individual factors such as mental health issues more likely to trigger homelessness. Redundancies. Retirement. Widowed. Marital breakdowns. Caregivers/parents of those with intellectual and physical disabilities die or incapacitated.</p>

2.4.1 Existing pathways research in New Zealand

To date, there is very limited research in New Zealand identifying specific pathways to homelessness. In one exception, qualitative semi-structured in-depth interviews were carried out with 30 single adults experiencing homelessness in Wellington (Al-Nasrallah et al., 2005). Three pathways were identified:

- **Driven** to homelessness – A breakdown in people’s family situation, characterised by domestic violence, abuse and substance dependency among household members. This led to disruption at school, institutionalisation in foster care, behavioural issues, prison, and unemployment.
- **Dropped** into homelessness – A discrete event occurred, such as unemployment, a family break down or sudden death of a family member. This led to acute mental health episodes for people and substance dependency resulting in homelessness.
- **Drawn** into homelessness – A natural progression occurred from relatively stable backgrounds. Behavioural issues lead to being expelled from school, and involvement with the criminal community. This led to a loss of social capital resulting in homelessness.

(Al-Nasrallah et al., 2005, p. 18)

The authors reiterated that their research was not aimed at providing a conclusive study of pathways to homelessness, and more research was needed to truly understand any pathways into homelessness in New Zealand.

In a second example, in a recent study conducted in Auckland, Alrudaini (2019) interviewed six people who had or were experiencing homelessness. The study was designed to determine if out-of-home placement in childhood and youth, in foster care and as a ward of the state, contributed to people’s risk of becoming homeless. All six participants had experienced out-of-home care in childhood and youth. Five had experienced abuse at home before going into care. Alrudaini concluded that time in out-of-home care in people’s youth increased the risk of someone becoming homeless in New Zealand. Time in care contributed to the adoption of maladaptive coping strategies such as problematic drug use and gang affiliation. Some of the participants had been retraumatised in care. These participants often saw homelessness as a way out of this cycle of traumatisation.

2.4.2 Summarising a Pathways approach

Pathways literature includes various combinations of common contributing factors, both individual and structural, which accumulate as background risk factors, exacerbating circumstances that have arisen at crisis point. Trigger events can also contribute to raising risk of single adult homelessness, adding additional pressure to existing background issues individuals already face. Trigger events may

precede homeless episodes by up to a decade. Many pathways start with disruption in childhood and youth, state-facilitated separation from kinship networks and time spent in the care of child protection services. Fractures in kinship links in childhood and youth contribute to many experiencing diminished social capital in adulthood. Individuals may face the prospect of homelessness alone. Having no financial reserve, and diminished access to financial resources, limits housing options at crisis point. Lacking accommodation options at this point is often the final pain-point in a journey that may have played out across an individual's lifetime. The various contributing factors have been succinctly summarised in the following formula (Anderson, 2001):

Background risk factors + immediate crisis + low income + nowhere to live in time = homeless.

In Anderson's formula, background risk factors can include proximal factors such as people's existing mental health and problematic substance use. The effects of ACEs and out-of-home placement in adolescence, which can contribute to increasing instability in people's later life, can also be included in this element. Other elements such as low social capital, and discrimination on the part of landlords and among social services, such as the health, welfare and justice sectors are factored in as background risk. Immediate crisis includes considering both structural and individual trigger events, such as loss of employment, a break down in household relationships and eviction from a tenancy. The effects of poverty constraining people's choices when in crisis are included in the form of low income. Additionally, this formula factors in time-dependent variables, such as a person's inability to be able to find alternative accommodation in time. The accumulative nature of each of these elements is also represented, which allows for consideration of people's progressive waning of resilience (Mabhala et al., 2017, p. 14). This formula may therefore be considered a representation of the broad consensus around contributing factors which are generally included in pathways identified. Importantly, a lack of access to housing is shown as being just one part of a much greater picture of disruption for people.

2.4.3 Criticisms of the pathways approach

While the pathways approach is generally considered a holistic method of exploring contributing factors to homelessness, there is criticism of this approach. Somerville (2013), for example, concludes that this approach is "one-dimensional", with often insufficiently specified elements. For example, identifying a relationship breakdown as a risk factor may not provide enough detail to determine the true nature of the link between this event and a person becoming homeless. A relationship breakdown can be caused by many things including mental illness, incarceration of one partner, or by structural factors such as having to seek work in another region or country. Somerville cautions that researchers need to consider the impact of additional factors, such as wider structural factors, of other non-

physical dimensions of home and homelessness, such as spiritual homelessness and of time-dependent variables, such as people's duration and frequency of homeless episodes.

2.5 Points and methods of intervention in pathways to single adult homelessness

Apart from the moral imperative to prevent homelessness occurring in our communities, preventing homelessness also has a tangible positive economic benefit. For example, considering the association between a high prevalence of ACEs in the life histories of homeless people, research from other countries has estimated that poor investment in interventions that provide safe and nurturing childhoods, aimed at intervening before ACEs occur, can cost around 3% of a country's gross domestic product (GDP) (Bellis et al., 2019). This estimation does not include the long-term monetary cost of ACE-related ill health issues, its effect on social issues such as unemployment and crime-related costs such as imprisonment. It also excludes cost associated with homelessness (particularly unsheltered homelessness) which includes the cost of people's reliance on emergency services and emergency accommodation, and increased costs of policing related to offending by and against rough sleepers, those living in cars and in make-shift accommodation, among other things. A conservative estimate made in 2016 was that the annual cost of unsheltered homelessness in New Zealand was \$65,000 per person. This primarily represented the cost of accessing crisis-related services (Cross-Party Inquiry into Homelessness, 2016).

To know when, and how to intervene effectively in pathways to homelessness, it is first important to understand which contributing factors have raised the risk of someone becoming homeless in any context. As has been discussed, contributing factors are often complex, dynamic, and interwoven in their effects on raising risk of homelessness. In section 2.2, discussion highlighted the complex combination of individual factors often contributing. Interventions to help alleviate the ongoing contribution of factors such as ACEs, mental health issues, problematic substance use, time spent in prison and high levels of personal debt may require specific focused interventions at critical points. The focus of such intervention may be simultaneously aimed at alleviating immediate need, as well as supporting sustained improvement over time. Other macro-level interventions are needed to address structural contributing factors, such as restricted access to housing, racism, poverty, and system's failure, as discussed in section 2.3. Additionally, methods of intervention aimed at prevention of homelessness must give equal focus to critical points along a continuum of homelessness, intervening before people are drawn into homeless pathways, interrupting pathways already established, as well as intervening to preventing subsequent episodes of homelessness.

Some contributing factors may be context-specific, with unique local (often structural) conditions exacerbating people's circumstances within a specific town, region, or country. Therefore, interventions may need to be tailored to these factors. Many factors (both individual and structural) contribute to raising people's risk of succumbing to multiple poor social outcomes, of which homelessness is one possible outcome. Therefore, some interventions, if effective, will have a far greater positive impact in people's lives, of which avoiding homelessness is one potential impact. To follow are measures which have been implemented in other countries, and in New Zealand, to prevent people being drawn into pathways to homelessness, or to interrupt their journey. Critical points of intervention are highlighted, points where such interventions have shown to have been most effective in lowering risk of future homelessness.

2.5.1 Identifying high risk cohort

For a community to consider who requires an intervention so as to avoid being drawn into homeless pathways, or indeed to identify those who may already be at high risk of homelessness, some method of identification is required. Identifying people who are at risk of homelessness carries with it complexities, particularly around the potential to further stigmatise a vulnerable cohort. Many government and other social services have existing methods of identifying at-risk service users within their own organisations, although these details cannot normally be shared with other organisations, unless there are significant safety concerns.

One example of a government department which is identifying people at risk of homelessness is Australia's Centrelink (Scutella et al., 2017). A flagging process in their client database is intended as a way of providing targeted services for people who may be at a higher risk of becoming homeless. The authors noted that this process relies on clients being prepared to disclosed details of their personal situations to departmental staff, which is a limitation.

Similarly, important ethical limitations have been exposed in other methods of identifying at-risk populations using predictive risk modelling. New Zealand researchers conducted a predictive risk modelling trial aimed at identifying children most at risk of abuse before the age of 5 years from linked administrative data from Work and Income and Oranga Tamariki/Ministry of Children (Vaithianathan et al., 2013). Following the model's development, trial and analysis of results, MSD commissioned a privacy impact assessment and a review of ethical issues implicated in the findings. The model was later withdrawn from use in this context by the then Minister of Social Development due to the ethical concerns raised in the review. This outcome highlights some of the complexities involved when identifying those who may be at risk of future poor social outcomes.

Prediction about future homelessness is often based on past experiences, and behaviours. However, past behaviours and experiences do not always predict future outcomes. Considering the association between a high prevalence of ACEs and homelessness, New Zealand-based research has shown that even when people have survived ACEs, several other factors can impact on prophecies of increased risk of poor later-life biopsychosocial outcomes (Reuben et al., 2016). Such factors include people's perception about past events, their beliefs about childhood adversity, and having a more positive "sunny" or negative "grey" disposition (Reuben et al., 2016, p 1111). Further, predictive risk models have been criticised for being overly focused on risk factors while ignoring protective factors (Walsh et al., 2019b). Walsh et al note that protective factors against ACEs, for example, include a child's involvement in a quality preschool facility, in sporting activities and other community social groups or having one trusted adult such as a church elder or teacher.

Institutional racism is inherent in social systems in New Zealand such as the health sector (Harris et al., 2018), child protection services (Atwool, 2019) and the justice system (Stanley & Mihaere, 2018; Workman, 2019). This adds further complexities to identifying individuals at risk of future homelessness. Discrimination and the ongoing effects of colonisation contribute to Māori being over-represented in these systems (Lawson-Te Aho et al., 2019; L. T. Smith, 2013). Negative stereotyping has ensued from this racism and contributes to misleading and stigmatising identification of Māori and other population groups of service users as being at higher risk of poor social outcomes, including homelessness (Shiloh Groot & Peters, 2016; Rua et al., 2019; Stanley & Mihaere, 2018). One method of overcoming this limitation is to promote diversity in groups designing solutions to homelessness in New Zealand (Cross-Party Inquiry into Homelessness, 2016). This would ensure appropriate methods of identifying individuals who may be at risk of future homelessness are developed (Ministry of Housing and Urban Development, 2020 ; Shum, 2021).

Identifying those at risk of future homelessness relies on systems and organisations having a genuine understanding of pathways to single adult homelessness (Rua et al., 2019), and an empathy toward providing additional support to those most in need who are engaging in these services. This is problematic if pathways and contributing factors to homelessness have not been well identified in a community. Additionally, staff may not have received training in supporting those who may have high and complex needs. It has been noted in a review of social services in New Zealand that some of this country's most disadvantaged people have been inadequately supported by social services they are connected with (New Zealand Productivity Commission, 2015). It is likely that single adult homeless fall in this category. Providing additional appropriately targeted support to those in the highest need relies on identifying those who would benefit most from this additional support. There is a fine line, however, between applying a genuine understanding of homeless pathways and avoiding further

stigmatisation and discrimination. However, as has been demonstrated in the case of the Australian Tax Office, other countries have successfully identified those at risk in their systems and applied specific resources to supporting these clients, based on an understanding of the need to offer additional support to those identified (Scutella et al., 2017).

2.5.2 Early intervention by social services

Effective early intervention in pathways to homelessness by social services is seen as critical to helping to reduce risk of future single adult homelessness, as well as other poor social outcomes (Chamberlain & Johnson, 2013; Suzanne Fitzpatrick et al., 2013; Gluckman & Lambie, 2018; Lambie, 2018; New Zealand Productivity Commission, 2015; Ravenhill, 2008). This section considers which social services are best placed to intervene early and what types of methods of intervention and supporting mechanisms have been applied successfully in other countries and New Zealand.

Many individuals who experience homelessness have been (and remain) highly connected with multiple social services, institutions and government departments, often at rates far in excess of non-homeless individuals (Nevil Pierse et al., 2019). Single adult homeless in New Zealand have had high and sustained interaction with emergency departments of hospitals, police, prisons, courts, and welfare agencies (Nevil Pierse et al., 2019). In childhood and in youth, many also had a high prevalence of interaction with child protection services. Research from other countries shows that single adult homeless have also often had high rates of interaction with youth health, welfare and justice services, and school disciplinary and truancy services (Chamberlain & Johnson, 2013; Ravenhill, 2008). Therefore, there are multiple points of potential early intervention across multiple social sectors. Each intersection with these organisations is an opportunity for positive intervention (Ravenhill, 2008, p. 236). Each institutional relationship holds potential for the organisation's representative to spot known predictors of homelessness, and to support people to avoid future homelessness.

The earliest potential points of intervention, therefore, relate to interactions with social services, which for many were with paediatric health professionals, family support services and child protection services. Given the association between a high prevalence of ACEs and an increased risk of future homelessness, preventing, or reducing the occurrence of ACEs, or supporting victims early after ACEs have occurred, is a critical starting point. Specific interventions related to this contributing factor are now presented.

2.5.3 Effective ACE detection and intervention

As was demonstrated in section 2.2, many pathways to single adult homelessness start with ACEs. Some types of ACE are associated with family violence (Felitti et al., 1998). Therefore, a community

focus on reducing family violence would likely reduce risk of future homelessness for some. New Zealand experts contend that family violence is a preventable problem (Lambie, 2018). ACEs involving family violence and ensuing household disruption also increases a person's risk of being drawn into the prison pipeline in youth (Gluckman & Lambie, 2018), and needing acute mental health support and rehabilitation for problematic substance use later in life (Felitti & Anda, 2014; Montgomery et al., 2013; Roos et al., 2013). Therefore, reducing family violence would lower people's risk of succumbing to these and many other poor biopsychosocial outcomes.

Providers of existing family-based programs and social, justice, health and education services need to detect and support at-risk families more effectively, focusing on preventing ACEs happening (Gluckman & Lambie, 2018; Lambie, 2018). Internationally, there are programs that help to support families at risk and provide an alternative to removal of children from destabilized family settings. For example, in America, Family First Michigan seeks to maintain intact families by providing intensive, short-term crisis interventions of 4-6 weeks duration (Michigan Department of Health and Human Services, n.d.) These programs include 24 hour support from dedicated case workers with very low caseloads. Case workers support families by teaching appropriate parenting skills, helping families avoid state intervention, supporting with budgeting and other skill building. A study of 33 Intensive Family Preservation Services (IFPS) across America and the UK showed that these services generally helped to prevent out-of-home placement of children at high risk of entering care (Bezecsky et al., 2019). As an example of the variety of IFPS services available, the study included review of a service called "Option 2", an organization in Wales which supports families with substance misuse problems to stay together. Overall, using the IFPS approach, the risk of being placed in care was reduced by 49% for children involved in these types of services, compared to those who received usual services. Therefore, increased support and resourcing of these types of programs and services in New Zealand is advocated.

A recent report from the Centers for Disease Control and Prevention (CDC) in America provides an approach to preventing ACEs in a community, as well as providing strategies aimed at addressing harm caused by ACEs (Centers for Disease Control and Prevention, 2019 p. 9). The main elements of the approach include:

- Strengthening economic support for families.
- Promoting social norms that protect against violence and adversity.
- Ensuring a strong start for children and paving the way for them to reach their full potential.
- Teaching skills to help parents and youth manage the challenges of adversity and stressful situations.

- Connecting at-risk youth to caring adults and pro-social activities.
- Intervening to lessen immediate and long-term harms of ACE. This involves enhanced primary care, trauma-informed support, support to mitigate family harm and problematic substance use among families.

Once ACEs have occurred, early detection and ongoing support of those affected is advocated (Felitti & Anda, 2014). In countries such as England, Wales, Scotland, and some states of America, this starts with policy targeted at reducing the prevalence of ACEs in a community. This generally involves mandating the detection, measuring, and amelioration of ACEs (California Department of Health Care Services, 2020; Couper & Mackie, 2016; House of Commons Science and Technology Committee, 2018). Early detection of ACEs can be carried out by midwives, doctors, early-childhood specialists, and family support services (Felitti & Anda, 2014; Lambie, 2018; Ravenhill, 2008). A child's involvement in quality childcare can have a protective effect against ACEs, especially among economically disadvantaged children (Walsh et al., 2019b).

2.5.4 Education sector intervention.

For some, compulsory school attendance is a positive intervention in homeless pathways, particularly when children are experiencing ACEs at home (Ravenhill, 2008). School attendance is compulsory in New Zealand between the ages of 6 and 16 years (Ministry of Education). Being at school may be a brief reprieve from harrowing homelives and an opportunity for skilled staff to intervene and support families at risk of poor social outcomes.

However, for others, the school environment provides additional pressures, with research showing many single adult homeless had disrupted schooling experiences, including bullying, truancy, and school exclusion (Ravenhill, 2008, p.118). Ravenhill notes school and education staff are ideally placed to identify behaviours in children which are predictors of child homelessness, such as running away from home, child abuse, frequent moves of home address, mental health decline and personal accounts of traumatic events. Once identified, resources must then be made available to educational staff, so that they can refer at-risk children to services providing appropriate support, both for the children and their families (Atwool, 2019).

Many young people have their first experience of homelessness when they are still at school (G. Johnson & Chamberlain, 2008, p. 576). In research looking at points of early intervention to stem the flow of youth who are homeless into adult homelessness in Australia, G. Johnson and Chamberlain (2008) made policy recommendations which included the promotion of programs aimed at preventing students who are homeless from dropping out of school. These programs work with teenagers to

facilitate family reconciliation. Secondly, this report recommended that intervention needed to be targeted at teenagers who had been in state care and protection, as these teens are at a greater risk of homelessness. Thirdly, researchers advocated that young people who make the transition from youth to adult homelessness need long-term support to help rebuild their lives and sustain conventional accommodation. A limitation to this approach is that students must first be identified as being homeless or needing additional support. Families may be reluctant to disclose these details for fear of state involvement from child protection services.

2.5.5 Points of intervention in adulthood.

Research involving a cohort of homeless New Zealanders showed that, despite sustained relationships with multiple social sector organisations, often beginning in childhood, homelessness still ensued (Nevil Pierse et al., 2019). Most of this cohort were aged between 26 and 44 years old. Perhaps as a last resort, this cohort had sought the help of a homeless service. Pierse et al (2019) concluded that lack of intervention at any point in often lifelong relationships with the multiple organisations constituted systems failure. In this case, this means a failure of organisations with a duty of care to provide positive interventions in pathways to poor social outcomes for those known to be at risk. The researchers concluded that to counter siloed approaches to supporting at-risk cohort, a more co-ordinated response was needed.

Many single adult homeless, both in New Zealand and overseas, have simply “fallen between the cracks” in siloed social service provision (Al-Nasrallah et al., 2005; Padgett et al., 2016; Shum, 2021). For example, many single adult homeless suffer with the “dual disorders” of problematic substance use and mental health issues (Tsemberis, 2015, p. 148). People seeking support with mental health disorders with an addiction may be asked to detox first before they are supported with their mental health issues. However, problematic substance use is often framed as a coping mechanism by those who are homeless (Watson et al., 2016), a way of masking physical, emotional and spiritual pain and a means of managing mental health issues such as chronic depression, anxiety or post-traumatic stress disorders while rough sleeping. This has led to the development of dual disorder treatment services in other countries, such as the US, to avoid such siloed treatment (Tsemberis, 2015).

Additionally, what service provision is available is not always culturally appropriate for some population groups (Lawson-Te Aho et al., 2019). A lack of appropriate (or any) organisational support can be a trigger event for immediate episodes of homelessness for some (Suzanne Fitzpatrick et al., 2013; Nevil Pierse et al., 2019; Ravenhill, 2008). Social services may lack empathy in supporting people at risk of homelessness because they do not have a genuine understanding of people’s lived experience (Rua et al., 2019), particularly if pathways and contributing factors to homelessness have

not been well identified in a community. Additionally, staff may not have received training in supporting those who have high and complex needs.

Authors such as Ravenhill concluded that any point of interaction with a social service along a pathway to homelessness is a potential point of positive intervention (Ravenhill, 2008, p. 235). Ravenhill suggested that many in the social sector and other community sectors are well positioned to spot predictors of homelessness, including social workers, medical professionals, legal professionals, banking staff, welfare services, church leaders, police, probation offices, educational staff and friends and family. Recognising those at risk is only part of the solution however, as this information needs to be acted on appropriately and the most relevant intervention applied. Given the complexity of issues many at-risk of homelessness or literally homeless face, this work may be better suited to specialist services (Tsemberis, 2015).

While interventions would normally be undertaken by front-facing staff in contact with people who are at risk of homelessness, at a macro level, government policy settings and mechanisms must support such initiatives. There are mechanisms and approaches which support more co-ordinated and appropriate interventions for those already drawn into a pathway to single adult homelessness, and other poor social outcomes. To follow are two examples of initiatives which have been implemented in New Zealand and other countries with this specific intention.

2.5.6 Trauma-informed support

Trauma-informed support is a strengths-based framework based on an understanding of and responsiveness to impacts of trauma (Hopper et al., 2010, p. 80). The effects of trauma can manifest as an inability to self-regulate, feeling unsafe, lacking a positive sense of self, a loss of perception of control, problems in inter-personal relationships and an increased risk of developing various health and wellbeing issues. In some settings, trauma-informed care equates to seeking to avoid retraumatizing service users. However, a more appropriate application of this framework in the homeless sector must involve having a genuine understanding of the life-long impact of past and present traumatic events. Trauma-informed care can be offered by non-specialist staff (McKenzie-Mohr et al., 2012), and is therefore able to be applied in most social service settings. This approach is critical in the support of both those who are homeless, as well as those at-risk of homelessness, as many single adult homeless pathways include a high incidence of traumatic life events (Suzanne Fitzpatrick et al., 2013; Montgomery et al., 2013)

Many social services fail to adequately account for the life-long and significant impact and effects of trauma in the lives of their service users (Atwool, 2019; McKenzie-Mohr et al., 2012; Rua et al., 2019). Despite individuals presenting at social services with mental health issues, problematic substance use

and other issues, people are not always asked about traumatic events that have exacerbated these issues (Atwool, 2019). This omission can come about because social service staff are wary that they are not specifically trained to support people who disclose traumatic pasts. Additionally, others may avoid asking about traumatic events because there is a perception of inadequate support in a community for those who may require complex support with these issues. However, trauma-informed support does not necessarily need to extend to encouraging disclosure of details of trauma. Merely understanding that presenting behaviours may be rooted in past traumatic events encourages an empathy in the treatment and support of people (Felitti & Anda, 2014; Hopper et al., 2010).

National programs providing training in trauma-informed approaches have been implemented in countries such as the USA and UK (California Department of Health Care Services, 2020; Couper & Mackie, 2016). Part of a trauma-informed approach involves understanding the life-long impact of ACEs. The originators of the ACE test conclude that for adults, testing for ACEs and referral for support is best suited to being carried out by people's general practice (GP) doctor (Felitti & Anda, 2014). This is because of the high risk of associated health-related illnesses that have been linked with ACEs where no treatment has been previously offered.

In New Zealand, child protection agency, Oranga Tamariki (Ministry of Children) are working to embrace a trauma-informed approach to service provision (Atwool, 2019). Discussing the challenges of operationalising these changes, Atwool (2019) noted that there is currently no shared understanding of what the term 'trauma-informed' means in this context. Importantly, Atwool notes that a lack of recognition of the experience of and effects of trauma in one generation can perpetuate intergenerational transmission of trauma. In this case, Atwool refers to adverse childhood events and other trauma experienced by the parents of children in child protection services, recommending that parents and caregivers should also be offered the possibility of healing and recovery alongside their children.

Lack of a trauma-informed approach to social service provision contributes to individuals experiencing ineffective, sometimes dehumanising interactions with these services (Rua et al., 2019). This leads some to avoiding asking these organisations for help when in crisis. Therefore, an adoption of national programs which foster a trauma-informed approach among social services is an important intervention, which may help avoid intergenerational transmission of trauma.

2.5.7 Co-ordinated support to navigate social services and systems.

In 2020, New Zealand adopted its first homeless action plan, aimed at co-ordinating a response to homelessness in New Zealand (Ministry of Housing and Urban Development, 2020). The plan has a focus on providing people with improved access to additional stocks of affordable housing, as well as

providing funding for additional specialist housing-based homeless services, such as Transitional Housing providers and Housing First services. As a preventative measure, Sustaining Tenancies services also support those at risk of losing existing tenancies.

Housing First is an evidence-based housing intervention, providing people who are homeless with both support to access appropriate permanent housing and ongoing support to help sustain a tenancy and attain a level of wellbeing and social inclusion (Tsemberis, 2015). In New Zealand, Housing First provider TPP assists in supporting people who are homeless to access the support they need across siloed services (Shum, 2021). Additionally, this service co-ordinates a community response to supporting those identified as at risk of homelessness. Those with lived experience in other countries have indicated that having easily accessible specialist services such as this in a community may have helped prevent people becoming homeless (Ravenhill, 2008). Importantly, ongoing support needs to be for extended periods, provided by “a centre that supports you, but doesn’t stop working with you until all your problems are sorted out” (Ravenhill, 2008, p. 227). Housing First principles adopted in New Zealand include a no graduation policy, which fits with this recommendation.

The Housing First approach has shown to have limitations. For instance, it has been criticised for focusing on personal inadequacies and people’s complex needs, placing less responsibility on structural contributing factors in a community (Stanhope & Dunn, 2011). This has found to be the case in New Zealand (Shum, 2021). Advocating for change to reduce the contribution of racism among landlords to local homelessness, for example, may not be a specific focus in a Housing First service in New Zealand.

Additionally, New Zealand-based research concluded that the Housing First approach needs adaptation to reflect fundamental Indigenous worldviews and the aspirations and rights of Māori who are homeless and at risk of homelessness (Lawson-Te Aho et al., 2019). Lawson-Te Aho et al. advocate for more culturally appropriate support of Māori who are homeless and offer an alternative framework, Whare Ōranga. This framework overlays Housing First principals with core Māori values, such as whanaungatanga, which is about the importance of relationships, kinship networks, and maintaining a sense of family connection. Applying this core value may result in an extension of support of those homeless or at risk of homelessness beyond the individual centred approach of Housing First.

2.5.8 Summary of existing points and methods of intervention

Overall, intervention is recommended to start early in a homeless pathway, ideally when adverse events first occur for people, or when the effects of such occurrences are first noticed by professionals

or social sector institutions and agencies. Intervention is however possible at any point in homeless pathways, with every interaction between high-risk service users and social sector agencies being a potential point of positive intervention. Other community groups are also in a position to spot those at risk of homelessness and direct them to services that can help.

Policy that is aimed at reducing family violence would reduce ACEs relating to this occurrence. The result would be a reduction in some contributing risk factors resulting in people becoming drawn into a pathway to homelessness. Additionally, reduction in family violence would stem the flow of people into a pathway to other poor social outcomes, including institutionalization in prison, state care in childhood and adolescence, and hospitalization in acute mental health wards. These occurrences are often interwoven with a raised risk of homelessness.

Social services need to be more responsive to their service users and have appropriate mechanisms in place to recognize and support people more at risk of poor social outcomes. Improved co-ordination across government departments and social sector agencies is advocated, so that highly vulnerable people in a community are identified and properly supported with a coordinated and trauma-informed response. Interventions need to be culturally appropriate and include an understanding of specific worldviews of various population groups. Without a collective understanding of pathways to single adult homelessness in a community, there is little hope of effective, appropriate, and empathetic intervention.

2.6 Chapter summary – literature review

The traditional explanations of factors contributing to single adult homelessness are succinctly summarised by Gowan (2010).

- The “*sin talk*” describes discourse broadly based on an assertion that single adults are able to take responsibility for themselves, and their actions. Therefore being homeless is often seen as a personal shortcoming (Clapham, 2007). This viewpoint assumes people have agency over their involvement in the justice system, in their lack of human capital, in their biopsychosocial response to deep traumatisation, in an accumulation of debt, and over other individual contributing factors.
- The “*sick talk*” is a discourse similar to the “disability ethos” recognised by Padgett et al (2016), assuming a lack of wellbeing is the main contributor to homeless episodes. This descriptor takes into account the high prevalence of single adult homeless with mental health issues and problematic substance use. These issues are mostly existing issues for people and have been often long before they became homeless. People’s existing health issues are often

exacerbated by the biopsychosocial pressures of homelessness, particularly if rough sleeping. Therefore, there is a circular nature to the contribution these issues have in people's homeless experience.

- The “*systems talk*” situates people as being subject to macro-socioeconomic and other elements beyond their control, such as a lack of access to adequate and affordable housing, living in poverty, with a dire lack of economic capital, and constantly highly constrained incomes limiting options in a crisis. It also includes discussion about the failure of people's often long-running relationships with systems and social sector services to act as a protective factor. Institutionalisation, including time in state care in childhood and youth, in prison, in acute mental health facilities and in rehab centres, further raises the risk of homelessness.

Beyond Gowan's explanations, the following factors can be added:

- The “*solo talk*” acknowledges social exclusion as a pivotal contributing factor to, and consequence of, homelessness. A dire lack of social capital contributes to having few dependable supports when faced with nowhere to live.
- The “*signpost talk*” considers generalisable pathways into single adult homelessness. Most of the research about pathways has been carried out in other countries. There is limited research in New Zealand identifying specific pathway to single adult homelessness. Many pathways start with ACEs, which precede life journeys characterised by instability, social separation, and chaos.
- The “*separate talk*”. In New Zealand various race-based complexities have further raise some population groups' risk of homelessness. Pacific people and Māori are over-represented in homeless counts. Racism has exacerbated inequity in policies, systems, services, and communities. Racism has contributed to people being excluded from housing options, from health care options and from equitable access to education, employment, and other resources in communities. Colonisation and historic trauma are linked with Māori homelessness. The impact of historic separation of Māori from ancestral land and disruption of familial and kinship networks is linked with further complexities for some Māori who are homeless. Intergenerational disruption has caused alienation from kinship supports some find vital in times of crisis. Other additional trauma-based biopsychosocial pressures add further complexity.

This summary demonstrates the broad consensus in homeless literature, mostly from other countries, about contributing factors which have raised the risk of single adult homelessness. The consensus holds that a complex interplay of both individual and structural factors contribute to a raised risk of

homelessness (Clapham, 2007). Wellbeing concerns such as people's mental health conditions and problematic substance use are often existing issues for people, and have been long before people became homeless (Ravenhill, 2008). These existing health concerns contribute to multiple other background issues people face, which have often accumulated over time (I Anderson & Tulloch, 2000; Clapham, 2007). Structural contributing factors and trigger events merely exacerbate existing individual and background issues (Piat et al., 2015).

The pathways approach incorporates many facets of traditional explanations and extends the scope of consideration of contributing factors, including considering the longitudinal effects of events and occurrences in people's journey in and out of housing over time. It is therefore seen as a more holistic approach to explaining homelessness (Clapham, 2007).

Despite contextual differences between countries, many single adult homeless pathways start with the same occurrences, adverse childhood events which contribute to chaotic and unstable adolescent years. While anyone can be at risk of ACEs, these experiences feature disproportionately in the life histories of people who are homeless. ACEs also contribute to raising risk of multiple poor biopsychosocial outcomes. There is still limited research about pathways to single adult homelessness in New Zealand. Further, any link between ACEs and homelessness in existing local research has often been gleaned incidentally, rather than intentionally. Therefore, more local evidence about this link is needed.

Interventions aimed at preventing single adult homelessness are often policy driven and generally target early intervention and co-ordinated support of those at increased risk of homelessness in a community. Preventing family violence would lower the occurrence of ACEs in a population. Reducing the prevalence of ACEs in a community would likely lower some people's risk of homelessness, as well as succumbing to many other poor biopsychosocial outcomes. A community-wide response is advocated to detect, measure and support those at an increased risk of poor social outcomes, including homelessness.

Chapter 3. Methodology and Methods

3.1 Introduction

Homelessness research is an example of sensitive social enquiry involving participants who are often survivors of extreme adversity (Martin & Kunnen, 2008). It was therefore important to design a study that was both non-exploitative and empowering for people to be part of, while at the same time providing a mechanism to collect evidence for achieving the following three research objectives:

1. To determine what factors triggered, contributed to, or raised the risk of single adults becoming homeless in Hamilton.
2. To determine if a pathway made up of common occurrences throughout people's lives raised the risk of people becoming homeless, and what age any such pathway might have begun.
3. To consider critical points of intervention, where appropriate intervention might lower the risk of single adults becoming homeless.

This chapter details the methodology that has framed this research, through conception, planning, implementation, analysis, and interpretation of results. It starts with an outline of the philosophies underpinning the inclusive research approach chosen (Martin & Kunnen, 2008). The chapter then moves on to explore each element of the overall design, including defining the methods chosen to collect, analyze, and interpret the data.

This chapter is then split between the two distinct data collection methods chosen, being quantitative and qualitative. Within each section, details are provided about measures, the participant selection process and criteria and the experience of implementing each method. Included are details of data collection challenges which prompted a redesign for one method. The methods used to analyze the two sets of data are described, along with the process used to validate the reliability of the overall findings. Finally, a reflection is provided on the researcher's part in the process. This includes providing some details of the researcher's frame of reference, and the influence this may have had on parts of the research process.

3.2 Philosophical approach

Two key theoretical frameworks guided the design of this research: the critical realism research paradigm and a pathways approach to understanding homelessness.

3.2.1 Critical Realism

Critical realism is an approach used by many researching homelessness (Kate Amore, 2019; J. T. Anderson, 2016; Suzanne Fitzpatrick et al., 2013). Under a critical realist worldview, reality is said to exist independent of human thought, and therefore cannot be fully understood (Bryman & Bell, 2015; Guba & Lincoln, 1994). Recognising that an exact account of reality is not truly attainable, we seek the most valid account possible, or at least a consensus about what is believed to be true about, in this case, single adult homelessness.

Under this approach, it is accepted that there will likely be divergent views. Further, people's interpretation of single adult homelessness might be temporary and dynamic in nature (Guba & Lincoln, 1994; Ryan, 2018). There is also a longitudinal aspect to this approach. A person's interpretation of reality is shaped over time, through the influence of multiple factors in their life, including social, political, cultural, economic, ethnic and gender factors (Bryman & Bell, 2015; Guba & Lincoln, 1994; Ryan, 2018). People's frame of reference is therefore unique, having been honed by their life experiences and spheres of influence, over the trajectory of their lives.

In applying this worldview to research, it is, therefore, important to adopt a methodology that allows for the collection of data about as many viewpoints and aspects of single adult homelessness as possible. An understanding drawn from such a varied array of elements is achieved by a researcher undertaking detailed and systematic observation (Bryman & Bell, 2015; Ryan, 2018). Additionally, the result of systematic analysis of such complex data must be validated for reliability with participants involved in a study. In this way, the understanding about single adult homelessness will be refined, until a consensus about what is believed to be true is arrived at.

As in all research, but particularly relevant to a critical realism approach, the researcher must remain objective during all phases of research, through design, implementation, and interpretation. The researcher must clearly articulate potential biases and work to remove their own perspective from the research process. The aim of a critical realism approach applied in this study is to reflect a true and fair view (Bryman & Bell, 2015) of single adult homelessness, based on the view of the participants being studied, not the views of the researcher. The "critical" part of this approach in part holds that findings of research based on this worldview must then be critically reviewed by the research participants and by scientific peers (J. T. Anderson, 2016).

This approach has been chosen because this viewpoint holds that the most that can be known about a phenomenon is known by those whose lives are most affected by it (Guba & Lincoln, 1994). In this case, the research participants who have themselves experienced homelessness in Hamilton know the most about it, especially in terms of how it is experienced locally. In her research working with people

homeless in the U.K., Ravenhill (2008) commented that some of the most insightful understandings about homelessness, and the most meaningful suggestions about interventions, were gleaned from listening to those who had been homeless.

Critical realism is, therefore, a research paradigm that embraces the concept of the participant as expert (Bryman & Bell, 2015; Martin & Kunnen, 2008; Ryan, 2018). This is a strengths-based approach, that recognises and emphasises individuals' potential, rather than highlighting their limitations or inadequacies (Martin & Kunnen, 2008). Under this worldview, people who have experienced being homeless are framed as having abundant survival skills, being resilient to some of the most traumatising life events and possessing intimate knowledge about the workings of the many social sector and other organisations they are connected with. Martin and Kunnen (2008) are critical of the automatic assumption that all people who have experienced homelessness are "vulnerable". There is a paternalistic element to this assumption. We should instead be inspired by people's resilience and their capacity for hope, despite the trauma they may have survived. Additionally, this approach has also shown to encourage more effective conversational exchanges, making for rich, and potentially more meaningful, data collection.

Another defining aspect of this approach is the assertion that something about the subject being studied needs to change, in so doing improving the lives of the participants (Bryman & Bell, 2015; Guba & Lincoln, 1994; Ryan, 2018). This is, therefore, highly relevant to the study of homelessness, a situation many consider to be a manifestation of systems failure. The researcher's role is as a facilitator of change. For this research, the change sought is a better understanding of potential points of intervention, critical crossroads where the right support or resource may have prevented someone becoming homeless. Guba and Lincoln (1994, p.113) state "judgement about needed transformations should be reserved to those whose lives are most affected by transformations; the inquiry participants themselves". The key concept of this worldview relevant to this research is therefore that of the person experiencing homelessness being the expert advisor in identifying the changes needed, if any.

Finally, under a critical realist world view, it is recognised that there is unlikely to be a single trigger of homelessness or a concrete cause. There is more likely to be a "constellation of inter-related causal factors" (Suzanne Fitzpatrick et al., 2013, p. 150) contributing to single adult homelessness in Hamilton. The key challenge identified in critical realist methodology is to identify common patterns that might increase the risk of single adult homelessness occurring. This approach, therefore, conceptually acknowledges that homelessness is complex, where one cause, one pathway, and one solution will unlikely be uncovered.

To summarise, a critical realist approach is a good fit for this study of single adult homelessness. It allows for an understanding that the best possible outcome one can hope for in studying this complex phenomenon is a consensus of views, based on rigorous observation. Importantly, the concept recognises that those who have experienced homelessness in Hamilton will know the most about it and must therefore be treated as expert advisors about this topic. They will know the most about the contributing factors that led to their experience. Equally, they will likely know the most about what resources or supports would have allowed them to perhaps solve their difficult housing issues themselves, without the help of a homeless service, and when and how these resources would have been welcomed.

3.2.2 Pathways approach

A complementary worldview to critical realism is the pathways framework in homeless research, which has been described in section 2.5. The pathways approach is defined as the description of the route an individual or household takes into homelessness, their experience of homelessness and their route from being homeless into secure housing (I Anderson & Tulloch, 2000; Chamberlain & Johnson, 2013; Clapham, 2003; MacKenzie & Chamberlain, 2003). This approach fits with the broad consensus in understanding about contributing factors to single adult homelessness, outlined in chapter two, which includes considering a mix of both individual and structural factors accumulated over time. Further, a pathways approach links in with the work of Ravenhill (2008), Fitzpatrick et al (2013), and many other authors who have identified that journeys to single adult homelessness for many people started long before they became roofless.

As noted in chapter 1, existing research using TPP data suggests that people's trajectory into homelessness may have started many years before needing help from this organisation (Nevil Piersie et al., 2019), although the exact starting point has not yet been determined. A pathways approach in this study is therefore appropriate to confirm if this is the case, and if so when this journey began for people.

The pathways approach considers many aspects of a person's journey, including the pattern of interactions a person has around housing over time and includes their concept of what it is to be homeless and what constitutes a home (Clapham, 2003). It also includes consideration of other events that occur in a house, including adjustments made when a person becomes unemployed or is evicted. It includes the influence of people's families on their lives and housing, as well as the influence the media has in the way a community perceives people who are homeless. It includes understanding how a person has been treated by professionals and the social services they interact with for help with

housing. Research utilising this approach must therefore be designed to collect data about these interactions and many other contributing elements.

Additionally, the pathways approach considers the ethos underpinning service organisations who have been assigned to “deal with the problem of homelessness” by policy makers (Clapham, 2003, p 6). This is because interactions with these services may be a pivotal part of people’s journey out of homelessness. Whilst the study of TPP’s values and approach to serving people experiencing homelessness does not specifically form part of this research, TPP’s organisational values and approach may have had influence on aspects of this research. People’s willingness (or not) to participate in research data collection activities may have been influenced by the TPP environment. An important aspect of the research design was therefore to include reflexivity to consider the impact contextual elements, such as the TPP environment, had in this study.

In summary, the pathways approach in homeless studies emphasises the dynamic nature of people’s lives in and out of housing over time (Clapham, 2003). There is existing research involving TPP program participants that suggests a pathway into homelessness may have occurred. Therefore, both the longitudinal aspect of this approach, and the consideration of the influence of an interplay of factors on peoples’ housing, are both elements that fit well with existing research about this cohort. Furthermore, a pathways approach is an epistemologically good fit with a critical realism worldview, which recognises people’s interpretation of reality is based on a complex interplay of biopsychosocial and other factors (Nooe & Patterson, 2010), experienced over peoples’ lifetimes.

3.3 Overall research design: Mixed method sequential explanatory design

The research design implemented was a mixed method sequential explanatory design. This design is characterized by the collection and analysis of a sample of quantitative data followed by collection and analysis of a smaller sample of qualitative data. The qualitative results assist in explaining and interpreting the findings of the quantitative study (Bryman & Bell, 2015).

Mixed method research is an approach to inquiry that combines or associates both qualitative and quantitative information about a topic to be studied (Bryman & Bell, 2015; Ryan, 2018). It is appropriate when neither the results of quantitative analysis nor qualitative analysis alone would be sufficient to provide a full explanation. Mixed methods provide multiple lenses in an inquiry, offering different perspectives on the same topic. The dual data streams resulting from this research design provide more, and richer, evidence to arrive at a consensus in understanding (Ryan, 2018). This approach is therefore appropriate for a study of the complexity of homelessness, and to explore opportunities to intervene in pathways to single adult homelessness.

Mixed-method sequential explanatory design involves two distinct phases: the collection and analysis of quantitative data, followed by the collection and analysis of qualitative data. The first phase aims to provide a general understanding of a topic, and statistical associations or patterns of relevance which may inform qualitative research questions. The second phase builds on the first, with qualitative data collected with the goal of refining an understanding of the statistical data, by exploring participants' narrative and views in more depth (Bryman & Bell, 2015; Ivankova, 2015; Ryan, 2018)

Quantitative inquiry seeks to test hypotheses, looking for cause and effect in phenomenon, with a view to predicting outcomes (Bryman & Bell, 2015). This method typically relies on larger samples of data. Data analysis often seeks to identify statistical relationships between individual elements or variables, or clusters of variables (Ryan, 2018). For this research, quantitative data were collected using a questionnaire. The questionnaire comprised 20 main sections with predominantly structured closed questions from established scales and research tools, requiring mostly fixed (yes or no) answers. The precise structure of the questionnaire, the measures this method was designed to collect data about, and the analytical process and tools used will be discussed more fully in section 3.4.

Qualitative inquiry seeks to understand an occurrence, event, case, or topic by collecting and analysing data normally made up of words, images or objects drawn from interviews, participant observations, field notes and reflections (Bryman & Bell, 2015; Ryan, 2018). The data is analysed to identify patterns, features, and themes. Qualitative research methods have been highlighted as appropriate for research involving vulnerable cohorts, due to the ability to be flexible with people around the approach (Martin & Kunnen, 2008). One example of this flexibility is the use of semi-structured interview questions, where questions act as a guide to conversation about a specific topic. The researcher has a great deal of leeway as to what additional questions may be asked, and can reframe questions to the specific experiences of the participant (Bryman & Bell, 2015). For this research, the qualitative method chosen was face-to-face semi-structured interviews. The precise structure of the interviews, the measures this method was designed to collect data about, and the analytical process and tools used will be discussed more fully in section 3.5.

Sequential explanatory design is useful when studying a complex topic, and when more in-depth explanation is required of the results of the quantitative phase, such as when there are statistically significant results or outliers that need clarifying. The quantitative phase is also useful to identify participants to study in more depth qualitatively (Ryan, 2018). This was the case with this study. Details about the purposive selection criteria of in-depth interview participant from questionnaire participants will be covered in section 3.5.3.

The specifics about the two methods chosen, qualitative and quantitative, will now be described.

3.4 Quantitative Methodology– Questionnaire

3.4.1 Method Design

Phase one of the research activities involved the collection of a sample of quantitative data, which was collected using a cross-sectional retrospective questionnaire (included in Appendix F). A cross-sectional design entails the collection of typically larger samples of data at a single point in time, in order to create a body of data with at least two or more variables, or data items (Bryman & Bell, 2015, p 62). In this research, each questionnaire allowed for the potential collection of over 200 variables for each participant, including data about a wide range of potential contributing factors related to people's experiences in a number of domains, from their earliest recollections of disruption in their childhood family homes to their most recent episodes of homelessness. This is therefore reflective of the pathways approach, collecting data about a wide array of experiences across a lifespan of an individual. These variables were then examined to detect any patterns of frequency and association (Bryman & Bell, 2015; Ryan, 2018).

Participant burden was an important consideration in this research. This is the degree to which a research participant finds participation in research difficult, time consuming, or emotionally stressful (Bryman & Bell, 2015; Martin & Kunnen, 2008; Ryan, 2018). Researchers need to consider the physical and emotional effects on respondents of such things as the duration of interviews, the cognitive complexity of the task, the frequency of interviews, and the psychological stress of invasive questions. Accordingly, a strength-based approach to interviewing sessions was adopted, situated the participant as the expert in understanding single adult homelessness (Martin & Kunnen, 2008). Participants were encouraged to set the pace of interviewing. Existing TPP program services were made available to support research participants. These includes free access to onsite mental health and substance dependency social workers and a doctor.

The potential for research to cause harm to research participants carries with it ethical responsibility on the part of the researcher to mitigate such risk (University of Waikato, 2008). Methods such as time testing, debriefing respondents and provision of an incentive have been shown to minimize respondent burden. For this research, the phase one research instrument was time tested. The questionnaire took approximately 45 minutes to complete. Participants were encouraged to take breaks as required. A review of interview protocols, and effectiveness was completed after pilot testing of the questionnaire, and some subsequent design adaptations made.

3.4.2 Measures

Questions asked were organized around the objectives of this research, as outlined in section 3.1. Specifically, the questionnaire for this research was designed to determine if the broad consensus about factors associated with pathways to single adult homelessness identified from research conducted in other parts of the world apply in New Zealand. This measure also sought to determine if there were other contextual factors specific to this cohort. Collecting information using questions from existing research enables international comparison. Additionally, TPP staff assisted in adaptation of existing questionnaire tools and formulating questions about suspected local contributors to homelessness.

Specifically, this method sought to measure:

1. The prevalence of contributing factors and triggers of single adult homelessness identified in existing international research among participants.
2. The prevalence of adverse childhood experiences among participants.
3. The prevalence of local structural and individual factors identified by TPP staff as possibly contributing to people's experience of homelessness in Hamilton.

The questionnaire themes, constructs and measures are outlined in Table 3 and will now be discussed in more detail.

Of the 20 sections in the questionnaire, 16 sections are comprised of predominantly structured closed questions, with mostly fixed choice answers (yes, no, declined to answer) (Bryman and Bell, 2015). Additionally, four sections allowed for collection of a small amount of narrative data. The questionnaire is an amalgamation of questions from three main sources; two surveys used in international research involving people experiencing homelessness and questions co-designed by the researcher and TPP staff to collect data about suspected local contributors to homelessness. The two surveys used in international research are the 10-question Adverse Childhood Experiences (ACE) survey developed by Felitti et al. (1998), and excerpts from the Multiple Exclusion Homelessness (MEH) survey developed by Suzanne Fitzpatrick et al. (2013). The specific content included from these two surveys in this questionnaire is discussed further in this section.

Additionally, the questionnaire gathered demographic details about participants, details about the local context of their homeless episodes, and narrative data from the larger participant cohort. The questionnaire sections are largely in chronological order across a lifespan, from earliest childhood experiences through to questions about people's experiences while homeless, immediately prior to engaging with TPP. ACE and MEH surveying had been time tested, with ACE surveying taking no longer

than five minutes to complete (CDC, 2018) and the full MEH survey taking on average 46 minutes to complete (Fitzpatrick et al, 2013). In the current study, the entire questionnaire took 45 minutes to 1 hour to complete. To follow is a fuller account of the measures included in the questionnaire.

3.4.2.1 Adverse Childhood Experience (ACE) questions and analysis

Section 5 of the questionnaire includes the 10 ACE questions developed by Felitti et al. (1998), as discussed in chapter 1, section 2.2.2. These questions were designed to measure the prevalence of traumatic experiences a person may have experienced in childhood before the age of 18 years. Five questions relate to abuse the participant may have personally experienced. These questions ask about experiences involving physical or contact sexual abuse and emotional abuse including recurrent humiliation. Two questions ask about physical and emotional neglect, including not feeling loved or not being taken for medical assistance when needed. Five questions relate to actions and events that happened to or between other members of a participant's childhood household. These questions are designed to measure if the participant has witnessed various behaviours or events or has been subject to the effect these behaviours, or events had on their childhood household. The behaviours measured are violent abuse toward a mother or caregiver, imprisonment of a household member, substance abuse among household members, serious mental illness including suicidality suffered by other household members and separation, divorce, or other loss (including death) of the participant's primary caregivers.

Each participant scores one point if answering 'yes' to a question, and zero if answering 'no' to a question. The final ACE score for each participant is the sum of the categories that were experienced, not the number of incidents within a category. A total ACE score therefore ranges from zero, meaning no abuse or neglect was sustained, to 10, meaning significant abuse and neglect was sustained (Felitti & Anda, 2014). As discussed in the literature review, research from other countries has shown that high ACE scores are linked with an increased risk of poor health and social outcomes, including homelessness (CDC, 2018; Felitti et al, 1998; Hughes et al, 2017; Larkin and Park, 2012; Montgomery et al, 2013).

The 10 questions and scoring has shown to be reliable and a valid screen for retrospective assessment of ACE, having adequate internal test-retest consistency (Cronbach's alpha = .88) (Dube et al., 2004). A New Zealand study testing the reliability of ACE recall among a cohort concluded that retrospective and prospective measure of adversity showed moderate agreement ($r=.47$, $p<.001$; weigher Kappa = .31, 95% CI: 0.27-0.35) (Reuben et al., 2016). Researchers cautioned that an individual's disposition may lead to bias toward under and over-estimating some ACE impacts although the association between personality factors and the propensity to recall adversity was extremely modest. The study

concluded that despite modest variations between retrospective and prospective recall, the results showed strong associations between ACE and poor physical, cognitive, mental, and social health outcomes by age 38 years.

An adaptation to the ACE questions used in this questionnaire is that data were gathered about what age an ACE first occurred for participants. This adaptation allowed a consistent format throughout the questionnaire, as other questions also asked participants about the age at which experiences first occurred. The inclusion of this consistent timing data allowed the participants' ACE experiences to be added to temporal sequencing analysis. The resulting data then provided additional evidence about the age at which any interventions may best be considered, and the approach that might best be applied. This approach aligns with the policy and application focus evident in a critical realism approach, as well as the longitudinal impact of contributing factors evident in the pathways approach.

Table 3 Questionnaire themes, constructs, and measures

Section	Section theme	Construct	Measure	Data Collected
1-3	Demographic information			gender, age, relationship status, ethnicity, length of time homeless, town of origin, reason moved to city
4	Meaning of word “homeless”	Defining research topic	Themes and word frequency	Narrative
5	Early childhood and youth (Age 0 – 18 years)	Prevalence of adverse childhood experiences (Age range 0 – 18 years)	10 ACE questions (Felitti et al, 1998; CDC, 2018) Measure: Scored out of 10 questions (Yes = 1, No = 0)	Yes = occurred No = did not occur Age first occurred Declined to answer
6	Housed and work status of participants’ caregivers in childhood (Age 0 – 18 years)	Context of ACE - relative stability of household.	Measure: Housed Working	Yes or No - Narrative re type of housing Father/Mother – Yes or No – Narrative collected re type of work
7-9	Additional MEH experiences before the age of 16	Prevalence of contributing factors identified in international research	Excerpts from Multiple Exclusion Homelessness Survey (Fitzpatrick et al, 2013) (Note: Question content adapted to local context e.g. Welfare provider names updated to Work and Income)	Yes = occurred/is an issue No = did not occur/is not an issue Age first occurred Declined to answer Narrative collected in the following sections: 9 Describing episode of discrimination 11 Describing reasons for loss of contact with family
10	Mental health and substance dependencies issues			
11	Physical health issues			

12	Social exclusion Issues communicating Discrimination	Continued: Prevalence of contributing factors identified in international research	Continued: Excerpts from Multiple Exclusion Homelessness Survey Measure: Frequency of prevalence of contributing factor Pathways analysis Occurrence by demographic factors such as age, gender, and ethnicity prevalence Themes and word frequency	Continued: Yes = occurred/is an issue No = did not occur/is not an issue Age first occurred Declined to answer
13	Time spent in the armed forces			
14	Justice system interaction			
15	Loss of contact with family			
16-17	Housing tenure and instability			
18	Income			
19	Work and Study			
20	Debt			
10 & 14	Exiting care from local institutions	Prevalence of TPP-identified suspected contributing factors	(Consultation with TPP staff, October 2018)	
Final page	Any other contributing factors	Other local contributing factors not otherwise specified	Themes and word frequency	Narrative

3.4.2.2 *Multiple Exclusion Homelessness (MEH) questions*

The questionnaire includes questions developed by Fitzpatrick et al (2013), researchers from the UK, who designed an electronic survey to capture data about people's experience of being without security of tenure (a stable tenancy), but also about three other overarching domains of deep social exclusion: experience of institutional care; problematic substance use; and people's involvement in street culture activity such as begging or hustling. The MEH questionnaire was also designed to capture data about people's experience in these domains over time, embracing a pathways approach.

The MEH research identified a common set of 28 experiences representing adverse life events that were reported by a very high proportion of their participants (about three-quarters or more) (Suzanne Fitzpatrick et al., 2013, p. 153). Questions about each of these experiences are included in the questionnaire for this research. These questions require a yes or no answer, with opportunity to include age of first occurrence. As for the ACE section, collecting information about the age of first occurrence is relevant in considering timing of possible interventions.

Additional questions also collect similar demographic details to that collected in the UK study (sections 1-2), details about the frequency and length of homeless episodes experienced (section 3), a few details about participants' parents (section 6), and some education and employment details about participants (section 19). Including a selection of questions from the MEH survey allowed for testing if these elements also played a part in people's homeless journey (if any) in New Zealand. Permission to use these questions has been granted by the researchers (Appendix H).

3.4.2.3 *Narrative Sections*

A small quantity of narrative data was collected during quantitative questionnaire surveying. This was derived from four questions which gave opportunities for free-text answers. The inclusion of an opportunity for a small field of free-text at the beginning of a structured questionnaire is designed to encourage the free-flow of ideas from the participant (Ryan, 2018). For this research, it had the effect of situating the participant as the expert advisor (Guba & Lincoln, 1994) and as a co-creative agent in the research process (Martin & Kunnen, 2008).

The free-text questions were specifically designed to collect data about the following constructs:

- Section 4 - Situating a joint understanding of the spectrum of homelessness to be discussed (from rough sleeping to couch surfing or doubling up, including temporary or emergency accommodation), applying the New Zealand definition of homelessness (Statistics New Zealand, 2014).

- Section 12 - Providing an opportunity to understand how discrimination may have contributed to people becoming homeless.
- Section 15 - Collecting data about the reasons people may have lost contact with family.
- Final page - At the end of the questionnaire, providing people with a final opportunity to add comment about contributing factors or triggers they felt had not already been covered elsewhere in the questionnaire. This opportunity was taken up by over three-quarters of the participants.

3.4.2.4 *Local context questions*

Four questions were included that had been developed in consultation with TPP staff. They were designed to specifically test the prevalence of people exiting care from local facilities to homelessness. These questions asked about participants' past connection with a now deinstitutionalised local psychiatric hospital (if any), more recent connection with the acute mental health ward at the local hospital and with a local service supporting people with intellectual disabilities (section 10). Details were also sought about the names of the prison's participants had spent time incarcerated in. This allowed for collection of data about the prevalence of participants exiting from two local prisons (section 14). Overall, these questions were included to test if inadequately supported exits from these facilities were contributing to homelessness in the city.

3.4.2.5 *Demographic characteristics – participants and their parents*

Questions designed to collect data about demographic characteristics of the participants prefaced the questionnaire (sections 1 & 2). Data was collected about gender, age, relationship status, ethnicity, and length of time homeless. Additionally, questions were included about where participants grew up and had mostly lived throughout their lives. This was to determine if participants were local or had come from out of area.

Two questions asked about the participant's parents or caregivers' work status during participant's early childhood and the type of housing they lived in together with their family while young (section 6). These questions were designed to explore potential contextual elements around any adverse childhood circumstances participants may have experienced. Specifically, these questions were designed to test if participants grew up in what might be considered a stable home, with parents or caregivers who were working.

3.4.3 Participant selection

Participants were a purposive non-probability sample of people working with TPP who had experienced being homeless in Hamilton (Bryman & Bell, 2015; Ryan, 2018). TPP program participants

at the time of this research were single adults or members of couples without dependent children. To follow are details of how sample size was calculated and details of participant selection criteria.

3.4.3.1 Power and Sample size

A power calculation was used to determine sample size, so that results of this research might be considered to hold statistical meaning and potentially represent associations applicable to other homeless populations in New Zealand (Bryman & Bell, 2015). The power calculation was based on determining a representative cohort of the potential segment of New Zealanders who may have ever experienced homelessness and experienced at least three of the adverse childhood experiences included in the 10 question ACE test. This measure was chosen for two reasons: firstly because research from other countries has shown there is an over-representation of people who have experienced trauma in childhood in homeless populations compared to non-homeless population groups (Montgomery et al., 2013; Roos et al., 2013), and secondly, because ACE testing was to be included in this research.

As there are no known studies in New Zealand that measure both lifetime prevalence of homelessness and ACE prevalence in a general population, estimates were taken from a study carried out in Washington State, in the US (Montgomery et al., 2013). In this study, 3.6% of the study cohort (n = 5,957) had experienced at least one episode of homelessness through their lives and had an ACE score of three or more. Based on estimating a representative cohort of the potential segment of the population living in Hamilton city at the time of the study (169,500 in June 2019) (Statistics New Zealand, 2019) who may have experienced both an episode of homelessness during their lives and at least three adverse childhood experiences included in the 10 question ACE test (n=6,102, 3.6%), a sample size of 112 participants was required (80% confidence level, 6% margin of error). Practical constraints influenced the final number of willing participants (n=100). This included TPP limiting research contact hours to no more than 8 hours per week, with research to be completed within the calendar year. Additionally, researcher stamina limited the number of research sessions per day, particularly because of the traumatic nature of the discussions experienced.

3.4.3.2 Selection criteria

Eligible participants for this research must have met the sole inclusion criteria of having been either a past or existing registered program participant of TPP, and therefore satisfied the New Zealand definition of having been homeless (Statistics New Zealand, 2014). Additionally, all TPP program participants who registered for support are over 18 years of age. Research participants were therefore legal adults who have experienced homelessness in Hamilton. The age criterion is relevant in relation to the existing TPP program services available to support people who participated in the research.

These supports include mental health and substance dependency social workers and access to a free onsite doctor. These services are specifically targeted at supporting people over the age of 18 years.

While no-one who met the criteria above and wanted to participate was excluded from completing the questionnaire, TPP managers and the clinical team reserved the right to advise if participation should be delayed because they considered that completing the questionnaire might compromise a potential participant's immediate recovery path. An example of when this occurred was when a potential participant was considered acutely mentally unwell at the time of volunteering to be part of the research. Where a person was referred to the researcher by a TPP case manager, it was agreed that the researcher would check in with the case manager immediately prior to interviewing and assess whether to proceed from there.

3.4.4 Sampling and research strategy.

Several methods of recruitment were employed. This included information posters placed in the waiting rooms and interview rooms of TPP offices in central Hamilton (Appendix G). The primary method of recruiting was referral from TPP case managers. Some case managers introduced interested potential participants to the researcher. Alternatively, case managers also initiated discussion about the research with potential participants during their own office meetings, and then referred those interested to the researcher when appropriate. Another very useful method of recruitment was participant word of mouth. One participant, who had particularly enjoyed the research process, volunteered to recruit other participants. She took posters and information sheets to a daily local free meal setting. She was invited by the event organisers to speak to those gathered about her experiences being part of the research.

After participants were referred to the researcher, a brief consultation took place. An information sheet was provided for people to take away (Appendix A). The information sheet was read out loud to each potential participant. In this consultation, the inclusion of the ACE questions was highlighted with an explanation of why these questions had been included. Participants were informed that they did not have to complete any section they did not want to answer. An interview appointment time was then scheduled. TPP management agreed to the researcher conducting regular weekly research sessions. Participants could choose to complete the questionnaire in the TPP office or at other locations. Most chose the familiarity and neutrality of the office. Originally, these sessions were scheduled to be conducted on Fridays at the TPP office, in the centre of Hamilton, starting from February 2019. Eight hours interviewing time per week was agreed. The in-town office space, including withdrawal space, was made available. This arrangement suited TPP because the office was closed to

program participants on Fridays while case managers completed in home visits and outreach. Therefore, interview rooms were available.

TPP management permitted research Fridays to continue throughout 2019 until all questionnaires had been completed. The researcher was responsible for co-ordinating the research sessions with willing participants, their support person (if applicable) and the staff of TPP. During the research sessions, the researcher facilitated the completion of questionnaires with participants. In all except one instance, participants preferred to have the researcher read the questions aloud and fill in the required questionnaire fields with their response. Narrative answers were dictated and transcribed verbatim.

Except for those participants who wished to be part of qualitative data collection in phase two of this research, questionnaire responses remained anonymous. Written consent (Appendix B) was gained and kept separately from questionnaires. Participants who wished to be part of data collection in phase two in-depth interviews were invited to provide their contact details and were given an information sheet which was discussed (Appendix C). Participants were reminded that in order to protect their anonymity, questionnaire response data were aggregated before findings were shared.

3.4.4.1 Interview protocol

Questionnaire interviews were conducted in the privacy of withdrawal space offices. Each interview started with thanking participants for volunteering and presentation of the koha/gift.

Koha/Gift

Questionnaire participants were given a koha (gift) of a \$20 supermarket voucher for agreeing to be part of the research. This was in recognition that people participating in surveying were providing expert advice and sharing their experiences to advance collective knowledge about single adult homelessness in Hamilton. The koha was offered at the beginning of each questionnaire session and given whether the questionnaire was completed or not.

3.4.5 Interview process

Participants were reminded of the research aims, situating them as expert advisors. People were additionally reminded that they did not have to complete any questions that they did not feel comfortable answering as there was an option to “decline to answer” with every question. Inclusion of the ACE questions was reiterated. In recognition that the questionnaire required recall of some disruptive events in people’s lives, all participants were given the following three resources:

- A “1737” card with free text number to connect to a free, phone-based, 24-hour counselling support service.

- A “Just a thought” information card – A free web-based resource to help people who are suffering from mental health issues.
- A TPP contact card with the service’s free phone number for any follow up calls required.

Prior to the commencement of the ACE questions, people were again reminded that they could decline to answer or skip this section. At the end of completing these questions, the following wording was used:

“I’m sorry that happened to you. Have you received any support around this? Would you like me to talk to your case manager who may be able to arrange counselling? Do you need a minute or are you happy to continue with the questionnaire?”

The wording acknowledging participants’ experiences and offering help to seek support is recommended by the original ACE researchers (Felitti & Anda, 2014; Felitti et al., 1998; Hari, 2019). Their research showed that patients who had their childhood trauma compassionately acknowledged showed a significant reduction in some illnesses they were suffering.

3.4.6 Data collection challenges and method redesign

Pilot testing of the questionnaire was carried out. After 17 questionnaires were completed, a review was carried out with research supervisors and the manager of TPP. Two incidents had occurred with research participants who had recently completed a questionnaire. TPP’s management were concerned that being involved in this research may have contributed additional pressures for people.

After further consultation with research supervisors, and TPP’s Project Lead, it was concluded that these behaviours could have ensued irrespective of whether the participants involved had completed the questionnaire or not. The behaviours were not out of character. After careful consideration, two research implementation adaptations were made. Firstly, it was decided that although the information sheet included instructions about how to seek support if there were any issues post-interviewing, a more pro-active approach to follow up was more appropriate. Post-interview follow-up would take place in the day immediately following completion of the questionnaire by a means agreed between participant and researcher.

Secondly, surveying on a Friday created the potential for participants to be left insufficiently supported over a weekend. This is because TPP offices are closed over weekends, leaving no support options for those who may have felt they wished to contact their case manager or the researcher. In a review with the TPP manager and the Project Lead it was decided that interviewing would be conducted on any weekday other than Friday. This protocol was observed for the remainder of research interviewing. Over the entire period of surveying, only two participants chose not to complete the

questionnaire due to sensitively around questions asked. Both were accompanied by support people. Both still received their koha as acknowledgement. No further concerns were raised by TPP management.

Practical constraints influenced the number of willing research participants. The original completion target was 112 questionnaires. However, only 100 questionnaires were completed. Additionally, the stamina of the researcher dictated that no more than three questionnaires be completed in one day. This was to mitigate the potential for vicarious traumatization. During interviewing, details about the traumatic events people had survived were often disclosed, though never requested nor any such discussion encouraged. Support structures were therefore an integral part of the research process (Martin & Kunnen, 2008). This included regular debriefing during the data gathering phase, which was carried out as part of research supervision meetings.

3.4.7 Data analysis

Quantitative data collected from questionnaires were aggregated and analysed using IBM SPSS Statistics version 27 quantitative data analysing software. Analysis produced frequency and descriptive statistics. Various inferential statistical tests were also carried out. Chi-square tests of independence were carried out to determine if there were significant associations between various potential contributing factors such as prevalence of out-of-home placement and participant characteristics such as gender and ethnicity. A one-sample proportions test was carried out to compare the incidence of problematic alcohol and drug use, and cardiovascular disease among participants against results from another New Zealand-based study involving a homeless cohort. To protect the anonymity of participants, any result of cell size 1, 2, or 3 is collapsed and represented as ≤ 3 . Statistical analysis is rounded to two decimal points.

Within the quantitative questionnaires, a small amount of free-text narrative was collected and thematically analysed using QSR International's NVivo version 12 qualitative data analysis software. Themes were identified based on recurrence, repetition and forcefulness (Gale et al., 2013).

3.5 Qualitative Methodology – In-depth interviews

3.5.1 Method Design

Qualitative data were collected using in-depth face-to-face semi-structured interviews (Bryman & Bell, 2015; Ryan, 2018). Semi-structured interviews are a qualitative research method where questions are used as a guide to conversation about a specific topic. Questions were purposely open-ended, in order to gain respondent context in relation to specific topics (Bryman and Bell, 2015).

Face-to-face interviews are recommended under a critical realism paradigm, which is aimed at giving voice to the participants' views about a topic (Bryman & Bell, 2015; Guba & Lincoln, 1994; Martin & Kunnen, 2008). Face-to-face interviews are also culturally appropriate in research involving Māori (Hudson, 2010). This format encourages an enhancement in the quality of relationship between the researcher and participant. Relationship building is the essence of the ethical research principle of whakapapa, which is a critical element in research involving Māori, and additionally important for this research involving a vulnerable population.

A phased approach allowed access to and identification of potential participants for the qualitative phase during questionnaire surveying. Sampling in qualitative research is not necessarily designed to be representative of a wider population. Rather, participants are selected to capture diverse perspectives about a topic (Gale et al., 2013). Those who had experienced multiple interactions with social sector organisations during their lives and who had high adverse childhood experience scores were the focus for inclusion in the qualitative phase. The exact criterion for inclusion is further outlined in section 3.5.3. Purposeful selection of people with these experiences allowed for access to views about what interventions, support and resources worked well for people and what (if anything) was missing.

3.5.2 Measures

Interview topics, guiding questions, and constructs are summarized in Table 4. Questions asked were organized around the objectives of this research reiterated in section 3.4.2. Interview questions, while broadly similar for each participant, were tailored to expand discussion around specific life experiences participants had outlined in their questionnaire. Four main themes were explored with participants:

- Factors participants considered raised their risk of experiencing a homeless episode.
- Whether participants considered the adverse events they had experienced in childhood and youth had any link to their experience of homelessness.
- Systems and structural factors participants considered contributed to homelessness more generally in New Zealand.
- Whether participants considered racism a contributing factor to homelessness in New Zealand.

Additionally, participants were invited to give advice about potential solutions - what things needed to change to lower people's risk of homelessness, in relation to each of the four themes being discussed.

Table 4 In-depth interview topics, guiding questions, and constructs.

Question Topic	Questions	Construct
Contextual contributors, triggers, and solutions	<p>What are all of things you think contributed to you ending up homeless?</p> <p>What intervention, help or resources would have stopped these things contributing to you becoming homeless?</p> <p>When should this help/intervention/resource have been available?</p>	<p>Identifying any contextual contributing factors raising risk of homelessness in Hamilton</p> <p>Determining solutions to homelessness and critical points of intervention</p>
Prevalence of ACE and solutions	<p>If ACE indicated in questionnaire:</p> <p>In your questionnaire you said that you had experienced traumatic events in your childhood and youth. Do you think the traumatic things you experienced while growing up had any long-term effects on your life? Do you think this contributed to you ending up homeless? If so, how?</p> <p>What resources, help or interventions would you recommend for people who had similar experiences in childhood to you?</p>	<p>Determining participant’s perception about link between ACE and homelessness</p> <p>Determining support, resourcing or interventions for people who experienced ACE</p>
Systems and structural contributing factors in NZ and Solutions	<p>The 2013 census showed us that homelessness is increasing in NZ. Why do you think this is?</p> <p>If you were the Prime Minister of New Zealand, what would you do to end homelessness in New Zealand?</p>	<p>Determining contributors to homelessness in NZ.</p> <p>Determining solutions to homelessness in NZ.</p>
Over-representation of Māori among people homeless Solutions	<p>Last census showed us there were more Pacific Peoples and Māori experiencing homelessness in New Zealand than other cultures. Why do you think this is?</p> <p>What can be done about it?</p>	<p>Determining the participants views on the relationship between racism and homelessness.</p> <p>Determining the participants views on solutions to racism linked to homelessness.</p>

3.5.3 Participant selection

3.5.3.1 *Sample size*

In qualitative research, sample size is generally smaller, and non-random, using selection methods such as purposive sampling (Ryan,2018). The number of interviews required can depend on when saturation is achieved, where no new themes or information are expected to arise from subsequent interviews (Bryman & Bell, 2015). When sampling a relatively homogenous group of participants, saturation has been shown to be achieved after 12 interviews (Guest et al., 2006). The final sample size of eleven participants was determined by saturation of themes.

3.5.3.2 *Selection criteria*

Criteria for inclusion in phase two interviews were as follows:

- Participants from phase one who were willing to be involved in the in-depth interviews and
- Questionnaire responses included:
 - An ACE score of three or more; and
 - interactions with multiple social agencies and organisations, such as prison, hospital, rehabilitation facilities and mental health facilities.

The rationale for considering participants with an ACE score of three or more was guided by research carried out in other countries involving ACE scoring among homeless cohorts (Bellis et al., 2019, Hughes et al, 2017, Roos et al., 2013, Montgomery et al.,2013). For example, Montgomery et al. (2013) in 2010 used data from phone surveys with 5,957 participants across Washington State. Using the 10-question ACE test, adult participants who indicated they had experienced homelessness had a mean ACE score of 3.4, compared with adults who had no experience of homelessness, who had a mean ACE score of 1.5 (Montgomery et al, 2013, p 40).

While there are New Zealand studies measuring the prevalence of ACE using the 10-question ACE test in general populations (Fanslow et al., 2021, Reuben et al., 2016, Walsh et al., 2019) none have measured the association between ACE using the 10-question ACE test and homelessness. Therefore, selection criteria for this study were guided by the research of Montgomery et al. (2013) in selection of qualitative participants with an ACE score of three or more to reflect the correlation between a high prevalence of adverse childhood experiences and later-life homelessness. Additionally, including people who had experienced higher levels of ACE gave an opportunity to test if survivors considered this element to be a contributing factor raising their risk of later-life homelessness.

Including participants with ACE scores and also with multiple social agency interactions across time afforded the opportunity for people to discuss their interactions with these organisations. Questions were designed to determine if these interactions had been useful, and what additional or alternative interactions, interventions and resources people might recommend.

3.5.4 Implementation

In-depth interviews were conducted concurrently with the questionnaire of phase one. This was because participants selected were enthusiastic and expected that interviews would follow soon after they had completed their phase one questionnaire. Additionally, concurrent collection fitted with time constraints around data collection being completed within the 2019 year.

3.5.4.1 *Interview protocol*

Although participants had a choice of location, all except one of the in-depth face-to-face interviews were carried out in withdrawal space in the TPP offices. The preference among participants of conducting interviews at TPP offices may be because participants felt the location was familiar, safe, and neutral. No interviewees elected to have a support person with them. As for the phase one questionnaire, interviews were conducted on weekdays other than Friday. All participants were contacted the day after their interview by way of debriefing. Interviews lasted approximately one hour and were audio recorded.

Koha/Gift

As with phase one, in-depth interview participants received a koha (gift) of a \$40 supermarket voucher for offering to participate in this additional research activity. The koha was offered prior to interviews commencing and given whether the interview went ahead or not.

3.5.5 Interview process

Each interview started with a read-through and discussion about the questions to be asked, an agreement about audio recording and a reminder that people did not have to answer any question they did not feel comfortable answering. All participants signed consent forms (Appendix D). Five participants chose a pseudonym to protect their identity. The remainder wished their first names to be referred to in the research. The interviews were transcribed verbatim by the researcher. To satisfy the research tenet of authenticity (Bryman & Bell, 2015; Martin & Kunnen, 2008) the transcripts were offered back to participants for correction, and verification to ensure they were an accurate, true, and fair record of people's responses. No participants requested the withdrawal of their transcript from the research.

3.5.6 Data analysis

The interview transcripts formed a data set that was thematically analysed. Thematic analysis is a method of identifying, examining, and reporting repeated patterns of meaning or themes within data (Braun and Clarke, 2006; Bryman and Bell, 2015; Ryan, 2018). A theme captures something important about the data, in relation to a research question. A theme can represent a pattern of responses or meaning within a data set. This can be based on the frequency or prevalence with which words, or concepts are expressed, but is not always dependent on such measures (Braun and Clarke, 2006). The coding of the transcripts was completed in the qualitative data analysis software, NVivo.

There are many forms of thematic analysis. The approach used for this research was a framework method. The justification for choosing this approach and its application in this research will be described in the section to follow.

3.5.6.1 *Framework method*

The framework method approach is an increasingly popular approach to managing and analysing qualitative data and has been used successfully in multi-disciplinary health research both internationally and locally, as well as being used broadly in policy-driven research (Barker et al., 2017; Gale et al., 2013; Ritchie et al., 1994). It is most commonly used for the thematic analysis of semi-structured interview transcripts.

One advantage of the framework method is that while analysis of key themes takes place across the whole data set, the view of each research participant is not lost (Gale et al., 2013). A second advantage is that the framework method is not aligned with any one epistemological, philosophical, or theoretical approach. It is therefore a flexible tool, adaptable to most qualitative approaches that aim to generate themes.

The approach's main output is a matrix made up of rows, columns, and cells of summarised data. The matrix provides a structured means with which to reduce data to core themes. This approach allows for analyses by case and by code. Each case is an individual interview participant's transcript. Each code is a descriptive or conceptual label that is assigned to excerpts of raw narrative data (Gale et al., 2013). Codes can refer to substantive things (e.g., particular behaviours, or incidents), values and beliefs (e.g., a core belief that New Zealand men are tough and can cope easily with life's adversity, so asking for help seems emasculating), emotions (e.g., a loss of hope, or helplessness) or impressionistic notions (e.g., participant became emotional). The flexibility in this approach is therefore appropriate for analysis of a complex topic such as homelessness.

The process of analyse under a framework approach applied in this research is summarised in Table 5 (Gale et al., 2013, p. 4):

Table 5 Framework analysis process

Process	Process Description
Transcript	Verbatim transcript of audio recordings produced for each interview
Familiarisation with interviews	Reread a sample number of transcripts in their entirety and noted any contextual or reflective notes about the interview. Made notes in transcript margins about thoughts or impressions.
Coding	Carefully read sample transcripts line by line, applying a paraphrase or label (a code) that described what had been interpreted in the passage. Noted unexpected narrative, including impressions, rather than literally interpreting the text.
Developing a working analytical framework	After coding the first few transcripts, initial codes were narrowed to core themes by identifying similarities and differences. Final codes were defined. A final matrix of codes was arrived at.
Applying the analytical framework	The working analytical framework was applied by indexing all of the transcripts using the codes. Data analysis software NVivo was used to speed up the coding process and ensure that data were readily retrievable.
Charting data into the framework matrix	A spreadsheet was generated of a matrix and the data were summarized by category from each transcript into the matrix. The chart included references to interesting or illustrative quotations.
Interpreting the data	Characteristics of and differences between data were identified. Connections between categories were mapped. Themes were linked, reviewed, and compared to pre-existing constructs and theories.

Table 6 represents the overarching framework which guided initial thematic analysis. The guiding constructs were organized within the research objectives; that is themes related to determining pathways, contributing factors and potential points of intervention. Initial coding largely fell within the constructs of a lack of physiological security (e.g. secure shelter where one feels safe) or psychological security (e.g. socially excluded) (Maslow, 1943). These constructs were drawn from existing literature about pathways, contributing factors and points of intervention in single adult homelessness from other countries.

Refined themes within the framework were identified based on three criteria: recurrence, repetition, and forcefulness (Barker et al., 2017; Gale et al., 2013). For example, coding including reference to high costs of living, the effects of intuitional debt and having inadequate income while on a benefit, were consolidated into a theme about the contribution of poverty to homelessness. Analysis was

completed by the researcher and reviewed by the research supervisors. Differences in views about themes were discussed until agreement was reached.

Table 6 Thematic analysis construct grid

Framework thematic analysis guiding constructs grid		
Hierarchy of needs (Maslow, 1943)	Pathways, contributing factors/triggers	Points of intervention
Physiological security		
<i>Basic needs met.</i> Food, water, clothing, shelter	<u>Basic needs unmet</u> Structural contributors include poverty, institutional debt, lack of supply of adequate housing, systemic alienation. Individual factors include barriers to accessing adequate shelter such as minimal income, high debt, criminal record, mental health issues, substance dependency. Alienated from supports. Homelessness a cause of and contributor to ill-health.	<u>Basic needs met.</u> Structural mechanisms that support easy access to food, water, clothing, and shelter. Individual factors supported. Barriers to shelter, food, water, and clothing mitigated.
<i>Safety needs met.</i> Safe, secure housing, income and feeling physically safe	<u>Safety needs unmet.</u> No access to safe, secure, affordable housing. Income precarity, domestic violence, ACE, unsupported.	<u>Safety needs met.</u> Access to a sustainable affordable home, secure income, access to work, support, well-being, positive role models.
Psychological security		
<i>Psychological needs met.</i> Belonging, connectedness	<u>Social disconnection</u> Disrupted social networks, shame around ACE, lack of institutional empathy, discrimination, racism, cultural disconnection, penal welfare, social exclusion, drinking culture, ill-health	<u>Positive social connection</u> Institutional empathy, a sense of belonging, supportive networks, advocacy, workfare, health equity.
<i>Esteem needs met.</i> Meaningful use of time, feeling of accomplishment	<u>Low/no self-esteem</u> Restricted access to work, exclusion from education opportunities, barriers to accessing meaningful pass-times, culturally disconnected, loss of hope and self-worth, lack of sense of purpose	<u>Purposeful/self-esteem</u> Access to work, peer advocacy, equitable access to education and training, accessing meaningful activities, cultural connectedness, a sense of positive contribution to community.
Ontological security – stable mental state derived from a sense of continuity, a sense of order, a positive view of self, meaning to life derived from experiencing positive stable emotions, avoiding chaos and anxiety (Giddens, 1991) .		

3.6 Reliability, Positionality and Research Ethics

Various forms of reliability and validity testing were employed to establish that the qualitative and quantitative data collected, and subsequent results of analysis, reflected a true and fair view (Bryman & Bell, 2015) of participants' experiences of single adult homelessness in Hamilton. First, statistical reliability and validity testing were completed during the analysis of quantitative data. For example, chi-squared tests were used to measure the degree of independence of pairs of variables (e.g. male versus female incarceration levels) (Bryman & Bell, 2015; Ryan, 2018).

Second, qualitative reliability testing included offering in-depth interview transcripts back to participants to confirm if they were a true reflection of their views about homelessness (Bryman & Bell, 2015; Guba & Lincoln, 1994; Martin & Kunnen, 2008; Ryan, 2018). Participants were offered the opportunity to amend any parts that they wished to and to add additional insights that they felt were important. Two participants took up this option and amendments were made to their transcripts accordingly.

3.6.1 Final results - feedback sessions

Once data analysis was completed, six one-hour one-on-one feedback sessions were completed with willing participants in October and November 2020. Four of these participants had completed both questionnaire and in-depth interviews and two had solely completed questionnaires. Four interviews were conducted in TPP's office and two were conducted in participants' homes. One-on-one sessions were advocated by TPP management to comply with COVID-19 restrictions on mass gatherings. Participants agreed to having their feedback included in this thesis.

A one-page synthesis of the data was presented to feedback participants. The synthesis was presented from a conceptual understanding that each person's journey into homelessness is unique. Therefore, the best outcome the research could achieve was a consensus about the main factors that had raised the risk of most participants (more than half) becoming homeless. Therefore, not all factors identified would apply to the journey experienced by all feedback participants. Based on this premise, participants were asked for feedback about the following elements:

- If they considered the results reflected a fair and accurate representation (Guba & Lincoln, 1994) of factors that may have contributed to single adult homelessness in Hamilton, based on their experiences.
- If there were important missing information or under or overstated factors.
- If the results were presented in a respectful, non-stigmatizing manner.

Additional insights provided during the feedback sessions were incorporated into the discussion chapter in this thesis.

Overall, feedback sessions provided for including participants in all aspects of the research process, including the synthesis of findings (Martin & Kunnen, 2008). Participants critically reviewed results (J. T. Anderson, 2016), and provided insightful contextualizing and reframing of data from the perspective of lived experience.

3.6.2 Positionality

There is no such things as unbiased observation in research (Bryman & Bell, 2015; Guba & Lincoln, 1994; Phillips & Pugh, 2010, p. 57). Every act of observation is based on the observer's frame of reference. All research starts with some expectation (either explicit or implicit) about the likely outcome. In light of this expectation, some observations are held to be relevant and some irrelevant. Braun and Clarke (2006) note that the researcher has an active role in identifying patterns and themes, and determining which are interesting, or important to the research, and which are not. Therefore, defining a researcher's positionality, and frame of reference, is an important part of research.

Critical realism allows for the co-creation of an understanding about a topic, by a particular researcher, and a particular cohort (Guba and Lincoln, 1994). Braun and Clarke (2006) consider it naïve to assume that a researcher will simply 'give voice' to participants when the researcher holds the power to present only the themes that support (or refute) a research hypothesis. To alleviate this criticism, they advise researchers to be transparent about their analysis process, to recognise and acknowledge the decisions that shaped which themes were reported and why. Reliability validation techniques, such as the feedback sessions held with interview participants, is one way of cross-checking that results reflect the participants' views about single adult homelessness, rather than the researcher's views (Bryman & Bell, 2015; Martin & Kunnen, 2008).

At the commencement of this study, I had a dual role as a TPP case manager and researcher. This held potential for issues to arise around role confusion for research participants, for researcher-bias, and for perceived power imbalances to influence participation (Bryman & Bell, 2015; Ensign, 2003; Fleet et al, 2016; Larkin & Park, 2013). To mitigate these challenges and potential biases, I was relieved of my TPP program participant caseload before interviews began. Program participants were assigned new caseworkers. This allowed for a meaningful separation between my role as a TPP staff member and researcher.

3.6.3 Reflexivity

Reflexivity can be defined as the process of reflecting on the implication of the researcher's impact on the construction of knowledge about a topic being studied (Bryman & Bell, 2015). This includes reflecting on the choice of research methodology, but also a researcher's own values and biases, and the impact of these on the decisions that were made about how a topic of study is observed and how knowledge learned is constructed and conveyed. This can require consideration of influence related to a researcher's culture, social context and location when researching.

The context for this research has been described in section 1.2. It could be said that the context of working in a Housing First homeless service may have influenced the researcher's choice of philosophical approach. Critical realism is strengths-based and participant-centred. Housing First principles include a client-centred, empowering approach to supporting people who are homeless (Tsemberis, 2015). The Housing First approach was adopted by TPP's parent organisation, the Wise Group, a charitable Trust, because it sat well with its overarching social justice focus. This is articulated in TPP's program goal's, which includes aiming to provide a just society for all (The People's Project, 2021)Therefore, TPP program participants have experienced being part of a supportive environment where their case manager acts as their advocate. Further, their involvement in the organisation is voluntary, being client-initiated, rather than mandatory. It is from a context of empowerment, therefore, that TPP participants may have been inclined to share their knowledge more willingly.

The questionnaire and interview content are deficit-based. However, participants knew that in order to change things for others, the non-homeless public of New Zealand needed to know how tough participants' (often accumulated) adverse circumstances have been throughout their lives, and for how long, and at what magnitude, any such level of adversity uncovered had been endured. Therefore, participants were expecting confronting questions because the complexity of homelessness is confronting.

Having experience as a case manager in a homelessness service has made me aware of gaps and inadequacies in current policy and systems people must interact with. A level of frustration around this has influenced the choice of this research topic, the design and the overall approach taken within this research (Martin & Kunnen, 2008). Critical realism allows for a focus in research on wanting to change something about the topic being studied and encourages a process of co-creation of potential solutions, situating participants as expert advisors (Guba & Lincoln, 1994). Critical realism is therefore a good fit epistemologically with my sense that change is needed. Further, this is a strength-based approach to research (Martin & Kunnen, 2008) which sits well with my views about social justice and inequity among marginalised groups in our community.

I have “insider knowledge” and a deep empathy for the participants. Where a researcher has developed a close affinity with people who are participants in research, it has been noted that researchers may find it difficult to disentangle their stance as a social scientist from their subject’s perspective (Bryman & Bell, 2015, p 40). While researching youth homelessness, however, Ensign (2003, p 43) noted that having a dual role as practitioner and researcher gave her the advantage of ‘insider status’ with participants but blurred some client/practitioner boundaries, because the researcher was known to participants in another context.

Remaining disentangled from applying insider knowledge in data collection and analysis was difficult. Thorough oversight and guidance from my research supervisors helped focus my attention on information and insights evident in and arising from the data or literature reviewed in chapter two, rather than from my sector experience. That said, these experiences allowed for useful insight during questionnaire sessions, and insider knowledge often guided lines of inquiry during in-depth interviews.

Considering role-conflict for counsellor-researchers, Fleet et al. (2016) argues that the researcher/practitioner role is a legitimately valuable context from which to generate important “knowledge in context” (p 339). The authors offer the following recommendations for managing role-conflict:

- Provide clear information about the research intention and processes for contributors.
- Cultivate self-reflexivity in all decisions.

These recommendations are fully reflected in this research design. The information sheets were couched in clear, accessible language and were read aloud to participants. Informed consent was gained before proceeding with interviews. Extensive field notes were taken about decisions made throughout the research process.

While insider knowledge may have influenced some aspects of the research process and initial expectations about outcomes of this research, it is through the rigour of scientific process that an altogether unexpected result has been achieved from analysis. This is, to some degree, testament to the robustness of the process as a means of transcending researcher bias.

3.6.4 Ethics

This research abides by the University of Waikato’s “Ethical Conduct in Human Research and Related Activities Regulations” (2008), and the “Student Research Regulations” (2008). Although participants in this research were consenting adults, they are part of a vulnerable population in society (Martin &

Kunnen, 2008) and therefore, additional care was taken to preserve participants' wellbeing during the research process. This included offering participants the choice of having a support person with them during all research activities, post-interview follow-up, and facilitated access to existing TPP program services. This includes free access to onsite mental health and substance dependency social workers and facilitated referral to other clinical specialists.

Questionnaire participants were not selected based on ethnicity. However, participants were asked about their ethnicity in the questionnaire. As Māori are over-represented among TPP program participants (Atatoa Carr et al., 2018), specific care was taken to ensure the research process was culturally appropriate for this population group. There is criticism that research about homelessness in New Zealand has tended to focus more on individual characteristics of people experiencing homelessness, such as ethnicity, often resulting in a culturally based victim-blaming approach (Groot et al, 2008). Therefore, to avoid such stigmatisation, the methodology design sought to embrace the tenants of Te Ara Tika, guidelines for research involving Māori (Hudson, 2010). These guidelines include observing the Tikanga or locally-specific practices, aimed at enhancing a research relationship. Additionally, the methodology implemented ensured the preservation of mana (justice and equity reflected through power and authority) of all participants, including those who identified as Māori. The following guiding principles were specifically embraced throughout the research process:

1. *Whakapapa* – Building and maintaining the research relationship.

Seeking to enhance the quality of the relationship between the researcher and the participant, all consultation and interviews were face-to-face. The research information sheet was clearly written in accessible language, specifying that data will only be used for the purpose agreed. The information sheet included discussion about a mechanism for reporting back results and allowed scope for the participant to discuss any issues they had with the interviewer, interview process or finding.

2. *Tika* – Research achieving positive transformation for participants and communities.

This research was conducted in a mainstream approach where the research may or may not have direct relevance to Māori. The recruitment method was face to face. Participants were made aware that they could decline to answer any question, including questions about ethnicity. Collection of ethnicity data is not of primary importance to this research but may provide important data for other research and may contribute to wider discussions regarding the disproportionate impact of homelessness on population groups.

3. *Manaakitanga* – Cultural and social responsibility and respect for persons.

In order to preserve the mana of both parties, strict protocols were established to preserve participants' confidentiality. All quantitative data results were aggregated, and qualitative transcripts were anonymized by pseudonym if the participant chose this. Feedback sessions sought participant comment about the sensitivity of the language, images and messaging used in the synthesis of findings.

4. *Mana Tangata* – Preservation of participant mana through risk identification and equitable distribution of risk.

Participants were fully informed of the potential sensitivity of some questions and the potential risk to their mana. Participant harm was carefully mitigated by consultation with clinical teams who are part of TPP prior to interviewing. A koha (gift) was given in recognition of the time, effort, and graciousness of participants in sharing their experiences for the furtherment of community understanding of homelessness. This was given at the beginning of quantitative and qualitative interview sessions, whether the participant completed the interview or not.

Whilst mindful of needing to avoid stigmatisation, collection, and analysis of ethnicity details will add to discussion among the wider community regarding the disproportionate impact of homelessness on some population groups (NIDEA, 2018), including Māori. The NZ Coalition to End Homelessness concluded that Māori need to be included in research, definition, planning, implementation, and evaluation of homelessness, to ensure that services were informed by Māori values (NZCEH, 2009). Therefore, this study sought to acknowledge and fairly represent the view of Māori who have experienced single adult homelessness in Hamilton.

Ethics approval for this research was given by the University of Waikato Human Research Ethics Committee (Health) on the 29th of January 2019 (ref#2018#73).

3.7 Chapter summary – methodology and methods

This chapter has provided a detailed overview of the methodology designed and implemented in this study. Quantitative and qualitative methods were used to collect a larger volume of data about participants experience and views about single adult homelessness in Hamilton. Specifically, the methods allowed for exploration about what factors participants consider contributed to them becoming homeless. The design allowed an opportunity to consider if people had experienced a

pathway into single adult homelessness similar to those identified in research from other countries. People were able to give advice about interventions that had worked for them, and what supports, and resources were lacking.

The research process was guided by critical realism, an epistemological viewpoint which puts people who have experienced homelessness at the center of gaining an understanding of what factors have contributed to increased risk of homelessness. The mixed data collection methods gave an opportunity to test if there were other elements not covered off by pre-existing research questions designed and implemented in other countries. Therefore, I was able to collect and explore specifics related to the local context.

In total, 100 participants were interviewed between February and December 2019, and October and November 2020. Combining questionnaire sessions, in-depth interviews, and feed-back sessions, over 101 hours of interaction occurred. Each of the 100 questionnaires held the potential to collect 222 individual data-points, providing a rich source of information and evidence. These data were analyzed for trends and prevalence. The 11 in-depth interview transcripts were recorded and transcribed verbatim. Transcripts were analyzed using a framework methodology.

Six participants were provided with preliminary results during one-on-one feedback sessions. This allowed for testing of reliability and validity of the results. Through this process, participants were able to further engage in the research process. Their input confirmed that the results presented a consensus about what had contributed to the risk of single adult homelessness in Hamilton, and what we could do to prevent it.

Chapter 4. Quantitative Data and Results

This chapter draws on the collation of data collected from 100 quantitative questionnaires carried out with participants. Data is made up of questionnaire responses and field notes about additional comments participants made while surveying. This method sought to collect data to achieve the research objectives, namely:

1. To determine what factors contributed to or raised the risk of single adult homelessness in Hamilton.
2. To determine if a pathway of common occurrences throughout people's lives raised the risk of homelessness, and what age any such pathway might have begun.
3. To consider critical points of intervention, where appropriate intervention may lower the risk of single adults becoming homeless.

Additionally, this method sought to measure the prevalence of adverse childhood experiences among participants, which is a focus of this study. It also sought to measure the impact of local structural and individual factors identified by TPP staff as suspected contributors to participants' experience of homelessness in Hamilton.

Firstly, demographic characteristics collected are summarised. This includes information about participants' connection with the Waikato Region, the region within which the city of Hamilton is located. Participants' lifetime experience of homelessness is then detailed. Results supporting the identification of a pathway into single adult homelessness are then presented, followed by results supporting the contribution of other individual and structural factors. This section also includes data about factors proven not to contribute to single adult homelessness in Hamilton.

4.1 Demographic characteristics

Table 7 is a summary of participant demographic characteristics. Additional explanations about descriptors used is as follows:

1. Participants' ages were collected individually. However, to protect participant anonymity, data about age has been collapsed into age bands.
2. Descriptors about participants' primary and secondary ethnicity were collected individually and have been collapsed into Statistics New Zealand Level 1 ethnicity descriptors.
3. All results with a cell count of between 1 and 3 will be represented as ≤ 3 .
4. The region of Waikato is the area delineated as the Waikato region territorial authority (New Zealand Government, n.d.). This authority includes the districts of Waikato, Matamata-Piako,

South Waikato and Hamilton City as well as Hauraki, Coromandel Peninsula, the northern King Country, and parts of the Taupo and Rotorua Districts.

Table 7 shows that participants were mostly male (n=64), with fewer female participants (n=36). The research cohort therefore has a lower female representation in comparison to TPP's client profile, which generally has a higher female representation (55%) (Atatoa Carr et al., 2018). Participants were aged between 18 and 66 years of age. The majority (62%) were between the ages of 31-50 years old, with the largest group of participants (39%) falling within the ages of 41-50 years old. Participants therefore fall within a representative age range of TPP participants, who are predominately aged between 25-44 years old (54.4%, n=695) (Atatoa Carr et al., 2018).

Most participants were either born in Hamilton, or in the Waikato District (n=40), or near Hamilton. Some were born in the nearby regions of Auckland (n=16) or the Bay of Plenty (n=4). Of those who were not born in Hamilton, 69 people provided the date they moved to Hamilton. Most of these (n=47) had moved in the last nine years, since 2010, with another 26 people moving to the city before 1990. Most moved to Hamilton with family, often as children (n=24). Along with most participants having been born locally, two-thirds of the participants (n=63) had lived their lives in the Waikato region, nearby in Auckland (n=11) or in the Bay of Plenty (n=6).

Table 7 Participant Demographics

Variable	Description	Prevalence
Gender	Male	64
	Female	36
Age (years)	Under 20	≤3
	21-40	24
	41-60	65
	61+	10
Primary Ethnicity	European	40
	Māori	58
	Other ethnicity	≤3
Secondary Ethnicity (n=43)	European	27
	Māori	13
	Pacific Peoples	≤3
	Other ethnicity	≤3
Civil Status	Single	75
	Married	≤3
	De Facto	8
	Divorced	6
	Separated	≤3
	Widowed	≤3
	Declined	≤3
Region or city of birth	Hamilton	22
	Waikato District	18
	Auckland	16
	Other North Island regions	33
	South Island	6
	Other countries	4
	Don't know	≤3
Region or city where lived most of life	Waikato	63
	Auckland	11
	Other North Island	15
	South Island	6
	Other countries	≤3
	Various locations	≤3
Where not from Hamilton, reasons for moving to Hamilton (n=79)	Moved with family	24
	Local family	20
	Work or study	9
	Relationship issue	6
	Escaping family violence	5
	Health related issues	4
	Prison release/court ordered	≤3
	Foster care/adopted	≤3
Other reasons	5	

Overall, 40% of the participants selected New Zealand European as their primary ethnicity and 58% identified as Māori. Over two-thirds of all of the participants (n=67) identified with an iwi or tribe. Therefore, many of participants identified with a Māori heritage. Of those participants identifying as Māori as their primary ethnicity, most identified with tribes and subtribes affiliated with Waikato Tainui (Tainui = 27, Ngāti Hauā = 3, Ngāti Maniapoto = 1, Ngāti Raukawa = 1). Waikato Tainui are the local iwi whose tribal rohe (territories or boundaries if iwi) are located within a 200-kilometre radius of Hamilton City (Te Puni Kokiri 2020).

Table 8 details participants' experience of homelessness through their lives. Most participants (n=82) had experienced episodic homelessness, having experienced two or more episodes of homelessness in their lives. Most (n=89) had been homeless less than five years in the last episode, with the majority (n=68) being homeless less than 6 years in total throughout their lives. Participants' total estimated length of time spent homeless over their lives ranged from 8 weeks to 39 years.

Table 8 Experience of homelessness.

Participant experiences of homelessness		Prevalence
Slept rough, in a garage, shed or vehicle as an adult aged 18 years or over		94
Housing status at interview	Housed	55
	Unhoused	45
Homeless - Lifetime episodes	Just this once	18
	2-5 times	38
	6-10 times	22
	More than 10 times	22
Length of time homeless – all of life	Less than 1 month	≤ 3
	Between 1- 6 months	9
	Between 6 – 12 months	9
	1-2 years	14
	3-5 years	35
	6-10 years	8
	11-20 years	15
	More than 20 years	9
Length of time homeless – Last episode	Less than 1 month	9
	Between 1- 6 months	19
	Between 6 – 12 months	16
	1-2 years	24
	3-5 years	21
	6-10 years	≤ 3
	11-20 years	8
	More than 20 years	≤ 3
	Can't remember	≤ 3

4.2 Common occurrences suggesting a pathway to single adult homelessness.

The results in this section include data about the prevalence of ACEs among participants. Also included is data about the prevalence of common adverse childhood, youth, and early adulthood experiences. Each of these experiences are known to have contributed to multiple exclusion homelessness in other countries (Fitzpatrick et al., 2013).

4.2.1 Adverse childhood experiences (ACE)

Table 9 describes the categories of ACE measured in the questionnaire using the 10-question ACE test (Felitti et al., 1998).

A variation in collation of ACE data involved recoding participants' responses where participants indicated that an experience has happened all of their childhood or adolescent lives, from their earliest recollection to age 18 years. Originally coded to first being experienced at age 1 years old, the all-of-childhood experiences were recoded to first being experienced at age 3 years old, when people may have first be able to recall any such experience. Where participants had specifically indicated their experience had started from age 2 years old, these data were not recoded to age 3 years. Recoding "all of life" responses to age 3 years had minimal effect on results. For example, the mean ACE age for data recording participant emotional abuse changed from 6.26 to 6.53 years.

Table 9 Description of ACE categories

Adverse childhood experience	Description
ACE 1 Participant emotional abuse.	Repeated incidents of caregivers or other adult household members swearing, insulting, humiliating, or threatening physical harm against participant as a child.
ACE 2 Participant physical abuse.	Repeated incidents of caregivers or other adult household members inflicting physical harm on participant as a child, including pushing, grabbing, slapping, being struck with an object, resulting in leaving injury marks or other physical injury.
ACE 3 Participant emotional neglect.	Participant as a child repeatedly feeling unloved, or insignificant to one's family or household members, not feeling close to or supported by family members.
ACE 4 Participant physical neglect.	Participant as a child experiencing repeated incidents of insufficient food, or of having to wear dirty clothing, or feeling unprotected by family or adult household members. Not taken care of including when needing medical support because family or household members are incapacitated due to problematic consumption of various substances.
ACE 5 Loss of a caregiver	Participant's primary caregivers separate, divorce, or die.
ACE 6 Caregiver inter-partner violence (against female)	Participant as child repeated or one-off incidence of witnessing female caregiver physically harmed during incidence of inter-partner violence (lasting a few minutes). This includes being threatened with a weapon.
ACE 7 Household problematic substance use	Participant as a child living with a household member with problematic substance use issues.
ACE 8 Household mental health	Participant as a child living with a household member who is mentally ill or suicidal.
ACE 9 House member incarceration	A household member has gone to prison.
ACE 10 Participant sexual abuse	Participant as a child experiencing contact sexual abuse by a person at least 5 years older at time of abuse.

Table 10 summarised the prevalence of ACEs among participants before age 18 years.

Table 10 ACE Prevalence

ACE	ACE description	Yes	No	Declined to answer	Can't remember	Average age of experience recalled		
						Median	Mean	Mode
1	Participant emotional abuse	81	16	1	1	5	7	3
2	Participant physical abuse	65	34	1	0	6	7	5
3	Participant emotional neglect	62	35	1	1	6	7	3
4	Participant physical neglect	43	55	2	0	6	7	3
5	Loss of a caregiver	53	41	1	5	5	7	3
6	Inter-partner violence between caregivers (against female)	56	41	2	1	5	6	3
7	Household problematic substance use	73	22	2	3	3	6	3
8	Household mental health issues including suicide	27	64	3	6	5	7	3
9	Household member incarcerated	7	65	4	24	9	9	3
10	Participant sexual abuse	43	50	6	1	9	9	5

Two participants chose not to complete the ACE assessment. Additionally, some participants chose not to answer various ACE questions, probably due to the sensitive nature of this disclosure. For example, six participants chose to decline to answer questions relating to sexual abuse. A larger number of participants (n=24) were unable to recall whether a household member had been to prison during their childhood and adolescence.

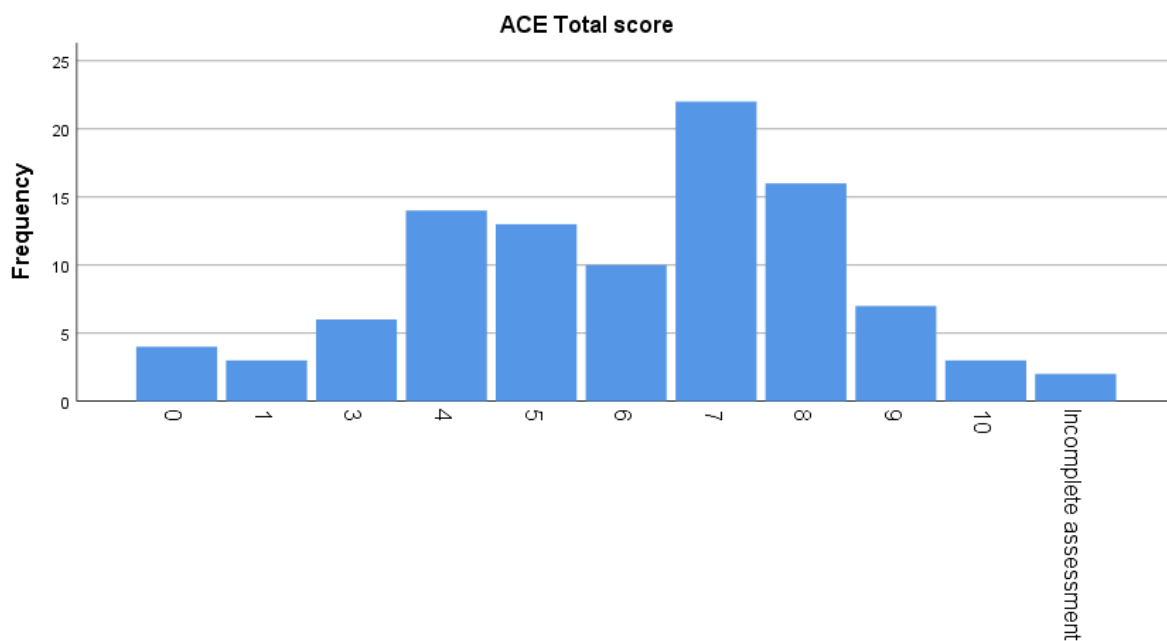
Overall, participants had experienced a high degree of abuse and household disruption in childhood. This was mostly experienced between ages 6 to age 9 years old, although the most common age that ACEs started was age 3 years, which for many participants meant from their earliest childhood recollection. This exposure was at a high rate. Most participants (95%) had experienced an ACE score of 3 or above. A high number of participants (89%) had experienced four or more ACEs. Half of the participants (50%) had experienced a very high level of childhood abuse, scoring 7 or above in ACE testing. The mean ACE score among all participants who completed the ACE test was 5.89.

As there has been no known comparable ACE testing among a cohort of single adult homeless in New Zealand, results were compared to ACE testing among adult homeless cohort in the USA (Montgomery et al., 2013) (n=318, M=3.97, SD=2.22) and Canada (Patterson et al., 2014) (n=364, M=3.90, SD=2.80). Results of a one-sample T test showed thesis participants' overall mean ACE score (5.89) was

significantly higher than the mean total ACE score for these comparative cohort ($t(97) = 8.36, p < .001$). Table 11 represents the spread of total ACE scores among participants.

Only four participants recorded no incidents of ACE. This represents 4.1% of all completed assessments. TPP case managers and social workers indicated that these four participants shared common characteristics. All four participants had either been diagnosed with an intellectual disability or had an undiagnosed but suspected intellectual disability. This commonality may indicate these participants had a different pathway to homelessness than other participants.

Table 11 ACE total score prevalence



To provide some context around participants' experience of ACEs, a small amount of data were collected about participants' parents or caregivers. Data were collected about the type of housing participants' families lived in during their childhood and adolescence. This was to gauge if participants had grown up in what might be considered stable housing. Additionally, data were collected about participants' recollection of their parents' or caregivers' work status while living in their family home, if applicable. Although living in a household with caregivers in paid employment does not necessarily guarantee a family is not living in poverty, families living on welfare benefits alone have additionally constrained income (Boston, 2013, Tanielu et al., 2020, Welfare Expert Advisory Group, 2019) which can be a contributor to family violence (Lambie, 2018). Overall, data collected about participants' parents or caregivers was aimed at giving some context to any prevalence of ACEs among participants.

Most of the participants ($n=84$) described living in housing they considered "stable" (not temporary) with their caregivers or parents. The types of housing participants recall living in are detailed in Table

12. Housing owned included participants' family homestead (n=13), meaning an intergenerational home, sometimes inherited, such as housing on a family farm or on ancestral land.

A few participants recalled that their parents had purchased their family home from Housing Corporation New Zealand, in rent-to-own schemes. Housing Corp's Home Buy scheme ran from 1996 to 1999 (A. Johnson et al., 2018). This was a time period where 75 of the participants were in their youth.

One participant's family lived in employer-provided housing. This was housing provided to a parent who worked for New Zealand Railways Corporation (NZRC), which is a state-owned enterprise (Rail Heritage Trust of New Zealand, 2012). NZRC was the first large-scale state housing provider in New Zealand. In the 1980's there were 6,000 railway houses throughout the country. This style of housing continued to be rented to railway workers until 1988, when railway housing was sold.

Table 12 Participants' caregiver's housing status during participant's childhood.

Type of housing	Frequency
Owned by caregivers/parents	51
Private rental tenancy	20
Public/state housing tenancy	12
Employer-provided housing	≤ 3
Tenancy status/type not known.	16

Seventy-five participants recall their caregivers or parents working during their childhood years. Twenty-one participants said their parents did not work and 4 participants could not remember. The main types of work of caregivers or parents is summarised in Table 13.

Table 13 Participants' caregiver's main vocation during participant's childhood.

Participants parents/caregiver's vocation	Father, Male caregiver	Mother, Female caregiver
Agriculture, Forestry, Fishing	6	≤ 3
Construction	15	≤ 3
Education	0	≤ 3
Engineering, Mechanic	5	0
Factory work	0	≤ 3
Farming	13	≤ 3
Healthcare	≤ 3	14
Hospitality or Tourism	≤ 3	6
Railways	≤ 3	0
Retail	0	≤ 3
Retired	≤ 3	0
Truck driving, heavy machinery operation	4	≤ 3
Multiple trades or work experience	5	≤ 3
Don't know	18	30
Not applicable	25	35

4.2.1.1 Section summary – Adverse childhood experiences

From this small amount of data, it can be said that the majority of participants (n=84) grew up in what might be considered stable housing. Additionally, most of the participants parents or caregivers were in paid employment (n=75). In the case of most participants, neither having a place to call home as a child, nor parents or caregivers who worked, provided stability in their early lives. A high degree of adverse childhood experiences ensued for the majority of participants (87% of those who had experienced ACE scored 4+) regardless of these seemingly protective factors.

4.2.2 Common childhood, youth, and early adult experiences

Table 14 summarises the prevalence of an additional series of adverse life experiences starting in childhood, moving through people's schooling experiences, disruptive experiences in youth and including some early adult experiences. Inclusion of age of first occurrence allowed for a clearer understanding of the chronology of these commonly experienced events. The experiences are ordered by mean age of first occurrence. Mode and median age are included to give a broader view of the age participants first experienced these disruptive events. Those experiences highlighted represent experiences that occurred for nearly half (45%) or more of the participants.

Results show a small number of people (n = 15) had experienced homelessness as children from age 7 years. From field notes, several of these participants commented that this mostly involved living or

sleeping in the family's vehicle. Another 23 people experienced homelessness as being doubled-up staying with other family members because their family had no place of their own. This resulted in over-crowding which is a form of housing deprivation.

From the results, we could incorrectly assume that 48 participants had to resort to sharing a bed with others or sleeping in places other than a bedroom before the age of 16 years. This might suggest that participants had lived in situations of severe overcrowding or that as youth they had slept in other places such as garages or sheds. These circumstances constitute homelessness under the accepted national definition, which includes sharing accommodation with another household because there are no other options (Statistics New Zealand, 2014). However, from participants' explanations recorded in fieldnotes, the cultural context provided added to a fuller interpretation of these results.

Some participants commented that the question about sleeping arrangements as children lacked consideration of Māori cultural norms and behaviors. The question asked if, as a child under 16 years of age, participants had shared a bed with others, slept on the floor or in a room that was not a bedroom. Some Māori participants who had answered yes to this question commented that sleeping in places other than a bedroom was more normal behavior for some. An example is when staying on a Marae (tribal meeting grounds). In this setting, people can sleep together in multi-use spaces, such as the meeting house. Additionally, people described communal sleeping arrangements when staying in friends or relatives' homes as "the marae-style of living". This implied that for some families when gathering, it was accepted that people may choose to sleep together, as they would on a Marae. In a domestic dwelling, this may mean people slept in many different locations other than a bedroom, such as the lounge area.

Only one person (the youngest participant) had stayed with their family in state-provided emergency housing, which in this person's case was a motel contracted to the Ministry of Social Development. State provision of emergency housing in motels for people in housing crisis (as opposed to emergency housing provided by non-government and faith-based organizations) is a relatively new occurrence in New Zealand, dating from 2016 onward. Most participants commented that there was no such resource as state-provided emergency housing in motels at the time their family experienced homelessness.

Thirteen participants can remember going to a Women's Refuge with their mother as a child. This result seems relatively small given that, among ACE data, 57 people said they had witnessed their female caregiver, their mother or stepmother, experiencing inter-partner violence. Perhaps women sought support without engaging Women's Refuge, or perhaps this disparity hints at the amount of unreported domestic violence in our communities.

Table 14 Childhood, adolescent, and early adult experiences by mean age of first experience

Experience	Number answering yes	Declined or can't remember	Age of first experience		
			Mean	Mode	Median
Shared a bed/slept in a room other than bedroom before 16 years	48	2	7	3	6
No food at home before age 16 years	40	1	8	3	8
Slept rough with family before age 16 years	15	2	8	5	7
Homeless with family before age 16 years	15	1	8	6	6
Doubled up with family before age 16 years	23	1	8	10	8
Bullied at school	50	3	10	5	10
Entered out-of-home placement (e.g., foster care)	47	0	10	13	11
Ran away from home before age 16 years	68	0	11	10	11
Truant from school	71	1	12	13	12
Expelled/suspended from School	50	1	12	13	13
Exited out-of-home placement (e.g., foster care)	47	0	14	15	16
Left school	100	0	15	15	15
Victim violent crime of domestic violence	63	0	16	3	13
Left home	90	0	17	17	16
Anxious or depressed	92	1	18	13	14

Experience	Number answering yes	Declined or can't remember	Age of first experience		
			Mean	Mode	Median
Excess alcohol use	85	3	18	13	16
Attempted suicide	51	1	18	13	19
Used solvents or inhalants	70	0	18	14	13
Street drinking	65	0	20	13	16
Self-harmed	39	1	20	19	19
Detoxed in police cells	72	0	23	13	18
Sold drugs to support drug use	33	2	23	16	18
Prison for substance misuse offences	42	2	23	16	19
Used street drugs	70	0	24	13	20
Injected drugs	20	1	24	19	20
Mental health hospitalisation	31	0	25	20	21
Hospitalised for substance misuse	42	0	28	13	23

At least half of all participants had experienced disruptive schooling. This included bullying (n=50), truancy (n=71) and being expelled or suspended from attending school (n=50). Disruption at school was experienced between the ages of 10 and 15 years. Children are legally required to be enrolled in a school in New Zealand between the ages of 6 and 16 years old (Ministry of Education, 2021) However, all participants appeared to have left school early, by age 15 years.

For this research, out-of-home placement means state-imposed care away from participants' family home, experienced as a child, before the age of 18 years. This includes living in foster-care under child protection services or as a Ward of the State. In New Zealand, the Ministry of Children /Oranga Tamariki (OT) is one of six government departments charged with protecting and improving the lives of vulnerable children, under the *Children's Act 2014* (Ministry of Children (Oranga Tamariki), n.d.). Since 1993, Oranga Tamariki's practices have been guided by the *United Nations Convention on the Rights of the Child*. Until 2017, child protection services were called Child, Youth and Family, abbreviated to CYFs. Most participants who spoke about child protection services still referred to this service by this acronym. Out of home placement does not include private, non-state arrangements, for example where children live with others, such as close relatives. Questions about these family-based arrangements were not specifically asked.

The results show that 47 participants had experienced an out-of-home placement. Table 15 represents the prevalence of out-of-home placement among participants by gender and ethnicity. A chi-square test of independence showed that there was no significant association between gender ($\chi^2(1), N=98, = 2.904, p = .88$) or ethnicity, ($\chi^2(1), N = 98, = 2.962, p = .85$), and out-of-home placements. Of the 45 participants who had been in care, the median age people first entered care was age 11 years. The age range for first entry varied between 1 and 17 years of age. One participant could not recall the age they left care. For the remainder, the median age participants left care was 15 ½ years, with the age range varying between 2 and 22 years. The median number of years participants had been in care was 4 years, with lengths of stay varying from 1 to 16 years. The median number of placements ranged from 1 to 12 with a median number of 2.

Table 15 Out of home placement by gender and ethnicity

Youth out-of-home placement by gender and ethnicity		Yes	% Yes	No	% No	Chi 2	p	Statistical significance
Gender	Male	26	40	38	60	2.904	.88	Not significant as p < .05
	Female	21	58	15	42			
Total		47	48	53	52			
Ethnicity	NZ European and other (<3)	15	36	27	64	2.962	.85	Not significant as p < .05
	Māori	32	55	26	45			
	Total	47	48	53	52			

Results show that most participants had experienced a high level of transience with their families in their early lives. Most participants (n=96) were able to describe the number of homes they had lived in before the age of 16 years. Nineteen participants had lived in just one home throughout that period of their lives. More than half (57.3%) had lived in between one and four homes. The median number of homes lived in for all of the participants who answered this question was four homes. The majority (70.8%) had lived in between one and five homes in their youth. Even within the context of New Zealand's high level of residential mobility (Howden-Chapman, 2015) this prevalence indicates a level of housing instability, which may be linked to the prevalence of participant out-of-home placements in youth.

The median age participants left home for good was age 16 years, with an age range varying from 2 to 52 years. Forty percent of participants were aged 15 to 17 when they left home. Participants were not asked about the specific reason they left home at this early age. However, some indications of reasons why this might have happened are given in qualitative results when people identify why they have lost contact with their family. These reasons are presented in chapter 5, section 5.1.2. Additionally, 70 participants said they did not get along with their parents or caregivers before the age of 18 years old, which is likely a contributing factor to their early exit from home.

Results show participants appeared to develop detrimental health and wellbeing issues in adolescence. Nearly all participants (n=92) experienced anxiety and depression from an average age of 18 years (age range 3 years, or earliest recollection, to age 62 years). Over a third of participants self-harmed (n=39) between ages 18 and 20 years and over half of participants attempted suicide (n=51) during the same age range. Feedback participants (n=6) concluded this estimate of the prevalence of suicidality among participants was likely grossly under-reported. These participants unanimously concluded that most people they knew who had experienced homelessness had

attempted suicide at some time in their lives. Over a third of all participants (n=31) said they had been hospitalised for mental health issues by an average age of 25 years.

Problematic substance use was prevalent among participants from an early age. This included excess alcohol use (n=85) (defined as six or more drinks on a daily basis) and problematic drug use (n=70) from a mean age of 18 years. Drug use included use of illegal drugs such as synthetic cannabis, and methamphetamine, as well as misuse of legal pharmaceuticals, such as benzodiazepine. Other substances used were solvents such as glue, and inhalants such as aerosol paint used in huffing activity (n=70). Problematic use of these substances contributed to 42 participants going to prison for substance-related offences from a mean age of 23 years and 42 participants being hospitalised for substance-related incidents from a mean age of 28 years. Results confirming the ongoing impact of these health and wellbeing issues during people's adult lives will be discussed in section 4.3.1.

4.2.2.1 Section summary – Common childhood, youth and early adult experiences

Overall, the data in Table 14 highlights a pattern of early-life disruption, characterised by participants' experience of a series of chaotic adverse events. People's first experience of homelessness often began in their childhood, at age 7 and 8 years, while living in a vehicle with family members, or doubled-up living with others, or at age 10 years, when nearly half of all participants were separated from family and their family home during an out-of-home placement in foster care or as a ward of the state. People endured disruptive educational experiences, with high school ending for all at age 15 years.

Most participants experienced a serious decline in wellbeing during their adolescence, particularly in their mental health. Most had also developed a substance-based coping strategy, engaging in problematic use of alcohol and other poly-substance misuse. These challenges contributed to participants being drawn into early contact with the justice system and needing treatment in the acute health settings.

By age 28 years, at least half of all the participants had come to the attention of child protection services, school behavioural officers, Police, Corrections, and crisis and acute medical services. All had left school by age 15 years. Results revealed that by early adulthood, most participants were highly unwell, had developed problematic behaviours, were already socially dislocated from their families, and had a high level of interaction with multiple social sector services and government agencies. This series of common experiences suggests a pathway to single adult homelessness exists in Hamilton.

4.3 Other contributing factors and trigger events.

This section details other contributing factors which may be considered to have raised the risk of single adult homelessness in Hamilton. This includes further data about people's adult health and wellbeing issues, and adult justice system interactions. Also represented is data about participants income precarity and potential trigger events, such as a loss of tenancy. Additionally, consideration is given to data supporting the contribution of exclusion from familial support networks to participants' precarity at crisis point.

4.3.1 Health and wellbeing issues

Table 16 represents medically diagnosed health issues prevalent among participants as adults 18 years and over. Highlighted are conditions common to nearly half (more than 45%) of all participants. There was a high prevalence of participants who indicated they had been diagnosed with mental health issues (n=89) and a similarly high prevalence of those who said they were diagnosed with a problematic substance use (n=87). Additional data showed 40 participants had attended rehabilitation (rehab) centres for substance-related issues. Most had attended once (n=18) or twice (n=8). The range of attendance at rehab fell from between one and 25 times. Based on previous results, there is a high likelihood participants' mental health issues and problematic substance use developed in childhood and adolescence had followed participants into adulthood.

A nonparametric binomial test was carried out comparing the portion of participants who indicated they had been diagnosed with mental health issues (n=89) and substance dependencies (n=87), and those who had been diagnosed with these comorbid issues among results from other New Zealand research involving people who had experienced homelessness. This research involved coroner's findings related to 171 deaths of people who were homeless at the time of death (Charvin-Fabre et al., 2020). The findings showed that among a group of 49 people who died due to suicide, 46.9% had received recent or past treatment for a clinically diagnosed mental health issues. Additionally, 38% had a clinical diagnosis of problematic alcohol or drug use. The binomial test confirmed that the portion of TPP participants experiencing these co-morbid health issues was significantly higher than expected (Mental health: 0.47, $p < .001$ (1-sided), 95% CI [.812, .944]) (Problematic substance use: 0.38, $p < .001$ (1-sided), 95% CI [.788, .929]).

Table 16 Diagnosed health and wellbeing issues.

Diagnosed health problems	Yes	No
Mental health issues	89	11
Substance dependencies	87	13
Headaches or injuries	58	42
Heart/blood circulatory issues	48	52
Chest/breathing problems	47	53
Skin conditions/allergies	39	61
Disabilities appendages, back and neck	38	62
Learning disability	34	66
Difficulty hearing	33	67
Digestive, liver, kidney issues	33	67
Difficulty seeing other than glasses	32	68
Diabetes	16	82
Dyslexia	15	85
Epilepsy	13	87
Stroke	10	90
Rheumatic Fever	10	90
Cancer	9	90
Hepatitis	9	91
Tuberculosis	5	95
Foetal Alcohol Syndrome	≤ 3	97
Human immunodeficiency virus (HIV)	0	100

Fifty-eight participants said they suffered severe migraines, headaches and/or had suffered a head injury in their lives. Research from other countries has shown that rates of traumatic brain injury (TBI) are often higher among people homeless than in the general population (Oddy et al., 2012). Therefore, sustaining a traumatic brain injury may be a risk factor for homelessness. Unfortunately, the association between TBI and homelessness in Hamilton was not well demonstrated in these results. This is because data about diagnosed TBI was not collected separately from data about prevalence of migraine and headaches, which may or may not be linked to a TBI. Therefore, this study does not add significantly to work determining an association between these factors in New Zealand. This is an area for future research.

Nearly half of all participants (n=48) had been diagnosed with heart and blood circulatory issues. A binomial test compared these results with the portion of homeless participants who had been diagnosed with cardiovascular disease at time of death from the research of Charvin-Fabre et al (2020). This test confirmed that the portion of TPP participants experiencing cardiovascular issues was significantly higher than expected (cardiovascular disease: 0.19, p<.001(1-sided), 95% CI [.379, .582]). The authors Charvin-Fabre et al (2020) concluded that cardiovascular disease was highly associated

with premature death among those homeless in New Zealand. This disease contributed to an increased risk of this cohort dying up to 20 to 30 years younger than the general population. The high prevalence of heart-related diagnosed illness among TPP participants further supports this understanding.

When participants were asked about Fetal Alcohol Syndrome Disorder (FASD), many participants did not know what these words meant. Once explained, many commented their mother had drunk excess alcohol while pregnant with them. However, only those who had an official diagnosis (n=3) were recorded in this survey. Therefore, this figure is likely an under-report. There is no current accurate indication of the number of people with FASD in New Zealand (Alcohol Health Watch New Zealand, 2007; Sutherland, 2020). People with FASD can experience learning disabilities, memory issues, communication difficulties, impulsivity, mood-related problems and are at an increased risk of developing mental health, substance use disorders and spending time in prison. Each of these experiences and issues can also contribute to raising a person's risk of homelessness. More research is therefore needed to determine if there is an association between FASD and an increased risk of single adult homelessness in Hamilton.

4.3.1.1 Section summary – Other contributing factors and trigger events

Overall, participants as adults 18 years and over had a high prevalence of health issues known to be associated with homelessness including mental health issues, problematic substance use, and cardiovascular issues. These issues have been linked to premature mortality among those homeless in New Zealand (Charvin-Fabre et al., 2020). Data could not clearly corroborate the true prevalence of diagnosed TBI among participants. More work is therefore needed to clarify this association, if any, in Hamilton. Additionally, participants were unclear what the words Foetal Alcohol Syndrome meant. More work is therefore also needed to understand the impact FASD has had on single adult homelessness in this context.

4.3.2 Poverty

There is a high correlation between homelessness and poverty in the form of a lack of income (Suzanne Fitzpatrick et al., 2013; Hodgetts & Stolte, 2017; Ravenhill, 2008). This section summarizes data about participant's various income sources, work experience and debt levels.

4.3.2.1 Income

Participants' main forms of income are summarized in Table 17.

Table 17 Participant main income source

Payment source	Frequency
Benefit - Supported Living	44
Benefit – Jobseekers	38
Benefit - Jobseekers with medical deferral	12
Superannuation	3
Student allowance – Studylink	1
Paid work	2
Total	100

Table 17 shows that nearly all of the participants (n=98) received government transfer payments in the form of either a welfare benefit (n=94), support provided to people studying (n=1) or government-funded superannuation paid to people 65 years and over (n=3). Two participants were receiving money from working. Generally, most TPP participants are on benefits, so this outcome was anticipated. Participants were mostly in receipt of a Supported Living benefit or a Job Seekers benefit.

The Supported Living benefit is paid to people 16 years of age or older, with a health condition, an injury, or a disability which preclude people from working (Work and Income, 2020). A doctor must certify that a person is unable to work for more than 2 years or is unable to work for more than 15 hours per week. The base benefit for a single person 25 years old and over (before any other allowances) in 2019 was \$273.30 net (after tax) per week.

The Jobseekers benefit is a conditional benefit paid to people over 18 years of age while they seek work. The base benefit for a single person 18 years old and over (before any other allowances) in 2019 was \$218.00 net per week. People on a Jobseekers benefit who have a health condition, injury, or disability for whom a doctor certifies that they may be able to work within two years, receive Jobseeker benefit with a medical deferral. The deferral date is determined by a doctor. This means that recipients are temporarily deferred from work-seeking obligations. When a medical certificate expires, a beneficiary must arrange (and often pay for) a doctor's appointment to have their health condition reviewed. The doctor may extend the deferral period if the person is still unfit for work.

Over half of the participants (n=56) were therefore certified by a doctor as unwell and unable to work. Supported living benefits were paid to 44 people and 12 people were receiving a Jobseeker benefit with a medical deferral from working. During questionnaire surveying, one participant on a Supported Living benefit commented that she felt people on this benefit type were permanently relegated to living in poverty, because unlike people who may be able to work in the future, they may never be able to raise their income level from \$273.30 per week.

Participants were asked about other forms of income they may have received while homeless. Table 18 summarizes their responses.

Table 18 Other sources of participant income while homeless

Income source	Yes	No	Declined or can't remember
Paid work including cash jobs	37	58	5
Friends or family (loan or gift)	32	68	0
Begging, hustling, busking	28	72	0
Churches or charities	27	73	0
Survival sex	17	83	0
Survival shoplifting	56	44	0
Illegal activity such as drug dealing	19	78	3

To clarify terminology used in table 18, “cash jobs” are cash payments for work undertaken as a worker who has not been declared by a business or organization for taxation purposes. An example is money received from window washing at traffic lights. Income from churches and charities included income offset by the receipt of food parcels. “Survival sex” means engaging in a sexual act in exchange for money, food, drugs or somewhere to stay (Fitzpatrick et al, 2013). Of the 17 respondents who had engaged in survival sex, 7 were male and 10 were female. Similarly, “survival shoplifting” means shoplifting because people need things like food, drugs, alcohol, or money for somewhere to stay (Fitzpatrick et al., 2013). Forty-four who had engaged in survival shoplifting were male, 18 were female. Some participants were reluctant to declare other sources of income for fear of reprisal. Therefore, these data are likely an underreport.

Overall, these results indicate that despite most participants (n=93) receiving regular weekly or fortnightly income from welfare payments (and for those living rough, having no rent or utility payments) participants have resorted to risky behaviours in order to “get by” financially. This activity may be linked to supporting substance and other addictive dependencies, including smoking cigarettes.

4.3.2.2 *Work experience*

Single adult homeless are often assumed to be work-shy (Clapham, 2007). During questionnaire surveying, field notes included comments by many participants expressed wanting to get back to work as a means of improving their financial position. Some viewed typical street-culture practices such as vehicle window washing at traffic lights and begging (or hustling) as legitimate work options. Many added that having had steady work may have allowed them to avoid homelessness. However, there were many barriers to people returning to work, including their health and wellbeing issues and Corrections histories. The following section explores peoples work and study history. Table 19 summarises the main work sectors people were last employed in, or if they had no work history, their most substantial work-related formal qualification. This table also records the prevalence of participants without work experience or formal qualifications. Table 20 explores the permanence and impermanence of people’s main work experience.

Table 19 Participant main work or study experience

Type of work or study	Frequency
Qualifications - NZQA, NCEA, School C	17
Multiple trades or work experience	22
Agriculture, Forestry, Fishing	8
Arts and Music	3
Construction	13
Engineering, Mechanic	4
Factory work	3
Farming	5
Healthcare	4
Hospitality or Tourism	5
Retail	4
Truck driving/Heavy machinery operation	4
No qualifications or work experience	8
Total	100

Most participants (n=75) had worked before and another 17 had some school and other trade and tertiary qualifications (Table 19). Only 8 people reported having no qualifications or work experience at the time of interview. Table 20 shows that a third of participants (n=28) had mostly casual, short-term or seasonal work experience or worked as a caregiver, sometimes caring for family members (n=2). Insecure short-term work adds to people’s economic precarity (Rua et al., 2019).

Over a third of participants (n=41) had mainly experienced working in steady long-term jobs. Having this type of work experience is an advantage in the labour market and is considered human capital (Shinn et al., 2007). The remaining participants (n=25) had never worked. Some of participants described having qualifications and work experience gained solely while in prison. Some commented

that although they had these qualifications, having a criminal record often precluded them from being offered jobs. This was the case even if their criminal record was gained in their youth and early adult lives.

Table 20 Exploring participant work precarity

Best description of majority of lifetime work experience	Prevalence
Casual, short-term, or seasonal work	28
Steady long-term work	41
Caregiver including elderly family and children	2
Unable to work due to sickness or injury	4
Never worked	25

100

Two-thirds of the participants (male n=44, female n=18) concluded that money management (budgeting) was an issue for them. A chi-square test of independence showed that there was no significant association between gender and perceived difficulty with money management ($X^2(2), N = 100, = 3.4, p = .64$).

4.3.2.3 Debt

Many participants financial means were constrained by problem debt. Problem debt has been defined as unmanageable debt leading to financial hardship (Expert Advisory Group on Solutions to Child Poverty, 2012). A high level of debt can limit alternative accommodation options in a housing crisis (Atatoa Carr et al., 2018; Suzanne Fitzpatrick et al., 2013; Ravenhill, 2008).

Debt can take many forms including institutional debt owed to government departments, debt owed to family/friends, or to various lenders who extend consumer credit (e.g., ranging from banks to pawnshops). Debt can be related to a tenancy (past or current) such as for unpaid utilities or rent. Debt can also be owed to a drug dealer.

Participants were asked to identify to whom they owed debt while they were homeless and, where possible, the amount of debt owed to each debtor. Their responses are summarized in table 21.

Four people described having no debt. Combined, the remaining 96 participants owed debt totaling \$1,058,582. For each participant, debt was owed to between one and twelve different debtors. Over half (n=54) owed money to between one and four different debtors. Of the known debt, each person on average owed over \$11,000 each. The highest individual amounts owed were reported to be \$48,000 to Work and Income, \$42,000 to Studylink and \$40,000 to a hire purchase company. The highest number of individual debts (n=83) were recorded to Work and Income, a subsidiary of MSD, with estimated individual debts ranging from between \$80 and \$48,000 owed per person.

Table 21 Debt frequency and total debt owed.

Debt Frequency	
Type of debt	Frequency
Work and Income	84
Court fines and reparations	52
Utility companies	48
Instant Finance/Pawn Shops	39
Studylink- Student Loans	39
Banks – Overdraft fees, credit cards	36
Friends and family	31
Hire purchase companies	27
Landlords	26
Mobile Retailers/ Trucks	23
Kāinga Ora/Housing NZ	8
Gangs	4

Institutional Debt
Predatory Debt

Total Debt by Debtor		n=95
Debtor	Amount	
Work and Income	\$324,678	
Studylink – Student loans	\$290,713	
Hire purchase companies	\$187,259	
Banks – Overdraft fees, credit cards	\$79,627	
Court fines and reparations	\$48,597	
Mobile Retailers/Trucks	\$24,510	
Friends and Family	\$21,530	
Utility companies	\$21,412	
Instant finance/Pawn shops	\$20,875	
Gangs	\$20,733	
Private Landlords	\$11,443	
Kāinga Ora/Housing NZ	\$7,205	
Total known debt	\$1,058,582	
Average debt per person	\$11,143	
Institutional Debt (63%)	\$671,193	

Overall, participants owed the greatest combined amount (\$671,000) to government departments. This estimate is likely an underreport, however. Twenty-four participants (29%) who knew they owed debt to Work and Income did not know the amount they owed this organization. Beneficiaries are encouraged to access such details online. However, many people who are homeless do not have the means to access their details online. Similarly, 15% of people who owed money to Courts (n=52) did not know the amount they owed. Known Court debt ranged from \$50 to \$6,000 per person. Thirteen people out of 39 did not know the amount they owed on their student loans. Where known, student loans ranged from \$700 to \$42,000. Half of those who thought they had a debt owed to Kāinga Ora/Housing New Zealand (n=10) did not know the value of the amount owed. Field notes showed that “not knowing” was sometimes a result of transience, and not having a permanent address to be able to receive mail. Sometime this was a result of not being able to easily access online platforms to retrieve their account details. As estimates of these unknown amounts are not included in data, the overall amount owed to these government departments is therefore underestimated.

For 14 participants, importantly, an unsustainable level of debt had resulted in them being declared bankrupt, or being subject to insolvency, or no-asset procedures. This status must be declared when applying for private rental accommodation. This status also affects people’s credit rating. Therefore, these participants had additional financial stress while seeking accommodation.

4.3.2.4 *Section summary – Poverty*

Overall, constrained income was a common occurrence among participants. Participants had low incomes being mostly in receipt of welfare payments. At the same time, people had high debt levels, with most debt being owed to government departments. Having constrained income likely lowered alternative options in a housing crisis. For some, poor credit ratings, being insolvent or bankrupt added additional financial barriers to being offered a tenancy in a private rental property. Poverty, in the form of constrained income, therefore contributed to raising risk of homelessness in Hamilton.

4.3.3 **Other local contextual contributing factors**

Data were collected to test if unsupported exits from local care and custodial institutions had contributed to homelessness in Hamilton. This included testing if Hamilton's proximity to two large prisons had an impact. Measures also included collecting data to determine if unsupported exits from Hamilton's current and historic acute mental health facilities had contributed, along with determining if unsupported exits from facilities dedicated to supporting people with acute intellectual disabilities had played a part. Participants' involvement in local gangs was also recorded, as it is often assumed people with gang affiliations feature disproportionately among homeless cohort. Results of this testing follows.

4.3.3.1 *Justice system interactions, impact of local prisons*

Time spent in the criminal justice system can have multiple ramifications for housing stability (Fitzpatrick, 2000, Gluckman et al., 2018, Pierse et al, 2019, Ravenhill, 2008). Therefore, data were collected to determine participants' interaction with any prison, as well as specifically lags in local prisons. In previous data it had been determined that nearly half of the participants (n=42) had been to prison for substance-related incidents, from approximately 19 years old. From demographic data, it had also been determined that 3 people had come to Hamilton because they were court ordered to do so or were released from prisons into the region. Additionally, 5 participants had lost their last tenancy because they had gone to prison. Therefore, a high level of interaction between participants and the justice sector has already been established. In this section, participants were asked more specific questions about their justice system interactions. Participant's incarceration prevalence is summarized in table 22.

Table 22 shows that nearly 60% (n=59) of the participants had been to prison for an offense in their lives. More men had been to prison than women. Twenty-one percent of participants had been to prison once. Another 21% had experienced two lags. Most participants who had been to prison had spent lags in multiple prisons throughout New Zealand, and some in Australia, not solely in those

prison’s closest to Hamilton. For example, 69% of those who had been to prison had been to between one and four different prisons each. The remainder (n=31%) had been to between five and eleven different prisons in both New Zealand and Australia.

Table 22 Prevalence of participants incarcerated by gender.

Gender	Been to prison	Have not been to prison	% of participants by gender who had been to prison
Male	45	19	70.3%
Female	14	22	38.9%
Total	59	41	

Nearly all the participants who had been to prison (n=58) were able to recall the total length of time, in years and months, they had spent in prison in their lives. These participants had spent a combined total of 390 years in prison, an average of 6.7 years each. The range of time each person had spent in prison varied from less than one year to 39 years. Sixteen participants (27.6%) had been in prison for a few months up to one year. Over half (58.6%) had been in prison up to five years. Given most people were aged 41 to 60 years old in this cohort, this meant participants have spent between 11% and 16% of their lives in prison. It is likely this level of lifetime incarceration has significantly impacted their housing stability.

Table 23 lists all of the prisons people had attended through their lifetime. Data highlighted orange concerns exclusively female prisons.

Table 23 Prison's attended throughout lifetime.

Name of prison attended	Frequency
Waikeria Prison	38
Spring Hill Corrections Facility	27
Mount Eden Corrections Facility	21
Rangipo/Tongariro Prison	17
Auckland Prison	10
Rimutaka Prison - Wellington	10
Auckland Region Women's' Correction Facility	8
Arohata Women's Prison - Wellington	5
Christchurch Women's Prison	5
Whanganui Prison	≤ 3
Auckland South Correction Facility	≤ 3
Various Australian prisons	4

Table 23 shows that participants had resided in 11 different prisons in New Zealand and others in Australia. The most frequent incarcerations were in local prisons Waikeria Prison and Springhill

Corrections Facility. These data do not sufficiently explore if unsupported exits from these two prisons contributed to local homelessness. More information is needed to explore this suspected contributing factor.

Overall, what is clear is that exposure to the justice sector was common and extensive. Those who had spent time in prison had spent an average of nearly seven years incarcerated over their lifetimes, and mostly in the two prisons within the Waikato Region. Having spent time in prison impacts housing stability and therefore a history of incarceration is a contributing factor raising risk of homelessness in Hamilton.

4.3.3.2 Impact of time in local three acute health facilities

Results of questions exploring participants experience of time spent in local acute health facilities showed that a small number of participants (n=21) had spent time in these facilities. Some (n=14) had spent time in current acute mental health facilities attached to Hamilton's Waikato Hospital, namely Henry Rongamau Bennett Centre. One person had spent time in a facility supporting those with intellectual disabilities. A few (n=6) participants had also spent time in Tokonui Psychiatric Hospital, a large local institutional facility that closed in March 1998. Tokonui was only 38 kilometres from Hamilton. The proximity of this facility to Hamilton has been mooted as one reason for there being a large number of people with mental health issues in Hamilton (Kearns et al., 2012). Overall, more than 20% of participants had spent time in one or these facilities. However, insufficient data were recorded to determine if these exits had contributed directly to any episodes of homelessness.

Further data were collected showing 18 people had lived in supported housing with mental health providers, such as residential care facilities in their adult lives. This group of participants are particularly vulnerable. It is not clear why they would have exited supported care to become homeless. Nor do we know when they were last living in care. Therefore, more information is needed to determine the impact exits from local residential care has had on single adult homelessness in Hamilton.

Overall, these data show that a fifth of participants had spent time in local acute mental health facilities, past and present. Given the high level of diagnosed mental health issues among participants, these results might have been expected to be higher. The data adds to an understanding that mental health issues are a contributing factor raising risk of single adult homelessness in Hamilton. More specific data is needed, however, to determine if unsupported exits from these facilities specifically impacted local homeless prevalence.

4.3.3.3 *Local gang affiliation*

Stereotyping of those homeless in New Zealand often includes assuming many single adult homeless are associated with local gangs. Gangs represented in Hamilton include the Mongrel Mob, Black Power, the Tribal Hucks, the Headhunters and the Killer Beez. Gangs are often associated with illegal drug supply and violent and antisocial behaviors.

There was reticence among some questionnaire respondents to talk about their gang affiliations. Three people declined to answer questions about this topic. Of the data that was collected, nearly a fifth of participants' parents or caregivers (n=19) were gang affiliated and nearly a third of the participants (n=28) considered themselves gang affiliated. During questionnaire surveying, a few participants commented that they were considered affiliated by birth, because birth parents or close family members were affiliated. In field notes, two separate older participants recalled being part of the formation of the gangs in New Zealand, while in state care and in prison in their youth. One participant said the gangs were mostly initiated by disenfranchised adolescent boys who had been Wards of the State and in foster care in the 1980s in New Zealand.

As with data about local prison and acute health facilities, research data is insufficient to determine any relationship between an increased risk of single adult homelessness and participants' association with gangs. More information is needed to determine any such association.

4.3.3.4 *Section summary – Other local contextual contributing factors*

Overall, quantitative data confirmed that participants exposure to the justice sector was common and extensive. Over half of all the participants had spent some prison time in either of the two local prisons. Due to the disruptive nature of incarceration on housing stability, time in prisons is therefore a local contributor to the risk of single adult homelessness. Some participants had accessed local acute mental health and other facilities. However, this prevalence was disproportionately associated with the level of those who were diagnosed with mental health issues, and the prevalence of those who had been suicidal in the past. Approximately one third of participants were connected with local gangs, either by birth or by their own volition. More data are needed to determine if this factor contributed to raising risk of homelessness.

4.3.4 **Social Exclusion**

There is a strong association between social exclusion and homelessness (Clapham, 2007). Demographic data confirmed that, by the very nature of this enquiry, most participants were single, divorced, separated, or widowed. Previous results had also determined that nearly half of the participants had experienced separation from their families in adolescence during out of home

placement. Further, time spent in prison represents time spent excluded from family and society in general. Table 24 represents additional data about loss of connection with family.

Table 24 Experience of breakdown in family relationships.

Experience of loss of connection with family	Prevalence
Did not get along with parents or caregivers before age 16.	70
Death of a long-term partner	21
Lost contact with family	82
Separated or divorced from long-term partner	67

Table 24 shows that more than a fifth of all participants (n=21) had experienced the death of a long-term spouse or partner. It is not clear how many people had experienced both the death of a long-term partner and separation or divorce from the same or another partner, as details about this were not specifically asked. Therefore, the impact of the combined category of losing a long-term partner to death, separation or divorce is not clear. The definition of “long-term” will also likely have varying meanings for people. What can be determined from these findings is that loss of connection with a former partner is a common element in most participants’ lives.

The questionnaire did not specifically ask if people had children and if they had been separated from these family households. Separation from one’s family including one’s own children often involves both emotional and physical upheaval, and has shown to be a trigger event for homelessness (Ravenhill, 2008). Additionally, in field notes, some participants commented that the survey did not ask about the death of other family members, such as children, grand-parents or other significant people in their lives. Participants noted that loss of these loved ones had been equally as traumatic and influential in their lives. This is therefore a further limitation in the questionnaire design.

Table 23 shows that a high proportion of participants (n=70) said they did not get along with their parents or caregivers as children before the age of 16 years. Given the level of adverse childhood experience among participants, this result is understandable. A high proportion of participants (n=82) had also lost contact with family as adults. It is not clear if they are referring to the family they were raised with, their birth family, a family of their own, an extended family, their iwi, or their street family. Whatever the case, participants felt strongly about this emotional detachment, and loss of social connection. Participants were asked the main reason that they had lost contact with their family. The answers to this question are presented in section 5.1.2.

4.3.4.1 *Section summary – Social exclusion*

Overall, various results from sections throughout the questionnaire support demonstrating the impact social disconnection from family has had on raising risk of single adult homelessness. This included separation from caregivers, long-term partners, and other family members. In some instances, this was through death of their loved one. Separation and divorce also contributed. Loss of contact with kinship and familial networks represents a loss of social capital. This factor was also strongly corroborated by qualitative results.

4.3.5 Other issues

4.3.5.1 *Perceived literacy, comprehension, and communication issues*

An additional contributing factor was evident in the data. Participants were asked if they had trouble reading, writing, or understanding documents. They were also asked if they had trouble communicating with others. As there was no scientific testing of their actual literacy, numeracy, or comprehension abilities, nor of their communication skills, at best these questions measure participants' perception about their abilities in these areas.

Over half the participants (n=55) said they had trouble reading, writing, or understanding written documents. Fifty-one of the participants said they had trouble communicating with others. There are many factors that may have caused this number of participants to have perceived literacy and comprehension challenges. It may be reflective of disrupted education in youth. Participants may have sustained cognitive impairments due to prolonged alcohol or drug use. TBI may contribute. Trauma in childhood can result in PTSD, which can cause some to be socially inhibited.

Lacking these abilities may have contribute to participants feeling further excluded from society. For example, most TPP clients are regular recipients of written correspondence from various social support agencies. People are also obliged to attend meetings to gain important information in relation to their ongoing support from these organizations. This might be in connection with being a beneficiary or being on probation, being a patient, or being a witness, victim or accused in a crime.

More work needs to be done to understand the specific reasons for the prevalence of perceived comprehension and communication difficulties among participants. Regardless of the specific reasons for this occurrence, communication issues have likely contributed to participants avoiding asking for help from the many organizations they were connected with when in crisis. Therefore, this barrier to seeking help can be considered a contributing factor exacerbating efforts toward solving a housing crisis.

4.3.5.2 *Homeless veterans of war*

In America, one cohort of those homeless who are disproportionately represented among single adult homeless are veterans of war; people returning from active military duty into homelessness (Montgomery et al., 2013). Montgomery et al (2013) showed that on a single night in January 2012, 13% (62,619) of all of the 634,000 men, women and children identified as homeless in America had registered veteran status.

Military service with any of New Zealand's Defense Force (NZDF), Army, Navy or Airforce, is not compulsory in New Zealand. Candidates must apply, be accepted, and complete basic training. Other than full enrollment, cadetships are offered with each of the three military forces. Some social agencies facilitate military-style training courses. For example, Work and Income provide a free six-week course for people between the ages of 17 and 25, called Limited Service Volunteers (LSV).

In seven years of operation, TPP has recorded one person registering with their service who has returned from active military duty. Questions about military service are not specifically asked at initial assessment. It was therefore important to confirm if this group were represented in Hamilton. Results confirmed that there were no research participants who had returned from active military service to single adult homelessness in Hamilton. Eight people recorded that they had completed cadet training. Two other participants had started training with the army but not completed it.

Discussion around military training and participants' interest in joining the NZDF did however net an important insight. From the beginning of interviewing, when participants were asked if they had ever spent time in the army, navy or air force, every participant immediately offered an opinion about whether military training appealed to them or not as a vocation. Because of the forcefulness and consistency of spontaneous comments about this question, a modification to the questionnaire made for collections of data about every participant's sentiment around this factor. Forty-one participants said they would have either liked to continue with their cadet-style training or to have had the opportunity to join one of the armed forces. Of these, 32 participants were male, and nine were female.

4.3.6 **Trigger events – loss of last tenancy**

Some homeless episodes can be triggered by a loss of accommodation. This section explores the type of housing participants were last domiciled in and reasons that contributed to the loss of their last accommodation. Participants were able to choose multiple reasons that contributed to the loss of their last housing. Responses are summarized in Table 24.

Results showed that most participants (n=46) had last resided in a private rental property, either as a tenant or a boarder. The next largest group (n=25) had been staying with others, but not as either a tenant, nor as a boarder. A further 19 participants had previously lived in social housing with Kāinga Ora as a tenant or boarder. The remainder (n=10) had last resided in other housing, such as housing provided farm workers or housing provided with temporary work. This category also included supported housing, transitional housing, a home owned by a participant and a living arrangement on participant's ancestral land. From previous data about the length of time homeless in their last episode (section 4.1), 80 % of participants had been homeless from between 2 months and 5 years in their last episode. Therefore, it may have been somewhere between a few months and several years since participants last lived in this housing.

Among all housing types, the most common factors contributing to the loss of participants' last housing was a relationship breakdown (n=39), domestic violence and other unsafe circumstances (n=35) and/or problematic alcohol or other drug use (n=34). For those in private rental properties, any combination of these factors may have contributed to participants having problems with the landlord (n=13) or being issued an eviction notice (n=22). The cost of rent in private rental properties had contributed to a loss of tenancy for 12 participants. Loss of work contributed to four participants losing their housing. This may have been due to the monetary impact of a loss of employment on a household. Five participants lost their housing due to going to prison.

Overcrowding had contributed to 11 participants having to move on from their accommodation. Participants had experienced overcrowding in private rental properties (n=5), in social housing (n=4) and in couch surfing situations (n≤3).

A few people had lost their last housing due to methamphetamine contamination (n=5), four of whom were residing in private housing. This occurrence may have coincided with inaccurate contamination testing guidelines, which occurred between July 2013 and May 2018 (Cooke, 2018). At the time, misinterpretation of Ministry of Health guidelines resulted in the eviction of over 800 tenants from Housing New Zealand properties, along with many others from private rental properties. These tenants were later compensated for being wrongfully evicted.

The descriptor "other reasons" in table 25 includes issues related to participant's gang affiliation, the property being condemned, a court-ordered eviction necessitating a move, various work contracts ending prompting a need to move location (fishing, farming and horticultural), properties being sold, and deaths of family members (a child and a partner). It also included the repossession of a property that was owned by one participant.

Table 25 Reasons for leaving last accommodation by housing type

Reasons for loss of last housing	Housing Type			Total number of responses per reason
	Private rental n=46	Kāinga Ora n=19	Couch surfing (n=25) & Other (n=10) n=35	
Relationship breakdown	17	9	13	39
Unsafe/Domestic violence	17	9	9	35
Problematic alcohol or drug use	16	9	9	34
Eviction notice	22	4	5	31
Problem with landlord	13	7	7	27
Asked to leave	9	7	6	22
Cost of rent	12	≤ 3	≤ 3	16
Other reasons	10	0	7	17
24-hour notice to leave	7	≤ 3	4	13
Overcrowded	5	4	≤ 3	11
Problem with benefit	4	≤ 3	≤ 3	7
Cost of utilities	≤ 3	≤ 3	≤ 3	5
Went to prison	≤ 3	≤ 3	≤ 3	5
Methamphetamine contamination	≤ 3	≤ 3	0	4
Asked to leave by caregiver	≤ 3	≤ 3	≤ 3	4
Lost job/no work	0	0	4	4

Once given notice, having time to find another place to live is critical. Over a third of participants (n=36) had received an eviction notice as part of having to leave the last place they lived. The notice periods were 90 days (n=13), 42 days (n=3), 28 days (n=7) and 24-hours (n=13). Shorter term eviction notice periods will have likely raised participants' risk of becoming homeless. Additionally, eviction from various tenancies had contributed to 43 participants having a tenancy tribunal order registered against their name. A tenancy tribunal order is a significant barrier to renting alternative accommodation in the private rental sector.

4.3.6.1 Section summary – Trigger events, loss of tenancy

Overall, table 24 highlights a number of individual and structural factors and trigger events had contributed to raising participants risk of tenancy loss and homelessness. Individual contributing factors include problematic substance use, which may have contributed to relationship breakdowns. Relationship breakdowns and problematic substance use are also likely linked to incidents of domestic violence. Therefore, problematic substance use, domestic violence, relationship breakdowns and eviction are linked in a circuitous manner in contributing to a raised risk of homelessness. Living in overcrowded circumstances, doubled up with others, also contributed as did loss of work and the repossession of a home, albeit to a lesser degree.

Structural factors included issues participants had with their welfare income. Benefit levels were insufficient to pay rents and utility costs. Other issues relating to benefit payments contributed to participants' last eviction, the specifics of which were provided in qualitative results in section 6.3.4. Unemployment contributed to four participants losing their last tenancy. Housing policy including eviction notice periods also contributed. In particular, short eviction notice periods of 28 days and 24 hours will have created pressure raising the risk of homelessness for a fifth of all participants. Misinterpretation of Ministry of Health guidelines surrounding problematic levels of methamphetamine contamination may have also contributed to the loss of some tenancies. Housing pressure such as the cost of private rental property had also contributed.

4.4 Chapter summary – quantitative data and results

Overall, quantitative data supports a pathway's understanding of single adult homelessness in Hamilton, as well as serving to identify other contributing factors which have raised risk of homelessness. Data also provided a measure of the prevalence of experience of adverse childhood events among participants. Additionally, the contribution of local structural and individual factors

identified by TPP staff as potential contributing factors were also explored. Key findings are now presented in relation to the research objectives.

4.4.1 Data supporting a pathway's understanding of single adult homelessness in Hamilton.

Quantitative results revealed a set of commonly occurring adverse life experiences which had happened across participants lives. Inclusion of age of first occurrence, within both ACE and MEH questions about adverse events in early adolescence, allowed for a clearer understanding of the chronology of these common events. Additionally, these data provide evidence about the age at which participants disruptive pathways to homelessness began.

Homelessness started for many in childhood and adolescence. For nearly half of the participants (n=47), homelessness was first experienced as a period of out-of-home placement in state care, with child protection services, or as wards of the state. For others, homelessness was first experienced living doubled up with others (n = 23), often in over-crowded circumstances, because their childhood families had no place of their own to live. Others lived together with their family, in the family vehicle (n=15). Participants' families had also hosted participants as adults when homeless (n=89). Some had worn out their welcome, being asked to leave this accommodation by their hosts.

There was an almost universal experience of abuse, neglect, and vicarious traumatising in childhood. These experiences started from a mean age of six years old but were also experienced by some from an earlier age, two or three years old. ACEs generally occurred in childhood settings where participant's caregivers were stably housed and where one or both caregivers were in paid employment. Having stable housing during childhood and caregiver's who worked did not prove to be protective factors against ACEs, or future homelessness, for participants.

Instability in childhood preceded brief and disrupted schooling experiences, often ending in people being suspended or expelled from High School. By 15 years of age, participants' schooling experience had ended. As an educational outcome, this represents a systems failure, and may have contributed to participants having less vocational options in adulthood and literacy, comprehension, and communication issues as adults.

There was a high prevalence of diagnosed mental health issues and problematic substance use among participants. These issues appeared to develop early, in participants' teenage years, and may be linked to a high level of trauma survived in childhood, and distress caused by being dislocated from family, starting for some with time spent in foster care or as a Ward of the State. These comorbid health issues contributed to 42 participants' early institutionalisation in prison and in acute health facilities. Mental health issues, problematic substance use, and intermittent experience of incarceration, and/or

hospitalisation in mental health facilities and rehabilitation centres, added to an accumulation of risks and challenges experienced across participants' lifespans. This complex accumulation of contributing factors over time raised the risk of episodes of homelessness. An accumulation of contributing factors over time supports a pathways understanding of single adult homelessness in Hamilton.

4.4.2 Other contributing factors

Despite disruptive starts to life, most people had experience of paid employment, having held either steady long-term employment or casual and more short-term employment. Many had work experience and qualifications in multiple trades and vocations. Despite this level of human capital, all except two participants were receiving welfare payments at the time of interviewing. Fifty-six participants were receiving benefit income paid to support those unable to work due to illness, injury, or disability.

Participants' constrained income while living on low levels of welfare income was further exacerbated by high levels of debt. On average participants owed \$11,000 in debt each, most of which was owed to government departments. Government debt has therefore contributed to participants having less available financial resources to find alternative housing when in personal crisis. Having limited income exacerbated some participants' ability to afford rent and utilities and contributed to an eviction from their last accommodation.

Participants' health and wellbeing issues, particularly their mental health and problematic substance use, followed them from early adolescence into adulthood and contributed to raising people's risk of being evicted from their last tenancy. These wellbeing issues may have contributed to a breakdown in participants relationships. A breakdown in relationship was a common factor which contributed to the loss of over a third (n=39) of the participants last accommodation. Lack of social capital is a consistent theme throughout the quantitative data. A high percentage (82%) of participants considered they had lost contact with family, sometimes through separation, divorce, or death of a long-term partner, but also through going to prison.

Additional systems failures contributed to losing housing. Five participants had lost their last tenancy because they had gone to prison. Participants had a high prevalence of interaction with the criminal justice system, which is a barrier to accessing housing and work. Participants also experienced issues with their benefits, which contributed to some being evicted from their last tenancy. Additionally, over half of all participants perceived they had trouble reading, writing and comprehending written documents, as well as communicating with others. These communication barriers likely contributed to participants avoiding asking some organisations they were connected with for help.

4.4.3 Potential points of positive intervention

Quantitative results highlighted several potential early and later-life points of intervention, where effective state intervention may have interrupted pathways to homelessness. There was also evidence that some state intervention had been ineffective at preventing later-life homelessness.

Child protection services were involved in the removal of 47 participants from their childhood family homes and placement in out of home care. This intervention did not however act as a protective factor against future homelessness for these participants. During their school years, participants had also come to the attention of education services, truancy officers and staff dealing with various behavioural issues. These support services had been ineffective at retaining people in the education system beyond 15 years of age.

From as young as 13 years old, a large portion of participants (72%) had come to the attention of Police, detoxing in Police cells. In their early 20's, many (42%) had been to prison for substance related incidents. A third (33%) were selling drugs to support their own drug use from an early age. Twenty percent were injecting illicit substances, from an age of 19 years. Early intervention by the justice system, by Police and Corrections services, was therefore a critical potential point of intervention lost.

Participants had multiple interactions with the health sector from a very early age. ACE data showed over two thirds of participants had sustained physical injuries as children (n=65) from an average age of six years. Over half (n=51) had attempted suicide. Many (n=39) had self-harmed. A third (31%) had been hospitalised for mental health issues by a median age of 21 years and 42% had been hospitalised for substance misuse by a median age of 23 years. Therefore, there were multiple potential points of intervention with medical services, predominantly before participants reached their late 20's. Effective intervention at this point in participant's lives may have helped mitigate the onset of lifelong health and wellbeing issues which contributed to a raised risk of homelessness.

Later in life, participants continued to be involved with multiple social sector and government agencies. Participants were almost universally in receipt of welfare income. Therefore, they likely had a high level of presentation at Welfare Agencies. Over half of the participants (n = 59) had spent multiple lags in prison for nearly seven years of their lives. Many had spent time in rehab, in hospital and other acute medical facilities. Despite a high and sustained level of social service interaction, these relationships had not proven a protective factor against homelessness.

4.4.4 Quantitative results supporting research aims

Overall, quantitative results support the aims of this method and measure. The prevalence of adverse childhood and adolescent experiences among participants was revealed, with age of first occurrence

providing a chronological perspective on the prevalence of these and other adverse life experiences. Additional structural and individual factors were identified. The results have provided data revealing factors supporting the development of a pathway's understanding of single adult homelessness in Hamilton. A series of adverse life events, starting in childhood from a mean age of six years old, and spanning people's adulthood, contributed to raising participants' risk of homelessness. Other key contributing factors, such as wellbeing issues, justice system interaction and constrained incomes further exacerbated participants' circumstances at crisis point.

Quantitative results alone do not however, provide a full picture of all of the contributing factors raising risk of homelessness in Hamilton. For example, there was insufficient data about housing constraints in Hamilton, and about the various issues participants had trying to find alternative housing for themselves. Additionally, the significance of social isolation as a contributing factor was not fully revealed using quantitative methods. Other systems failings revealed in participants level of institutional distrust were not able to be explored in any depth, nor was the precariousness participants felt trying to make financial ends meet on meagre incomes appropriately reflected. Qualitative results to follow allowed for more in-depth exploration of these issues and revealed other important contributing factors. Results further strengthened the development of a pathways understanding of single adult homelessness in this context.

Chapter 5. Qualitative Data from Questionnaire Surveying

This chapter draws on a small amount of narrative data from participants comments collected from 100 quantitative questionnaires carried out with participants. This method sought to contribute towards collection of data to achieve the research objectives, namely:

1. To determine what factors contributed to or raised the risk of single adult homelessness in Hamilton.
2. To determine if a pathway of common occurrences throughout people's lives raised the risk of homelessness, and what age any such pathway might have begun.
3. To consider critical points of intervention, where appropriate intervention may lower the risk of single adults becoming homeless.

Specifically, questions sought to measure:

- How participants defined the word "homeless".
- Reasons why participants had lost contact with family.
- Types of discrimination participants may have experienced.

Thematic analysis of the responses revealed the following constructs and themes identified in the data:

- Lack of access to safe, appropriate, permanent housing.
- Disrupted social networks.
- Discrimination.

These constructs represent contributing factors which have raised the risk of single adult homelessness in Hamilton and will now be discussed.

5.1 Lack of access to safe, appropriate permanent housing

Participants were asked to describe what the word "homeless" meant to them. Data from 100 responses were thematically analyzed. It was expected participants would equate this word with having nowhere permanent to live, or being without shelter, which most did. To follow are three examples:

"On the street, living with someone else, without own home." (QR-013)

"Not having a roof over my head". (QR – 026)

“Don't have own home. Don't live anywhere. No actual address for systems. No fixed abode.”
(QR – 037)

The most frequently used word among this narrative data was “place”, showing that participants craved somewhere to stand still, a place of their own. The word “nowhere” was the second most frequent word used. Again, this speaks to a sense of dislocation. The opposite to this is having somewhere to reside, but not somewhere impermanent, like emergency housing, backpackers, boarding houses, temporary housing, co-living circumstance where boarding house tenancy rules apply or a motel room. The third most frequent word used was “family”. The implication of this theme is discussed in section 5.1.2.

Fourth equal were the words “street” and “without”. Most participants had experienced rough sleeping (n = 94). Therefore, it is understandable that participants identified homelessness as rough sleeping homelessness, being homeless living on the streets, in cars, or in other places not meant for human habitation. Fewer participants identified couching surfing, being doubled up or living in emergency housing with the word homeless, although these situations are included in the national definition of homelessness (Statistics New Zealand, 2014).

The prevalence of the use of the word “without” speaks to deficits participants are feeling. They are not only without shelter, but they are also lacking other critical elements, such as support from family and friends. Participants also used the words isolated, helpless, and hopeless to describe the meaning of the word homeless to them.

As in the example above, some participants (n=6) referred to being of “no fixed abode”. This phrase is not a common every-day turn of phrase in New Zealand. It has connotations of transience, and of impermanence, and is used by government departments such as MSD and in public health sector patient management systems as a descriptor of homelessness.

A sense of dislocation was also evident in some participants’ descriptions:

No permanent residence. Not grounded. Unstable. (Q-R42)

Not knowing where you’re going to sleep the next night. (Q-R27)

Participants also identified that not having a place to live meant that they were unable to tend to other issues. This included their own or other family member’s wellbeing needs.

Without somewhere where you can end your day. Four walls and a roof. Security, safety, stability, not able to focus on other areas such as wellbeing and children (Q-R54)

In this excerpt, the participant not only wanted a place to go to at the end of a day, they also wanted a place to feel safe in, to recuperate in, and a place able to accommodate interaction with family.

Overall, in describing the word homeless, many participants identified not having permanent safe housing as the main descriptor. A lack of space in which to feel safe and where interaction with family is possible was also highlighted as important. Being homeless by participant definition is therefore a lack of access to appropriate, safe housing. Lack of housing is therefore identified as an important contributing factor.

5.2 Disrupted social networks

The significance of the sense of isolation people felt at crisis point, particularly isolation from family, was also made evident in participant's responses to defining the word "homeless". Word frequency analysis showed that the third most commonly used word to describe the word homeless was "family", in this case denoting a lack of connection with family. Many responses included describing having no one to help at crisis point and 13 responses described solely disconnection from family, without any reference to being unsheltered. For some, lack of familial support was the strongest theme in their definition of the word homeless, as in the examples to follow:

"Have nowhere to go, no-one to turn to for accommodation, no friends or relatives" (QR-050)

"Being alone, no family supports, breakdown in family, unsafe..." (QR- 090)

"Living on the street, under a bridge, knowing nobody, a family that doesn't want to know you, wishing you were dead." (QR – 014)

Quantitative data had revealed that 82 people had lost contact with their families. Seventy-eight of these participants offered a reason for this relationship breakdown. Thematic analysis of this narrative data highlighted separation from parents, with the words mother, Mum and parents being most frequently used.

Analysis showed that responses were evenly split between participants needing to distance themselves from family for safety reasons and participants being rejected by family, mostly for safety reasons. To follow are subthemes related to these two main themes:

Reasons for participants needing to distance themselves from family included:

- Family was violent or unwell, including mentally unwell.
- Family were perpetrators of ACEs
- Issues relating to time in foster care
- Issues relating to domestic violence between family members
- Issues related to gang affiliation

Reasons participants had been rejected by family included:

- Participants' problematic substance use
- Participants' criminal histories and ongoing connections
- Issues related to participant's own transience

Below are examples of some of the reasons people gave for being estranged from family:

"Separation of parents, put in foster care, not growing up with or around family" (QR-013).

"The system and social welfare wouldn't allow me to go back to my birth parents until I was 13 years old" (QR-031).

"Didn't want my children involved in abuse family put me through" (QR – 078).

In two of these examples, an experience of an out of home placement in participants' adolescence is implicated in their estrangement from family in adulthood. In the last example, adverse childhood events have led the participant to concluding it is not safe to take their own children home.

Separation from familial and kinship supports is therefore a strong theme in this participant narrative. Both while defining the word homeless and in describing why participants had lost contact with family, a breakdown in family ties meant many lacked this vital support when faced with homelessness. For some, this tie was severed long ago, either as a result of state intervention, or as a result of family violence and abuse suffered in their childhood household.

5.3 Discrimination and racism

Quantitative data showed that 78 participants described having experienced discrimination. Seventy-four of these participants provided narrative to describe their most recent or worst experience of discrimination. Of those offering a description, 22 participants had experienced racial discrimination, particularly against Māori. For six Māori participants, their worst experiences of racial discrimination occurred during their high school years, which for most of the participants was between 10 and 20 years ago. An example is:

“At school, a white boy called me a nigger”. (QR-012)

This quote represents a vivid experience of interpersonal racism, in this participant’s case resulting from a traumatic event which happened 23 years earlier while at school. During participants schooling years, many were also experiencing their first homeless episode in an out-of-home placement with child protection services, as well as coping with mental health issues and substance-based coping strategies as a result of adverse life experiences. Therefore, these experiences of racism may have added further pressure as background issues for people. For example, school-based racism may have contributed to or initiated internalized racism or exacerbated intergenerational historic trauma, which in turn may have manifested or contributed to other complex biopsychosocial issues.

Some had experienced structural racism. The following example involved one participant’s experience in interactions with child protection services:

“Labeled as a Māori by Oranga Tamariki during a case, which put me into a high-risk group”
(QR – 060)

In this example, being Māori meant the participant’s family were subject to additional obligations and scrutiny in the process of considering the return of their children into their care.

One example of racism contributing more directly to homelessness is the excerpt below:

“Judged (negatively) on appearance and skin colour when viewing houses for rent.” (QR - 032)

This Māori participant experienced racism while viewing potential rental properties. In field notes, the participant commented that he had not bothered to submit rental applications for these properties and was deterred from viewing other rental properties. Discrimination therefore contributed to his inability to secure alternative accommodation in time and contributed to a subsequent experience of couch surfing and rough sleeping.

Fourteen participants had experienced discrimination in relation to their physical appearance while homeless, either while rough sleeping or while being involved in other street activities, such as begging. This included discrimination based on appearance when dealing with government departments such as MSD:

“WINZ judgement about appearance” (QR-025)

“Kicked out the door of WINZ and wouldn’t help me, based on being homeless”. (QR – 044)

In the case of the later quote, the participant explained that he had felt department staff had made judgements about him based both on his appearance, as well as his homeless circumstance.

Overall, these data provided evidence of both personally mediated racism and structural racism (C.P. Jones, 2000) contributing to a raised risk of homelessness. A sense that real estate agents and landlords were discriminating in the rental application process had contributed to some Māori participants avoiding applying for rental accommodation. Some participants had also experienced structural racism when dealing with various government departments. Other Māori participants had held on to racist comments and events from their adolescence, mostly occurring while at school. Some participants had also experienced discrimination based on their appearance while homeless. These findings contributed to an understanding that discrimination is an additional factor which has contributed to participants feeling socially excluded in Hamilton.

5.4 Chapter summary – Qualitative data and results from questionnaire surveying

Overall, additional narrative data collected during questionnaire surveying allowed for collection of pivotal information about the contribution social exclusion has made to raising risk of homelessness in Hamilton. Analysis confirmed that most participants defined homelessness as a lack of access to a place to shelter. However, a strong theme emerged about the contribution of a lack of access to familial and kin-ship support when in housing crisis. Some defined homelessness solely in these terms. Reasons given for being separated from this support were equally split between it being unsafe to return to family, due to historic and ongoing familial disruption, and family feeling unsafe about the participants returning home, due to their own often acquired, many times accumulated, disruptive behaviors and characteristics.

Additionally, analysis revealed that discrimination and racism had also played a role in participants feeling socially excluded. Both historic, current, and accumulated discrimination had contributed. These experiences had contributed as a barrier, inhibiting perceived options when applying for housing, and when seeking support from various community groups and government departments.

Chapter 6. Qualitative Data and Results

This chapter draws on analysis of data collected from 11 qualitative semi-structured interviews carried out with participants, as well as participant comments and narrative recorded in field notes made during interviewing. This method sought to collect data to achieve the research objectives, namely:

1. To determine what factors contributed to or raised the risk of single adult homelessness in Hamilton.
2. To determine if a pathway of common occurrences throughout people's lives raised the risk of homelessness, and what age any such pathway might have begun.
3. To consider critical points of intervention, where appropriate intervention may lower the risk of single adults becoming homeless.

Additionally, this method sought to measure:

- If participants considered the adverse events they had experienced in childhood and youth had any link to their experience of homelessness.
- Systemic factors participants considered contributed to homelessness more generally in New Zealand.
- Participants view about the reasons for the over-representation of Māori and Pacific Peoples among those homeless in New Zealand.

Firstly, demographic characteristics of the participants are summarised (section 6.1, table 26). To situate participant responses in context, a vignette of one participant's life experiences is presented in section 6.1.1. The specific themes and subthemes presented in this section are then outlined in table 27 and presented in sections 6.2 and 6.3. Finally, participant views about points of intervention and means of lowering risk of homelessness are detailed in section 6.4.

6.1 Demographic characteristics and representative vignette.

Table 26 is a summary of some sociodemographic characteristics about the participants and their experience interacting with a selection of government and other social sector organizations. This information is drawn from their questionnaire responses.

Table 26 Characteristics and social sector interaction - In-depth interview participants (n=11)

Demographic		Frequency
Gender	Male	5
	Female	6
Age	31-60	9
	61+	2
Primary Ethnicity	NZ European/Pākehā	4
	Māori	7
Housing status at interview	Housed	5
	Homeless	6
ACE score (out of 10)	3	2
	5	4
	7	3
	8	2
Social sector interaction	Been to prison	6
	Out of home placement in childhood or adolescence	7
	Hospitalised for drug-related incidents	7
	Been to substance rehabilitation facility	8
	Income from benefit	11
	Diagnosed with mental health issue	11
	Diagnosed with problematic substance use	11

6.1.1 Representative vignette

The first approach to presenting the qualitative narrative collected is to present one participant's story of his life experience. This is to situate the reader in understanding what life has been like for some of the single adult homeless involved in this research. This story was recorded in field notes and told to the researcher to give context about the participant's answers to his questionnaire responses. It is an example of a life-course with elements shared by many of the participants. The participant wished to be referred to as "T".

"You just got to start with a house". (Field notes – QR-066)

T says his life trajectory changed when The People's Project assisted him to be offered a property to rent three years ago. It's the same place he is living at the time of the research. He admits there have been a few relapses around behaviour and substance use while living there, but he is motivated to change these behaviours for the sake of his children, whom he has recently reunited with.

T has a prominent gang tattoo which he hides with clothing. He has tattooing on the top of his hand as well. He shares that one of his children has recently asked him, "Dad, can you stop going to jail".

He described difficulty in trusting people while living on the street. He described his experience of rough sleeping as dangerous and draining. At the time he was in that situation, he said a group of eight "streeties" developed a syndicate who took shifts, Monday to Friday, looking out for each other and everyone's belongings while people slept. T commented:

"The main killer on the streets is loneliness. It comes over you like a shadow".

He describes his childhood and youth living in newly built social housing in another part of the country. His mother grew lots of fruits trees on this property. She planted one fruit tree for each of her children, including feijoa, peach, and nectarine. They grew corn and lived off this land. His father worked as a farm hand. His mother was the main caregiver. There were nine children in the house. His mother's primary language was Māori. She was often frustrated by having to understand official documents and processes in English.

He describes daily life in the household of his youth as being like the New Zealand movie "Once Were Warriors"⁶. He said it was "spiritual warfare with sexual deviance committed by adults we were supposed to trust". Unprompted, T describes his life trajectory from an abusive childhood, to being expelled at school, to his life in foster care, to life in a gang, to his extensive time in prison. He sees it all as an extension of being bullied throughout his life.

"I was surrounded by bullies at home, so it was no different."

T said homelessness was "a disease that came along later" in his life. He says he was encouraged to drink beer by his uncles from the age of 4 years old. He recalls a time at age 7 where he was caught by his father trying to sniff the petrol in the lawn mower. His father encouraged him to "stop that shit and come inside". Inside, he was welcomed to smoke cannabis with his father's friends and his uncles. He remembers family violence being commonplace and can picture his inebriated father beating up his pregnant mother.

He recalls he didn't use synthetic cannabis until 2013 when he used the then recently legalised drug "Kronic" for the first time. That said, he was no stranger to drug use, having injected methamphetamine from about age 19.

About feeling discriminated against, T says "this is a racist country". When I ask him to describe a recent event when he felt discriminated against, he describes people crossing the road rather than walking near him on the street. I ask him if he thinks that is because of his gang tattoos. He thinks it's because he is Māori.

Talking about the length of time he's spent in jail, he recalls committing crime to get back into jail where he would "recoup, eat well, get fit and healthy". He has his Corrections history RAP (record of arrest and prosecution) sheet at home and although it shows he has been in prison a total of thirty years of time served, he says he has been sentenced to over 70 years in prison. We calculate he has been in eight separate prisons throughout New Zealand. He feels angry about the length of his life spent in prison and describes it as a "waste of time".

He has recently been diagnosed with post-traumatic stress disorder while going through the ACC Sensitive Claims process⁷. He had never been offered counselling before and said it was

⁶ The New Zealand movie "Once Were Warriors", written by Riwi Brown and directed by Lee Tamahori, explores aspects of life within a Māori household living in an impoverished suburb in Auckland, in the 1990's. The movie includes violent scenes involving excess alcohol consumption, domestic violence, rape of a minor, and suicide.

⁷ The ACC Sensitive Claims process is a mechanism for applying for financial support from ACC for treatments relating to a claim of mental or physical injury caused by a criminal act such as injury by sexual violence. Financial support may cover the cost of counselling and other therapies. The process includes an assessment to prove assault causing mental injury.

helpful. He is most proud of being part of a process review panel with ACC and seeing his words quoted in a paper outlining a recommendation for process change. He feels heard.

When I ask him what he would change, if he was Prime Minister, to stop homelessness in New Zealand, he said he wished there were organisation like The People's Project back in his youth, when he first needed help. He added, "People just need to listen". There is a sense that many times he has felt his needs went unheard. He said there was need for Kaupapa Māori services because there were so many Māori shouldering the burden of homelessness in New Zealand.

About his abuse in childhood, he said that "kids needed to be heard". Describing his life in his family home, he said he got "treated like an adult but I was a child" and described his sexual abuse as the "ultimate breach of trust". (Field notes - Q-R66)

6.1.2 Constructs, themes, and subthemes

In initial analysis of narrative data, themes were coded into four main domains relating to adverse childhood experiences, factors contributing to physiological insecurity, or psychological insecurity, and systems failure. Within these domains, 59 nodes were identified under eight main themes. Nodes were collapsed and themes combined to align with research objectives. The main constructs, themes and subthemes identified are outlined in Table 19. These themes and subthemes will be presented in two main sections. Firstly, themes that identify links between early-life experiences and subsequent pathways to homelessness are presented. Secondly, themes that identify additional contributing factors are then presented.

Table 27 Qualitative constructs, themes, and subthemes – Contributing factors

Construct	Themes	Subthemes
When pathways began	Traumatic childhood and youth experiences	Safety and survival Alcohol fuelling domestic violence Out of home placement
Additional contributing factors	Disrupted social networks	
	Existing health issues and substance dependency	
	Lack of access to safe, affordable, appropriate permanent housing	Difficulty accessing housing Affordability Discrimination Adequacy – a home, not a room
	Poverty	Cost of living Debt
	Organisational distrust and poor treatment	Poor treatment results in loss of trust Inadequately supported exit from care and custodial settings
	Community discrimination and racism	

6.2 When pathways began.

Analysis of the qualitative narrative showed that participants linked disruptive events experienced early in their lives, often in childhood, with instability in their adult lives, including instability in housing. This section presents themes relating to participant’s expression of the link between ACEs and their experience of homelessness. A link between excess alcohol consumption by caregivers and disruption in participant’s childhood households is also described.

6.2.1 Traumatic childhood and youth experiences

Participants articulated a link between traumatic experiences during their childhood and adolescence and later-life disruption, including housing insecurity. The long-term and lifelong consequences of these experiences were highlighted.

6.2.1.1 Safety and Survival

Apples talked about the ongoing impact sexual abuse as a child has had on her life:

“Being unsafe as a child...That’s what made everything what I am today. And what the future is for me today...The impact for me was emotional impact, and stability. I don’t know how to

settle down because I've always moved around since I was little...I'm a product of my upbringing." (Apples, in-depth interview)

Apples, who is homeless at the time of interviewing, clearly identifies that the abuse she survived as a child has had an ongoing impact on her ability to achieve a level of stability in her life, including housing stability. She recognises that the emotion attached to these experiences continues to have an impact on her. In Apples' case, housing alone may not solve this pattern of instability, due in part to the coping behaviours she has adopted. These patterns are well ingrained in her life's journey.

Similarly, Piri notes that the physical and emotional abuse he suffered in childhood, and as a Ward of the State, has been part of an ongoing daily struggle for him. These experiences have contributed to life-long instability for him, ultimately resulting in his dislocation from family. This dislocation limits his social support network, and alternative housing options, when facing homelessness.

"As a kid, I was bought up in a situation of survival. I couldn't speak out. I couldn't go anywhere...it was all swept under the carpet...I've dragged everything from the past and pulled it with me wherever I was situated. I used that as my backdoor issue out. Because it never went away...I can say for myself, I've taken all my issues, and I've held onto them. And at a certain time, it'll catch up. And I know it's all over, but it's too late. (Piri, in-depth interview)

At the time of interview, Piri talks about his recent experience being part of a Royal Commission of Inquiry into Abuse in Care⁸, a process he found cathartic. Throughout his transcript, Piri describes his problematic use of alcohol as a coping mechanism, a way of dealing with the ever-present memories of traumatisation experienced in his childhood household and in state care. Piri is very clear that it is excess alcohol consumption that has caused a fracture in the relationship between his own family, a wife, children, and grandchildren. Having limited contact with family and feeling whakamā (shame) around his part in the breakdown in his family, means he had fewer people to fall back on for help in times of crisis, including housing crisis. Piri says he is both a victim of ACEs and a contributor to his own family's disruption. This is therefore an example of the intergenerational effect of ACEs.

6.2.1.2 The role of alcohol fuelling domestic violence.

Alcohol was the most cited substance contributing to household disruption within participants' childhood homeless. Participants said this is because it is legal, relatively low cost and easy to obtain.

⁸ The Royal Commission of Inquiry into Abuse in Care was established in February 2018 to investigate abuse perpetrated against children, youth and vulnerable adults occurring between the years of 1950 – 1999 while in State and faith-based care in New Zealand. Information is being collected from survivors in private sessions. There is a specific focus on Māori, Pacific People, and people with disabilities because of the disproportionate amount of these cohorts in care at that time. The inquiry will run until January 2023 when a report will be made to Government.

Sarah describes the disruptive influence alcohol had in her childhood household, and also the ongoing impact this early-life traumatising has on her life.

“...there was violence in the family when Mum and Dad were drinking...my father was physically abusive to my mother...she’d go black and blue ...I built up a wall where I didn’t want anyone to come so close to me...And it was hard to actually let walls down, because of that. And lately, since I was homeless, just looking back at things, I reckon if that didn’t happen, I wouldn’t have been so very, very self-conscious. Didn’t really want to trust anyone. Didn’t know how to really. At the end of the day, it’s me that’s got to live with what had happened, and I still do”. (Sarah, in-depth interview).

Sarah has experienced both witnessed inter-partner violence between her parents as a child and physical and sexual abuse herself later in life. Included in the list of people Sarah feels self-conscious about approaching for help are organisations that she needs to interact with for her benefit income, her housing, her physical safety, and her health and wellbeing.

Mike is homeless at the time of interviewing. Like Sarah, he talks about violence between his mother and his father in his childhood home, and the contribution excess alcohol made to this disruption. Mike has survived a high level of ACEs in this setting. He is angry about the amount of violence in his early life. ACEs led to his first experience of homelessness. Talking about these experiences as linked to disruption throughout his life, Mike comments:

“It wasn’t really a safe home. What so they say, if you get raped every day you can’t see any way out? ‘Cause it’s just going to make you pack up and then (hits his fist into his palm). And you wanna get away from everybody that you can. Cause everybody hurts you. ...Dad was working...He was beating Mum up just about every day I think...Too much alcohol.” (Mike, in-depth interview)

Throughout his transcript, Mike readily identifies the impact ACEs have had throughout his life. He has received no formal support around these experiences and has told few people about it. He sees a clear link between these traumatic events and his downward spiral into persistent episodes of homelessness.

A recurring theme in the data is a high level of violence in the households of participants childhood often exacerbated by excess alcohol consumption. The movie “Once Were Warriors”, mentioned in the opening vignette, is also mentioned by several of both the in-depth interview participants and the questionnaire participants. Participants refer to this movie as describing what life was like for them while growing up, identifying with the violence and dysfunction portrayed in this movie, which was

often accompanied by excessive alcohol consumption. For example, this participant references this movie when described what daily life was like growing up in the house of his grandmother:

“Nan’s house was like ‘Once Were Warriors’”. (Q-R058)

6.2.1.3 *Out of home placement*

For seven of the participants, along with being survivors of ACEs, further childhood and adolescent instability ensued due to being separated from family in an out-of-home placement. This mostly involved child protection services and regular and significant housing insecurity. Vee talks about her experiences as a Ward of the State:

“I was Ward of the State. I did nothing wrong but survive of being mistreated by my mother...but I was the one punished...I was the one put in a cell...and nobody explained anything to me. And I was shoved and moved and moved...from foster home to family home...physically abused...you had no counselling...and if you complained, they just moved you.” (Vee, in-depth interview).

At the time of interviewing, Vee is in emergency housing. She is in the process of undergoing a sensitive claim through the Accident Compensation Corporation (ACC) Sensitive Claims Process for the abuse she survived in childhood and as a Ward of the State. ACC has given her a large folder of official documents about her time in state care, however, much of the documentation is redacted. Vee describes the sense that she has been multiply victimised, by her family, and then through inappropriate support by successive social services throughout her life. First, she is a victim of ACEs in her childhood family homes, then survives ACEs while in the care of child protection services, and again in adult life, she is victimised by being turned away from help by Work and Income when she finds herself with nowhere to live. She describes this as “double jeopardy”, a punishment meted out twice for the same offence. It is a sentiment shared by many participants who are ACE survivors.

Similarly, Ben talks about the disruption he experienced in the child-protection system, which he says was court ordered through the justice system. This starts with a crime he is convicted of at age 13 years.

“I still remember the first time I got busted, done a crime. And all they done is sent me to a foster home. So, they put me in with people that were doing the same as what I was doing and cause of the age I was, like about 13 or 14. So, that was the age I was interested in learning. But that’s when I ended up going to live with my Dad. I hadn’t really had much to do with him up until then. And then I was sort of stuck with him.” (Ben, in-depth interview)

Ben refers to this time in his life as very disruptive. He was negatively influenced by the other children he was placed with in foster care before going to his fathers to live. Ben indicated that his time with his father was not a positive experience. Ben sees this point in his life as a critical point where a more positive experience such as being able to stay in school may have influenced his life's trajectory. He reflects that he lacked a positive male role model when growing up.

Apples describes her experiences while in foster care:

"I was in the orphanage home at (age) 10...They knew what was happening. There was a girl in the foster home with me and I told her what was going on and she said, that was wrong. You need to get out of here. So, we ran away that night...Because what happened to me when I was young, the only place that was safe for me was on the street, because that's where I first went to... (Apples, in-depth interview)

Apples' early life disruption began with ACEs as a child in her childhood household and then physical abuse while in foster care. She has spent long periods of time on the streets, where she says she feels safe. Her time in a gang was also disruptive. Despite her adverse experiences in foster care, Apples expresses a sense of abandonment by child protection services at the point that she aged out of care. She comments that people need ongoing state care and support beyond the point of leaving foster care, and probably throughout people's lives.

6.2.1.4 Section summary – traumatic childhood and youth experiences

Participants clearly linked the disruptive events survived in childhood and adolescence with lifelong instability, including housing instability as adults. All participants had survived a high level of abuse in childhood. Additionally, some participants had suffered further abuse and traumatisation while in the care of child protection services. Participants reported a high prevalence of domestic violence between caregivers often resulting in vicarious traumatisation. Inter-partner violence between caregivers and household members was often exacerbated by excess alcohol consumption.

6.3 Additional contributing factors.

Other themes were identified as contributing factors that raised participants risk of homelessness in Hamilton. These factors added complexity, or reduced access to resources at crisis point. A lack of access to housing was the main presenting issue when participants sought help from a homeless service. Often, participants sought this support because they lacked other social support when in personal crisis. Additionally, some were whakamā, or too ashamed to ask family for help. Further, participants were mostly unwell, and lacking adequate financial resource to have many alternative options. To add to this accumulation of factors, participants had received inadequate support from

the multiple organisations they were connected with. Many had been turned away when asking these organisations for help. There was evidence of institutional and personally mitigated racism (C. P. Jones, 2000). These themes are now discussed in more detail.

6.3.1 Disrupted social networks

Participants often described being socially distanced from family and other kinship supports. This contributed to many participants having little positive familial support at the point of facing homelessness. Linking in with the findings from narrative collected in quantitative surveying (section 5.1.2), for some participants this was because it was unsafe to associate with family. For others, family had disassociated themselves from participants, often due to safety concerns. Having no one to help at crisis point meant some faced homelessness alone. This was one of the main reasons' participants sought the help of a homeless service.

Piri talked about the impact of a relationship breakdown with his wife as contributing to his trajectory into homelessness:

"I think that's where it all stemmed from, a breakdown in marriage of 25 years. I took that very hard." (Piri, in-depth interview)

Piri sought work in another country to boost the family's finances. While away, circumstances led to a rekindled addiction to alcohol which contributed to a breakdown in his marriage on his return to New Zealand. Piri describes the isolation he feels at being dislocated from his tight-knit family. He is too whakamā (embarrassed) to ask them for help at crisis point.

Similarly, David blames himself for his separation from his family:

"It was me that tore our family apart. It was my habit that wrecked it." (David, in-depth interview)

David's problematic substance use contributed to a fractured relationship with his large family including a wife, several adult children, and grandchildren. He walked away from a home he had bought off Housing New Zealand Corp early in a long working career. On separating, he signed ownership of the house over to his wife. He has sparse ongoing contact with his family, only being contacted to attend some family tangi (funeral). This separation triggered many years of transience and single adult homelessness for David in central Auckland, as well as in Hamilton. He did not feel he could call on their support when faced with nowhere to live.

Some of the participants do have the support of local family, but do not wish to burden them further by asking for support with accommodation. There is a sense that family are struggling with their own

issues, including financial constraints and wellbeing issues. Brosh described this feeling in the quote below:

“I don’t want to be a burden to nobody. I know they’ve got their own lives and families. But I do see them out here. Any they invite me over. But I never go. I know it’s rough for them too, with all their kids.” (Brosh, in-depth interview)

For other participants, being around family including former spouse can be risky. Bel describes the vicious cycle of co-dependence some who experience domestic violence become trapped in:

“But I ran back to (husband’s name) because it’s a cycle...But we broke the cycle. He hasn’t hit me in years”. (Bel, in-depth interview)

Bel and her husband have experienced several episodes of rough sleeping in Hamilton. A methamphetamine addiction contributed to the couple losing their social housing and being separated from their three children. Bel concludes that estrangement from her own birth family and ensuing disruption in her education contributed to her life trajectory.

“My mother...disowning me and kicking me out of Australia and moving me back to New Zealand to live with my sister (contributed). Things would have been better if I’d finished school. ‘Cause I only got to not even 4th form.” (Bel, in-depth interviews)

Brosh describes the actions of a family member who’s problematic and risky behaviour has contributed to her eviction from two social housing properties:

“Being around someone who’s been in and out of jail a lot doesn’t help at all with our family...taking it out on family...I was kind of fearful that he would come in absolutely intoxicated and bang down the door, until I opened it.” (Brosh, in-depth interview)

At the time of interviewing, Corrections have recently approached her to ask if she is willing to have this relative electronically bailed to her address. She declines the request, although she feels torn arriving at this decision.

Vee describes a sense of utter despair having no one to support her when in crisis. She is estranged from her birth family. In this quote, Vee is talking about a time when she has aged out of out of home placement at age 18 years. She is placed in her final temporary accommodation with this service, which is a boarding house:

“I was at a boarding house and that was it. I actually had no one to turn to...And that’s when I first tried to kill myself.” (Vee, in-depth interviews)

6.3.1.1 Section summary – disrupted social networks

Overall, participants were predominately disconnected from their families, either because it was unsafe for them to associate with them, or because family did not encourage this association, often due to safety concerns. Additionally, some felt ashamed to ask for help, particularly if the participants themselves had contributed to family disruption in the past or if asking for help would contribute to existing burdens their family were facing. For some, disconnection from family contributed to a sense of deep despair.

6.3.2 Existing health issues and substance dependency

All eleven in-depth interview participants were either currently battling problematic substance use or had experienced this issue in their recent past. Additionally, all were either suffering from or had suffered with mental health issues throughout their lives. These co-morbid health issues were often discussed concurrently by participants. Therefore, themes around these two health issues will be presented together.

Participants identified that problematic substance use was a factor contributing to various episodes of homelessness people had experienced. Its use was often framed as a coping mechanism. This often involved coping with an existing mental health issue, such as depression and anxiety, and/or coping with the lasting impact of historic traumatic events, that were exacerbated by situational pressures.

Problematic substance use was implicated in incidents of domestic violence experienced in people's former adult relationships, including their marriages or de facto relationships, in loss of contact with childhood family, in the loss of their last tenancy, the breakdown of people's later-life family units, and incidents of being excluded from accommodation options, and work. Alcohol was the most cited substance implicated, due to it being legal, relatively inexpensive, and accessible. In the following excerpts, participants talked about the long-running (sometimes intergenerational) impact of problematic substance use in their lives, often framed as a coping mechanism when suffering with mental health issues.

Craig comments about his addiction to alcohol, his mental health and intellectual disability issues and how these various health issues contributed to an episode of rough sleeping for him.

“Just upbringing has contributed...just mental and emotional abuse, along with physical...just low self-esteem. Battling with addictions, with alcohol. I’ve kind of grown up with it all my life, and my father too, with alcoholism. It’s kind of like part of the journey through life...that’s about numbing the pain, a coping mechanism...Some of the situations that we’ve been through moulds us into who we are as adults. Whether it’s being abused by family...and huge trauma,

losing parents to divorce...At one stage, I was staying at the men's night shelter...and they kicked me out because I was battling with my addictions, and they had no tolerance or understanding with that" (Craig, in-depth interviews)

Craig identified that his addiction to alcohol has its origins in his childhood. Alcoholism has contributed to disruption in Craig's relationship with his father and his wider family. This quote therefore supports the theme of the contribution of disrupted social networks to his pathway to single adult homelessness. Craig reveals that his father has very recently apologised for his contribution to Craig's early life disruption. Craig's mental health and addiction issues have led to stigmatisation and a period of rough sleeping when he was evicted from the men's night shelter for being inebriated.

Ben recognises that his problematic use of both drugs and alcohol have been indirect contributors to multiple episodes of conviction and imprisonment throughout his life. Time spent in prison often impacted his housing security.

"If I look at my whole history of offending, there is not one charge that I can say that I wasn't either stoned or straight. Every single charge, I was drunk...I used alcohol as a coping mechanism." (Ben, in depth interview).

For Ben, problematic substance use contributed to tenancy issues for him, resulting in the loss of two tenancies in six years. Between tenancies, Ben resorted to rough sleeping or staying at the men's night shelter. He links substance use with his history of offending and offending with episodes of homelessness. Substance use is a coping strategy for him.

Brosh is intermittently rough sleeping and couch surfing at the time of interviewing. She talks about her use of drugs, mostly synthetic cannabis, as a means of helping her manage her depression while homeless.

"Myself, I've turned to the drugs. I've been so depressed. Just trying to get out of that hole...(it's) something to turn to" (Brosh, in-depth interview).

Brosh is diagnosed with depression. She relates her depression to both feeling trapped in a state of episodic homelessness, feeling reluctant to ask family for support who are themselves in a precarious circumstance and feeling isolated from family when grieving for a loved one who has passed away. These factors appear intertwined in contributing to Brosh resorting to drug use as a coping mechanism.

Brosh talks about the anguish she feels at having lost two public housing tenancies. In both cases, she let a close relative stay with her, who caused damage to the dwelling. Consequently, she was asked to

relinquish these properties by the landlord. When asked why she let the person back into her house a second time, she explains that they are family who have been rejected by everyone else. She can relate to this situation and feels compelled to help.

Problematic substance use sometimes contributed more indirectly to episodes of homelessness for some. In the two examples to follow, participants identified problematic substance use as contributing to a relationship breakdown, which was identified as a trigger event for various periods of homelessness.

“There’s a lot of druggies out there. There’s a lot of people who’ve got an addiction out there. And that’s where half their money’s going to. That’s what’s breaking families up... It was me that tore our family apart. It was my habit that wrecked it... that’s why people come onto the street, so they can have heaps of money to buy drugs” (David, in-depth interview).

“I think that’s where it all stems from, a breakdown in marriage (of) 25 years. I fell off the wagon...the “boogies” were back with me... I took it hard... Alcohol has been part of my life from an early age, from an infant. I was bought up around it. My grandparents were boozers. My uncles and aunties were boozers”. (Piri, in-depth interview).

For Piri, the “boogies” is an addiction to alcohol. Both David and Piri have experienced multiple episodes of homelessness throughout their lives. For both men, problematic substance use contributed to a breakdown in relationship with their wives, and children. When in housing crisis later in life, being distanced from their families contributed to having no option of temporarily accommodation with family. Piri notes that excess alcohol consumption has had a detrimental effect on his family’s lives for at least two generations.

Problematic substance use was often a coping mechanism for various pre-existing mental health issues participants had. These existing mental health issues were often exacerbated by the pressure of impending homelessness. Various substances were used as support in a crisis. Themes identified showed that this pressure led to a sense of hopelessness, overwhelm and suicidal ideation for some.

In the preceding section (6.3.1), a quote from Vee talks about contemplating suicide after being placed in temporary lodging in a boarding house, her final placement as a Ward of the State. Vee felt abandoned by child protection services. She was 18 years old when she was first hospitalised for this attempt on her life. She is still receiving support for her mental health issues.

Similarly, Sarah describes a decline in her mental health when at crisis point.

“It even gets to you, when you get homeless, well when I was homeless, yes, I admit I thought the easy way to do it was to just end my life. That’s the easy way out, because I had no help.”
(Sarah, in-depth interview)

Sarah has been diagnosed and treated for mental health issues since in her 30s. She is in her 40s at the time of interviewing. She moved to Hamilton to look after an unwell relative. Once in Hamilton, circumstances changed and she found herself with no reserve of money to have options about her next move, and no local support to help her out of her situation. She and her two adult children slept under a local bridge. In cold weather, she slept in various hospital waiting lounges. In Sarah’s account, her diagnosed depression worsened when faced with homelessness, escalating to suicidal ideation.

These two quotes highlight that the pressure of homelessness can significantly exacerbate people’s existing mental health issues.

6.3.2.1 Section summary – existing health issues and substance dependency

Mental health issues and problematic substance use were perceived by participants as contributors to a raised risk of homelessness in Hamilton. These issues had been persistent and often lifelong issues. Problematic substance use started as a coping mechanism for many, often in people’s youth and early adolescence. This issue often fuelled early involvement in the justice system and was implicated in later-life relationship breakdowns and loss of tenancies. Sometimes, these issues were implicated in immediate episodes of homelessness. Participants who described themselves as addicts were quick to point out that for them, substance use is a form of anesthetizing against past and/or present traumatic events and circumstances. Problematic substance use is therefore not the cause of participants’ homeless episodes.

All in-depth interview participants had either ongoing or past mental health issues. Participants’ mental health issues were exacerbated by the pressure of impending homelessness. This led to a sense of hopelessness and suicidal ideation for some. Participants often discussed the contribution of existing mental health issues in tandem with problematic substance use. These comorbid issues were linked together in discussions about the contribution these elements had made to episodes of homelessness.

6.3.3 Lack of access to safe, affordable, appropriate permanent housing

Unsurprisingly, all 11 in-depth-interview participants described their main reason for registering for help with TPP as seeking assistance to access suitable alternative accommodation in a time of housing crisis. The accommodation sought was appropriate, safe, and affordable permanent housing. Participants wanted a home, not a room, and talked about the difference between a house and a

home, between permanent accommodation and temporary accommodation. What housing was available for rent was often over-subscribed and too costly to afford on while a benefit. These various themes are now discussed.

6.3.3.1 *Difficulty accessing housing.*

Participants found it difficult to secure affordable single-person housing in Hamilton, whether public housing or private rental properties. Private landlords of affordable rental properties had an abundance of potential tenants to choose from. Vee comments about her frustration at this situation.

“...trying to find another rental where you’ve got 10 to 15 people also looking at the same rental...The market is a property manager’s dream at the moment...they’re picking and choosing.” (Vee, in-depth interview)

As has been described in section 5.1.3, “picking and choosing” among landlords and rental companies extended to some population groups being excluded from being offered tenancies.

Even when participants were waiting to access public housing, the wait was long.

“Even with housing, it took us two years living out of a motel, being homeless and couch surfing...with a young baby”. (Craig, in-depth interview)

While waiting for a public housing offer and placement, Craig, his wife, and their young son lived in temporary accommodation in emergency housing in a motel room provided through Work and Income. They paid 25% of their combined net benefits (before deductions) toward this accommodation. Their child started schooling in the school closest to this accommodation and was then moved to another school once the family accepted public housing in another area of town.

6.3.3.2 *Affordability*

What housing was available was unaffordable in relation to people’s income level while on a benefit. David and Rangitahi comment about the cost of housing and a lack of supply of housing in Hamilton:

“That’s why people live on the street, because being realistic, you’re paying \$180...or you’re paying \$300 for a house, a home. It’s not compatible with your benefit” (Rangitahi, in-depth interview).

“...people just want to get their own home...and put the rent down so that they can afford it...cause they’re paying too much rent and they’re not getting much on the DOLE (benefit)”. (David, in-depth interview)

Affordability and a lack of supply of housing contributed to Bel and her husband making the decision to sleep rough.

“We have no choice because we have nowhere to go...the cost of housing, there is no housing” (Bel, in-depth interview).

Part of the reason Bel and her husband are excluded from being offered rental tenancies is due to their level of indebtedness. Have deductions coming directly out of their benefits before they receive the remainder means they have even less money to be able to afford what housing is available.

“We can’t get another home because of our credit rating.” (Bel, in-depth interview)

Along with debt contributing as a barrier to being able to afford to pay rent, having a poor credit rating is a significant barrier to being considered for a private rental tenancy. This is particularly the case in times of high rental occupancy and high rental demand. Bel and her husband were relegated to accepting accommodation living in a cramped co-living style studio apartment in a complex in the centre of the town. They were unable to have any of their children to visit from foster care. This is partly because there are complexities surrounding bail conditions for other tenants in this complex which makes it difficult for children to visit safely. Even if conditions did allow, there is simply not enough physical room in their studio apartment to accommodate any visitors.

6.3.3.3 *Discrimination*

Participants had experienced many barriers when trying to access what affordable housing was available in the private rental market. Rental applications were routinely declined. Although real estate agents are not obliged to divulge reasons an application is declined, many participants felt they had been declined due to having a criminal record (which is required to be disclosed if asked), being a beneficiary, having a tenancy tribunal order recorded against their name in a public register, having debt and subsequent poor credit ratings, and being a person of colour. Apples discusses the discrimination she experienced while applying for rental properties:

“You got no work? You’re unemployed? No, you’re not going to get a place...they want people who are working...I can’t get a job because of my criminal record...Because if you’ve been locked up, you can’t get a job...You got no work, you’re not going to get a place.” (Apples, in-depth interview)

6.3.3.4 Adequacy - A home, not a room

Some participants talked about the inadequacy of co-living style accommodation. In the following quote, Apples talked about the difficulty she experienced living in studio-style apartments with communal facilities:

“I really want a home. I don’t want a little room. That’s not a home. But I know when I get a proper place, it’s mine...I’ll have my own kitchen and stuff. It’s just all these little things that people will take for granted...Cause you’re all around people. And you’re in people’s business...I was frustrated. And I’m looking forward to my daughter coming to stay with me.” (Apples, in-depth interview)

For Apples, the proximity to others with complex issues of their own proved too intense an environment for her. She relinquished the tenancy that required this co-living and returned to rough sleeping and couch surfing. The design of the property, and a challenging dynamic among tenants, some with complex issues and circumstances of their own, meant Apples did not feel comfortable spending time cooking in the shared kitchen, a pastime she used to enjoy. Nor did she feel she could have her daughter living with her, or any other family visiting without infringing the strict tenancy rules, and potentially putting her tenancy at risk.

6.3.3.5 Section summary – lack of access to safe, affordable, appropriate housing

Participants identified that they lacked access to a place to call home, somewhere safe, affordable while on a benefit, and with adequate space to connect with family. There did not appear to be an adequate supply of this type of single person housing in Hamilton. What housing was affordable, accessible, and available, was still overpriced while on a benefit, and oversubscribed. Participants had resorted to inadequate, unsafe, mostly temporary accommodation. Sometimes, rough sleeping seemed liked a better alternative.

6.3.4 Poverty

Lacking access to adequate income contributed to participants having fewer housing choices in a personal crisis. Participants had low incomes and high debt. All qualitative participants were receiving welfare payments, or superannuation (public pension). Participants felt the level of their benefit income had not kept pace with the cost of living and participants often found they had insufficient disposable income to afford available accommodation, as well as other living costs. In the following extracts, participants express their sense of income precarity, and the emotional pressure this contributed to their lives.

6.3.4.1 Cost of Living.

Ben talks about the weekly struggle he has as a beneficiary making financial ends meet:

“Rent’s gone up, the price of food...just the basics. Everyday things has gone up. The average income hasn’t...especially when the person is on a benefit. They’re struggling every week regardless...just a little minute hike in the price of something can throw everything out...” (Ben, in depth interview).

Ben’s comments echoed that of many participants who noted that there is an increasing disparity in the ratio between people’s benefit income and a rising cost of living. This resulted in a decline in the potential for having a financial reserve to fall back on when in personal crisis. Ben also notes the precarity he feels in this situation, adding that just a small increase in the cost of everyday items can have a destabilising effect for him. Ben frequents community meals which are free, or cost \$1, to try to make his weekly income stretch. He also sees this as an opportunity to socialise.

Brosh also reflected that the cost of housing and the cost of food are too high in Hamilton:

“I reckon because the houses are too pricey...so, can’t afford it. Food cost has skyrocketed as well” (Brosh, in-depth interviews)

When Apples is asked how much money would be enough to live on per week, she replies:

“Enough for food. Because when you’re in a home...like when I was in a place (it cost) \$260 (per week). I only had \$30 left. See, so that was a struggle” (Apples, in-depth interview).

Apples’ comment implies that she doesn’t always have enough money for food. Her low level of weekly income is partly because Apple has deductions made for various debt repayments. As per Ben’s comment, Apples finds the precarity of this meagre level of disposable income (\$30 per week) stressful.

Sarah identified income precarity as the most significant contributing factor influencing her most recent episode of homelessness.

“One of the main reasons would be lack of income...before I came here, into this house, I was living...on, after I’d get me a wee bit of groceries...probably left with about \$30-\$40 (a week). When I moved into this house, with the rent, gas, power, and my AP’s (automatic payments), I was left with \$5 a week to live on for quite a long time...then they’ll (WINZ) say “budgeting”. And then they’ll say, “This woman can’t really live on \$5”. And at the end of it...to me it’s WINZ that declines me. I’m like, well, how would you like to live off \$5 a week...I try and make sure

my rent, power, and gas is paid. I'm not really fussed on food. I'd rather be homed..." (Sarah, in-depth interviews)

Now housed in public housing, Sarah's weekly disposable income is still low because she has various weekly deductions from her benefit and bank account. Work and Income make multiple deductions from her weekly benefit to cover debt repayment to this department, as well as various other government and non-government organisations. These include deductions to repay fines, and repayments for advances from Work and Income. Additionally, she has multiple other deductions from her bank account for other repayments, including various mobile retail purchases. She also pays bank fees and overdraft fees. Sometimes, Sarah goes without food rather than risk having insufficient income to cover rent. She does not want to lose her housing.

6.3.4.2 Debt

Some participants reference debt directly as a contributor to their income precarity. David is one participant who talked openly about the contribution debt makes to both raising people's risk of homelessness and also keeping people trapped in homelessness. He describes the level and types of debt many rough sleepers he knows have, and the pressure indebtedness creates.

"Half these fellas on the street, they all got debt...getting in debt is worse than smoking drugs...People (not) paying back debt is getting them into trouble...And I know where their debts are too. Those bloomin' trucks...cause the truck comes to them and its (the purchase) got a couple of zeros on it...they get rubbish off the trucks. Phones and things. Things they don't need" (David, in-depth interview)

Like Ben, David identifies the pressure income precarity places people under. David comments that the pressure of being in debt is worse than the pressure of drug taking. Elsewhere in his transcript, he talks about needing to "hustle" or beg for money to make ends meet due to the ongoing pressure of his indebtedness. He considers this his daily job.

In terms of other forms of debt, David also talks about a high level of predatory lending single adult homeless having amassed with mobile retail vendors, for day-to-day items such as phones. He also comments about the frustration he feels about institutional debt being recovered directly from people's benefit income before they receive the remainder each week. David notes the futility in the cyclic nature of the flow of benefit income to a beneficiary from one government department (Work and Income) only to be subject to often court-ordered deductions made to pay another government department (e.g., Work and Income for advances, Corrections for fines or reparations, or Inland Revenue for Child Support).

“But all this (benefit) money they get anyway, they got to pay it all back cause they got to pay WINZ ...so the government is just giving people money to pay the government back. It’s a waste of time.” (David, in-depth interview).

These deductions are made before a beneficiary receives the remainder as a weekly or fortnightly payment⁹.

Debt also contributed directly to Vee’s inability to find alternative accommodation in time before the end of a tenancy.

“So, I had signed the contract with Vodafone, not realising when I signed up for the (technology) rental it was supposed to be long term...I signed up a contract to get a better deal... I asked Vodafone if they could waive the contract and the \$200 early exit fee, and they wouldn’t. So, now my credit is affected, by this one Vodafone bill...I tried to pay it...you know, to try and drip feed it and it’s gone back up to \$190, because it’s gone to debt recovery. They’ve put their fee on it...I’ve been with Vodafone, you know, I’ve been a loyal customer...11 years...So, that put me in debt. Bad credit”.

Vee explained that at the time of this incident, she was in fulltime, long-term employment and was settled into a long-term tenancy in rental property in another city. The rental property was sold, and Vee was given a 42-day notice to exit. Inflexibility on the part of a utility supplier resulted in a debt she could not afford and a blow to her credit rating. Having a poor credit rating subsequently limited her ability to rent alternative accommodation. Additionally, the rental environment at the time was such that landlords had multiple rental applications to choose from.

At the same time, Vee had an ill family member. This contributed additional emotional pressure to her circumstances. As with all the in-depth interview participants, Vee had survived a high level of trauma in her childhood and additionally had also experienced an out-of-home placement in her youth. Consequently, her relationship with her family was strained. Vee’s mental health suffered under the strain of not being able to find alternative accommodation in time, and she lost her job. She approached Work and Income for help with emergency housing and was turned down because she did not have any children. She was told families were a priority when seeking emergency housing. She

⁹ Institutional debt includes amounts that have been loaned in advance by Work and Income for people to pay for items such as rental bonds (normally four-weeks rent), rent-in-advance (often another two weeks rent), the purchase of whiteware, and payment for emergency dentistry. An unsecured loan is advanced by Work and Income. Amounts can be advanced for up to six times the amount of a person’s main benefit. It is advanced for up to a two-year period and must be paid back in incremental weekly amounts deducted from a benefit before a person is paid either weekly or fortnightly (Community Law New Zealand., 2020). A debt is established against the beneficiary’s name. Institutional debt also includes court fines, justice systems reparations, child support payments and student loans.

spent several nights sleeping in a park. Vee's story is an example of how one relatively small additional financial burden, overlaid atop a pathway of complex contributing factors, can act as the final pain point for participants, where an episode of homelessness may seem like the only alternative.

6.3.4.3 Section summary - poverty

Participants had highly constrained incomes and commented that their level of welfare income was insufficient to provide them with many options in a crisis. Participants felt the cost of living, including the cost of rents, food and utilities had increased disproportionately in relation to their welfare incomes. This created precarity around their financial circumstances. One small increase in day to day living expenses caused financial stress, adding additional pressure.

Participants had high levels of debt. High debt levels had contributed additional financial burden to highly constrained incomes. Government departments often contributed to participants having very little income left each week for living expenses, including rents. Additionally, even quite small amounts owed to debt collectors contributed to participants having issues with their credit rating. This in turn acted as a barrier to being considered as tenants in alternative accommodation. Overall, constrained income contributed to participants living in a state of financial precarity, or poverty. Having a lack of access to adequate income lowered people's options when faced with homelessness. Participants had very little financial reserve to weather a personal crisis.

6.3.5 Organisational distrust and poor treatment.

At critical points, participants were inadequately supported by the many organisations they were connected with. This contributed to feelings of exclusion when in crisis. Additionally, participants described incidents of systemic discrimination and racism which added to a sense of being ostracised. Participants were deterred from asking these organisations for help when it was needed. These themes will now be further discussed.

6.3.5.1 Poor treatment results in loss of trust

Participants described unsympathetic, discriminating, and demoralising treatment by many social sector organisations. This led some to feeling as though they had been actively abandoned and contributed to some avoiding asking for help at critical points. The following excerpts describe incidents of inadequate organisational support which contributed to an episode of homelessness for some.

When asked about contributing factors which increased the risk of her becoming homeless, Sarah replies:

“Lack of support. Mentally, physically...And just no support that you could find easily. Work and Income say they’re there to support everyone, when to be honest, my point...they’re not. They judge you before they even know you... And when WINZ don’t give you a food grant, you’ve got to be in a certain Salvation Army area. Because (WINZ) didn’t give me a letter, I had to go back to WINZ and get that letter, but they wouldn’t give it to me. So, no matter what I tried to do for trying to justify wanting some food, WINZ would still stuff me around... That’s why I don’t really like going to them. Because they’ll just say “no” ...Toss me onto someone else. They don’t want to listen to my story... It even gets to you...when you get homeless...Because I had no help.” (Sarah, in-depth interview).

In this excerpt, Sarah describes attempting to access a free food parcel from Salvation Army, because she has been declined financial support for food through Work and Income. Sarah is frustrated and humiliated having to prove entitlement to support to access food. Sarah describes other situations like this that have contributed to a loss of institutional trust for her. As a result, she has a sense the answer to asking for help may always be “no”. Because of this, Sarah does not bother asking any organisation for help with accommodation when she has nowhere to live. She resorts to rough sleeping. This combination of pressures contributed to a sense of hopelessness and a decline in her mental health.

When faced with having nowhere to live, Vee had a similar experience:

“...when I first asked (Work and Income) for help... I was told ‘I can’t help you’and that’s when I actually ended up in the park... they dangle that little carrot... and can say yes or no to you. They can say ‘well, we’re not paying for you (to be in emergency housing) anymore...because you didn’t meet the obligations.’” (Vee, in-depth interview).

Vee is initially declined support with emergency housing because she is single and homeless. She is told because she is not part of a homeless family, she does not meet criteria for support with emergency housing. She is forced to sleep rough in a public park in Auckland. She describes this experience as humiliating and frightening. After several days rough sleeping, she persists asking for support and is placed in emergency housing in a motel in Hamilton. Her ongoing entitlement for this support is conditional on her meeting various obligations. This includes providing the department with proof of rental property viewings and proof of applications/or decline letters for between six and ten rental properties a week. Vee describes this weekly ordeal as harrowing and unrealistic given her credit rating, and the scarcity of accommodation for rent. She describes feeling constantly at the mercy of this government service, as they indicate they will cease offering emergency housing support if the property search conditions are not met.

Brosh describes being instructed by a government department to relinquish her public housing due to damages caused by a visiting relative:

“...They (public housing provider) were well aware that I didn’t do it. He did...I didn’t know what to do at the time. I asked her, the landlord, and she brought in someone else higher than her as well into the office. And I just said ‘What do you want me to do?’ ...She pretty much said, ‘We want you to sign the house back. Sign here’. They got me to sign papers which I didn’t even read, and then, yeah...they just ticked off any old boxes after I had signed the paper... I know a lot of people that are out there, some under mental health, can’t read or write, don’t know the system”. (Brosh, in-depth interview).

Brosh describes feeling forced into signing papers that end her public housing tenancy. She does not appear to have been offered an alternative to the outcome prescribed. Once evicted, Brosh receives notice to attend a tenancy tribunal hearing in relation to the damages caused at the property. She does not attend the hearing because she feels the outcome is a forgone conclusion. A judgment is made in her absence, resulting in a tenancy tribunal order for recovery of the property damages. The tenancy tribunal order seriously impacts her ability to rent in the private rental market. She exits the tenancy to a precarious period of couch surfing, rough sleeping, and emergency housing, where she is trapped for eight months. Her use of synthetic cannabis increases, and the severity of her depression worsens.

6.3.5.2 Inadequately supported exit from care and custodial settings.

Several interview participants talk about a decline into homelessness after exiting care settings without adequate support. This included exits from prison, rehab, hospital, and child protection services. Apples talks about relapsing back into problematic substance use after forced detox while in prison. This was due to a lack of support exiting this custodial setting:

“...but once you’re all cleaned up, you come back and all you know is the same thing that you knew when you went in...There was no change at all. Because they just... yep, ‘see you later’. Steps to Freedom. Oh yeah! (Makes drinking gesture and smoking gesture)”. (Apples, in-depth interview).

Being inadequately supported exiting from prison meant that Apples reverted straight back to circumstances and behaviours which contributed to her eventually resorting to rough sleeping and couch surfing. Apples talks about the inadequacy of the “Steps to Freedom” payment, a one-off cash payment of \$309 from Work and Income given to people on exit from prison. Many questionnaire and

in-depth interview participants talked about the futility of this payment. Participants agreed that it is mostly used by releasees to pay immediate debt or to purchase drugs and alcohol.

Similarly, Craig describes how an inadequately supported exit from rehab leads to a relapse which ultimately contributed to an episode of homelessness for him:

“When I came out of rehab...you get left alone and then you relapse again...down the track, when something goes wrong...Educate the justice system, the police, CYF’s...(to) have more understanding for people battling with addictions and mental illness.” (Craig, in-depth interview).

As a result of this relapse in his addiction to alcohol, and subsequent problematic behaviours, Craig explains that his partner issued a trespass order so that he is prevented from seeking accommodation at their former home, where she still resides. Craig attempts to seek accommodation in the men’s night shelter. Because he is inebriated, he is denied entry and resorts to rough sleeping.

6.3.6 Community discrimination and racism

Participants had experienced discrimination when applying for tenancies, and jobs and when seeking help from social agencies and government departments. Participants felt discriminated against based on being a beneficiary, their ethnicity and on their appearance while homeless. They also felt discrimination in relation to difficulties some experienced communicating with social sector organizations and navigating social sector systems and processes. Participants had also experienced discrimination in relation to their gang affiliation, their criminal histories, and their health issues.

Craig had experienced discrimination related to his health issues. These issues include depression, anxiety, post-traumatic stress disorder, a learning disability and problematic substance use. He describes discrimination experienced during interactions with multiple government departments, social agencies, and health organizations. He expressed a sense of frustration that organizations lacked a genuine understanding of the complex health and wellbeing challenges many people faced, as well as the long-term impact of traumatization in childhood and youth.

“Battling with addictions, with alcoholism...same with mental illnesses and disabilities, you get judged by that, and there’s a whole ignorance around it.” (Craig, in-depth interview)

In this quote, Craig is talking about a lack of understanding of these issues among staff involved in emergency services and crisis housing providers. This includes those he has interacted with in the hospital’s emergency department, police, ambulance drivers and emergency housing providers.

In-depth interview participants were asked for comment about the disproportionate experience of homelessness among Māori and Pacific Peoples in New Zealand. Sarah's comments below regarding the impact of racism on pathways to homelessness were reflective of the views of other participants:

“Me, Māori's and Islanders, are brown. And, I'm not being racist, but, if you're whiter than us, or lighter than us, I'll put it that way, you've got a better chance in the end...(of) get(ting) more help, more support. Whereas the darker coloured skin...have very minimal, or none at all... Māori's, and dark people, are really at the end of all that long list of people. Which is sad. We all us should be one. We're not. Trying to get credit, for example, they've looked at you, well looked at me and go 'You're brown. You can't afford it.' So, before you even apply for it, you get declined. And I'm like, that's discrimination.” (Sarah, in-depth interview)

In her comment, Sarah talks about feeling generally disadvantaged because she is darker skinned. She describes racism as limiting her access to multiple resources and supports in society. Her comments about having “a better chance in the end” convey a sense of societal inequity. Sarah talks specifically about racial discrimination she has experienced when applying for credit to purchase essential items. In Sarah's opinion, being Māori is a barrier to equitable access to many resources in Hamilton, including housing.

Similarly, Rangitahi talks about a general sense that Māori are living in a manner dictated by the settler culture, New Zealand European or Pākehā. In her comments below, she challenges the government to address this perceived inequity. When asked why she thinks there is a disproportionate number of Māori and Pacific People shouldering the burden of homelessness in New Zealand, she replies:

“Because we live in the Pākehā world. We don't live under Māoridom in New Zealand...Government doesn't want to hear it.” (Rangitahi, in-depth interview)

Rangitahi alludes to a general cultural divide and inequity in communities, a detrimental situation she feels is ignored by the current government and organisations she is connected with. Like Sarah, Rangitahi describes experiencing both personally mediated and structural racism. She feels she has not received equitable access to resources and support, including housing, because she is Māori.

6.3.6.1 Section summary –Organisational distrust and poor treatment

An institutional distrust had developed among many participants, based on poor and inadequate treatment when engaging with various government and other community organisations. Participants described poor treatment when approaching organisations for support with food, money, emergency housing, health, and wellbeing support, for support when applying for rental properties and for support to navigate social sector systems and processes. For some, inadequate support in the past

lead to participants avoiding asking these organisations for support when in housing crisis. This particularly applied when participants sought support from government departments. Some participants also felt abandoned when exiting institutional care, whether from prison, rehab, or child protection services. This was a trigger event for a homeless episode for some.

Some Māori participants had experienced racism in their dealings with various social sector agencies and community organisations. There was evidence in the data of participants experiencing personally mediated racism, as well as structural racism. This led to some people feeling they had little hope of equitable access to resources in the community when in crisis, based on their ethnicity. This included equitable access to housing.

6.4 Critical points of intervention.

A focus of this research was identifying points of intervention, where appropriate support or resources may have helped people avoid being drawn into a pathway to single adult homelessness. These opportunities for asking in-depth interview participants for their advice on these topics will now be presented. Table 28 summarizes the various themes and subthemes which will be presented in this section:

Table 28 Qualitative themes and subthemes - Solutions and points of interventions

Themes	Subthemes
Early intervention Mitigating early-life adverse experiences	Supporting survivors of traumatic life experiences
	Supporting at-risk families
	Sustained support after out-of-home placement
Interrupting pathways Supporting people already on a pathway to homelessness	Access to adequate housing – a home not a room
	Adequate support with existing health and wellbeing issues
	Adequate income and addressing barriers to work
Crisis response Supporting people once homeless	Improved access to housing plus ongoing support

6.4.1 Early intervention

Participants advised early intervention was needed as a means of preventing people being drawn into multiple poor social outcomes, including into a pathway to single adult homelessness. Most advice related to better supporting survivors of ACEs and out-of-home placements. Based on both positive and negative personal experience, people advocated a holistic approach to supporting at-risk families. These themes are now presented.

6.4.1.1 *Supporting survivors of traumatic life experiences*

All in-depth interview participants were survivors of ACEs. Most participants were also parents. However, most were estranged from their families, their wives, husbands, parenting partners, and children. Some of the participants who were housed were in the very early stages of attempting to reunite with family. This process was made more delicate because some had been both victim and perpetrator of ACEs.

Participants did not generally express ways for families to avoid ACEs occurring, nor was discussion about this prompted. Therefore, most advice was themed around supporting children and adolescents who were survivors of ACEs. This included suggestions about how to break down barriers to encourage discussion about the topic of ACEs, and providing an environment conducive to encouraging disclosure, both for children and adults. Critically, participants provided insight into the ongoing impact childhood traumatization had on their lives and advice about what type of intervention or resource was needed to better support people, and when such support would have been welcomed.

Rangitahi summarized many participants sentiments about the difficulty ACE victims have seeking help:

“...a lot of us that’s been abused, mentally, physically, emotionally. That scars us....some of us are too shy to talk about it or get help...You see, a lot of people are whakamā...Whakamā is shy. Who wants to talk about your abuse? Māori people like me, we weren’t brought up like that. We were brought up to sweep it under the carpet...Why do that? So you can degrade your family?” (Rangitahi, in-depth interview)

Rangitahi acknowledges the difficulty people have talking about surviving ACEs. This sentiment is echoed by many participants who had survived ACEs, irrespective of their ethnicity. Rangitahi does allude to a cultural element around additional reservations people who are Māori may have in disclosing their experience of ACEs.

The phrase “swept under the carpet” is used by many participants, both during questionnaire research and in-depth interviews. In this context, this phrase indicates families choosing not to disclose the details of abuse to anyone, particularly authorities. The comment about families concealing abuse was made by both Māori and Non-Māori survivors. Rangitahi points out that disclosing ACEs impacts entire families. This is a major barrier for people disclosing abuse at any age. Some participants only felt safe disclosing ACEs to others once a perpetrator has died.

Rangitahi advocates encouraging discrete korero (discussion), with children, with families, and with adult survivors:

“Some of us, are too shy. So, what’s helped? I’m doing this (research) ..and I want to do it like I’m doing this...Do it by saying “hey, it’s ok”. It’s about having a person, like yourself... doesn’t matter if its interview... just listening...Gotta be open. Keep talking about it. Keep korero about it. Stop being shy. It happened. Tell your children ‘Don’t be scared’. Tell your mokos (grandchildren). One on one. In privacy. Educate the children. Educate the parents.”
(Rangitahi, in-depth interview)

Rangitahi highlights a need to educate children and parents about avoiding ACEs, as well as providing discrete methods for people to disclose ACEs. She advocates the opposite of sweeping things under the carpet. Like many participants, Rangitahi felt comfortable enough using a mechanism such as the research process to talk about having survived ACEs, despite no encouragement to share the details of her ordeal. This is an example, therefore, of research as therapy. Rangitahi reiterates that only someone who had survived childhood abuse themselves could possibly know how to relate to, and support, another victim. Peer-support is therefore advocated.

Despite all interview participants being survivors of ACEs, most had never had the opportunity to disclose that they had survived abuse to anyone before. Equally, most had never been offered any other supports to deal with the life-long effects of trauma, such as counselling. For some, having had acknowledgement that abuse had occurred, confident in the rigour of anonymity protecting research participants, many participants expressed feeling a cathartic release. Most ACE survivors elected not to pursue counselling or other support through their TPP case manager.

For some, there was fear that disclosure would lead to violent familial retaliation. For Sarah, this fear was enough for her to keep this part of their childhood veiled in silence for most of her life:

“Because my family are mainly gang affiliated... if they had found out what had happened to me years ago, God knows what would happen. But I didn’t want that to happen. At the end of the day, no matter what they done, it’s me that’s got to live with what had happened. And I still do.” (Sarah, in-depth interview)

Sarah’s comments are representative of the sentiment among many ACE survivors, who advocated for the need for an accessible, discreet, safe mechanism of disclosure about these experiences, with potentially no reprisal against the perpetrator.

6.4.1.2 *Supporting at-risk families*

Several respondents discussed the impact of a lack of positive adult role-modelling when they were young. In answer to what resources or help would better support people who had experienced ACEs, and when that support would have been welcomed, Ben commented:

“Maybe a buddy system when you’re young. Like I wasn’t brought up with a mother and father in the same place. They were separated...I never really had a male role model in my early days.” (Ben, in-depth interview)

Ben describes a childhood where his parents separated when he was very young. His mother suffered with mental health issues and struggled to cope on her own as a parent. Other household disruption ensued. One outcome of the disruption for Ben was that he had very limited behavioural boundaries imposed during his youth. Without firm guidance, he describes falling into problematic alcohol use at a very early age. Ben identifies a lack of positive male role-modelling as one reason he was drawn into the justice system at a young age.

Many participants spoke about the need for support for families to develop positive parenting techniques and relationship skills. Rangitahi was both victim of early childhood trauma, and a contributor to her own family breakdown. She talks about an intervention that had worked to help her reconcile with her own children and grandchildren:

“I’m being real. I’ve been hit, kicked, you name it. You know, I’ve been booted left, right and centre. I’ve been the bully. I’ve been the victim. I’ve been the prosecutor. All of it. And it all stems back from the beginning....What worked was when a whole family goes on a camp, which is a behaviour camp...And it’s a health camp. It’s good...You learned to interact and help them...For me, I feel that’s the only way families are going to interact and (get) help. So, if your child’s been abused, or you’ve been abused, I would go to one of those...So, uplifting them out of their circumstances, put them (elsewhere) for a weekend... Do it on a regular basis, and check in. See how they’re going...It’s taken me eight years since I lost my children ... when I lost my kids...they are my rocks. They helped me to change, to realise that I could be a parent, (that) I could be a better person.” (Rangitahi, in-depth interview)

The camp was attended by one of her children and grandchildren. Rangitahi advocates that families need to be uplifted out of their chaotic circumstances to a camp-like surrounding. There, they can be offered positive parenting support. At the same time, children are offered behavioural support. Importantly, Rangitahi stipulates the need for regular ongoing follow up.

Attempting to reconcile with family was important to Rangitahi. Not many of the in-depth interview participants had been able to or been permitted to reconnect with their families. The rift within Rangitahi’s and David’s families remained strained however, with forgiveness only being achieved once these two people died, in April and November of 2020.

6.4.1.3 Sustained support after out-of-home placement

Participants who had survived ACEs and then been taken into care of child protection services, sometimes as a Ward of the State, advocated people needed very specific early intervention, and importantly, sustained, possibly life-long, support after exiting state care.

Below, Apples discussed feeling abandoned by child protection agencies when she most needed them. She feels she was denied much needed ongoing supported at a critical point in her life.

“... the system at the moment is just, at the age of 16, you’re gone. They need to care for you longer, because, when I was 16, bang, I was tossed aside...when you get a young child, you need to work with them right through till they’re a teen. Not let them go. We were just left. Like sacks of potatoes. We need to be supported right through.” (Apples, in-depth interview)

Apples’ quote was echoed by other participants who had experienced both ACEs and then out-of-home placements. They too strongly advocated for ongoing, possibly lifelong support, beyond the time when a person aged out of care.

Some participants who had experienced an out-of-home placement commented on the inadequacy of the placement. Some were abused during these placements. Vee was a Ward of the State in her youth, enduring several out-of-home placements, including in now-closed Girls’ Homes:

“I know they don’t have girls’ homes now. I know they’re all closed. Um, but they still need homes or, I don’t know how they do it now. I really don’t. Hopefully anything’s better than what it was back then.” (Vee, in-depth interview)

Vee was a victim of physical and emotional abused during some of these placements. Vee sees an ongoing need for out-of-home care for children, but not in the same form as in her youth.

Bel, as well as having endured a disrupted childhood herself, including suspected (but not confirmed) physical abuse as a baby, has experience of having her own children uplifted by child protection services. Despite feeling that, on the whole, the system was not there to help when she reached out, she is able to recall one type of intervention by child protection services which she and her husband found helpful:

“...coming in and working with us. Because eventually they (child protection services) did. We did a twelve-week pilot program with Child Youth and Family. We went in every single day. It was like a FGC (Family Group Conference).” (Bel, in-depth interview)

Bel describes feeling grateful being able to see her children on a daily basis during this pilot. She contrasts this experience with the trauma of having her youngest child uplifted by child protection

services from the neo-natal intensive care unit shortly after birth. Bel had not had as frequent visits with this child and feels the natural bond between mother and child had not been given time to form. She therefore advocated for programs that encourage constant and consistent contact between children and their biological parents.

6.4.1.4 Section summary – early intervention

Participants had emotionally charged views when discussing interventions to better support survivors of ACEs. The same sentiment was felt as they discussed means for families to avoid the need for child protection services intervention, and to avoid out-of-home placements happening for children. Some participants had been both victim and perpetrator of family household disruption.

Despite having very divergent experiences, participants signalled that early intervention for victims of ACEs is important. Most advocated for a discreet, safe mechanism for survivors, whether young or old, to be able to disclose and discuss their experiences, if desired. These events needed to be safely outed from their hiding place under the rug of familial suppression. Similarly, participants cautioned against poor and sometimes unsafe out of home placements by child protection services, as this had contributed to participant traumatisation in many cases. The intergenerational effects of ACEs were also evident amongst participant accounts. Interventions that help heal the whole family were therefore advocated in order to prevent the intergenerational transmission of trauma.

6.4.2 Interrupting pathways

Participants identified that having improved access to resources such as money, affordable, safe, appropriate, and permanent housing, and adequate support with their existing health and wellbeing issues may have allowed them to be in a better position to resolve their own housing and other personal crisis, without the support of a homeless service. These themes are now discussed in more detail.

6.4.2.1 Access to housing

The primary resource participants advocated to interrupt people's pathway to single adult homelessness was a permanent and sustainable housing solution. More accurately, this needed to be a place to call home. It also needed to be affordable.

In his comments below, Dave talks about how access to affordable housing ended his episode of rough sleeping. In answer to what resources helped end homelessness for him, he replied:

“When I was given a place to stay. That what's stopped me. Yeah, given a place to stay...People just want to get their own home...Just put everybody in houses and put the rent down so they

can afford it. Then they'll stay in their houses, and they won't move... We've just got to build more houses... Yeah, having a house will make these people better. They're all happy now they got a house. They're all happy to have a house. Even those guys up (name of street), they're all happy. They don't even bother coming to town anymore." (David, in-depth interview)

In this quote, David comments about his observation of the positive effects housing has had on the behaviours of other former 'streeties'. This includes a positive impact on people's demeanour and no longer needing to come into town to congregate with other fellow streeties.

Most participants who were homeless at the time of interviewing were on the public housing register, waiting to be offered a home. Craig made comment about the lengthy and tortured process he and his wife had to endure to get into public housing.

"Even with housing, it took us two years of living out of a motel, being homeless and couch surfing and that, with a young baby. (Baby's name) was two at the time. I had to come off the (public housing) list. Five minutes later, Housing (HNZ) rang up, to do the update with me. Within five minutes, they rang my wife and said, "Oh, your husband said he'll come off the list. Is that ok with you?" She said yes and within 24 hours, they rang her up and said they had a three-bedroom place for her. Why? Why do that? And it's a three-bedroom house. We could have had the place and we could have all lived together. It felt like it's a case of divide and conquer." (Craig, in-depth interview).

Craig implies that he had to separate from his family in order that they are housed faster in Public Housing. Craig's comments highlight that not only is there a need for more public housing, the process of accessing this housing needs review.

Participants had innovative suggestions for increasing housing stock in Hamilton. Several participants alluded to the number of homes that appear to be untenanted in Hamilton. This frustrated people. David had noticed empty public and private housing in the town.

"...There's a lot of empty houses around. People just can't be put in them because they're getting done up...Oh yeah, there's a lot of Housing NZ houses that are empty, just empty." (David, in-depth interview)

David refers to some public housing being untenanted because they are being refurbished. He is aware that some are being remediated due to methamphetamine contamination. Similarly, Craig has noticed several empty houses in Hamilton.

“Even with the homelessness, you know, there’s so many empty buildings around Hamilton. Put more emphasis on the City Councils and that to actually free up some of these buildings that are not actually being used...” (Craig, in-depth interview)

To help alleviate a housing supply issues, Craig feels local government has a responsibility in addressing the issue of untenanted housing in the town.

Many participants advocated for involvement of local Iwi in forming solutions about homelessness, including exploring ways to increase the supply of affordable housing in Hamilton. Bel notes that there needs to be more housing specifically designated for Māori, involving housing that is built on Māori land.

“Oh, this (city) is Māori land. You know. If that’s the case, where’s all the Māori’s houses?... I don’t understand that. All this Māori land, and yet, we’re not building houses for our Māori on it. We’re building it for immigrants. You know. When they come to the country, they get a house... A benefit straight away. What do we get? ...We don’t get the same help.” (Bel, in-depth interviews)

Similarly, Craig identifies that social services need to work with local Iwi, to support them to help their own tribal members who are in need of housing and culturally appropriate support.

“...empower the Iwi’s a lot more. Give them the opportunity to be able to work with the government, work with the police and the justice system, to come up with a solution. Yeah, work with the Iwi’s... And give them a lot more leeway with funding... and programs, to be able to help their people.” (Craig, in-depth interview)

Craig’s comment echo that of many of the participants, both Māori and non-Māori who advocate for more involvement of local iwi in solutions to single adult homelessness, including increasing appropriate, affordable, housing stock.

6.4.2.2 Adequacy – A home, not a room.

Many participants distinguish between being offered accommodation, a roof over someone’s head, and having a place to call home. Some participants advised services supporting those with limited options not to encourage people to accept co-living style accommodation. In preference, participants favoured single person housing that was self-contained, without shared amenities, and ideally including space to be able to reconnect with friends and family.

After an episode of rough sleeping, Bel and her husband have been staying in co-living accommodation in the centre of Hamilton for two years at the time of interviewing. Over this time, their oldest son has

aged out of the care of child protection services, and now stays with them some of the time. Bel talks about the inadequacy of this situation.

“We’re in a one bedroom, the three of us... Our son sleeps on the floor because there’s no room for a bed”. (Bel, in-depth interview)

The rigid guest policy in this style of tenancy, cramped living conditions and shared facilities makes it difficult for their son to stay with them. Many participants reiterate Bel’s comments about the difficulties co-living circumstances can bring for people. For some, the additional scrutiny and support with guest management provided a sense of security. For most, it was not the home-of-choice. This is in part because of a lack of privacy due to having shared facilities such as laundries and kitchens. This sense of lack of privacy can be exacerbated by the configuration of many co-living blocks. Other detracting elements include the level of landlord scrutiny and strict conditions around people’s tenancies. This can often mean that visitors are discouraged or prohibited from staying over, including family.

6.4.2.3 Section summary – Access to adequate housing, a home not a room.

Overall, participants advocated increasing the supply of local affordable single person housing as a way of interrupting pathways to single adult homelessness. These properties need to be more accessible, particularly for people on a benefit. Participants want permanent accommodation, a place to call home, with adequate space and provision for visitors including family and friends. Empty homes, both privately owned and publicly provided, need to be freed up to improve the supply shortage in Hamilton. Participants, irrespective of their own ethnicity, identified that Māori are over-represented among people homeless in Hamilton and that it is therefore important that local iwi are included in the design of solutions to help local Māori in housing crisis.

6.4.3 Adequate support with existing health and wellbeing issues

Both problematic substance use and mental health issues contributed to episodes of single adult homelessness among participants. Overwhelmingly, therefore participants pointed to the need for better support and understanding from the organisations they had relied on to help them with their health issues, before these issues impacted on their housing circumstances.

Craig suggested a raft of pragmatic ideas to minimise the contribution these co-morbid health issues make to homelessness:

“...Put more funding into rehab and facilities to actually help people to get back (to social inclusion) ... and it’s not just about the rehab itself. It’s having that support afterwards. The counselling, for long terms afterwards, to make sure that they actually stay ...Probably two

years, minimum. Make it two to five years to make sure they can stay clean and sober in their own good environment, good headspace. ...When I came out of rehab, it's like, ok, you've done your rehab, see yah! And that's basically it. You get left alone and then you relapse again... down the track, when something goes wrong...Maybe make some law changes about how easy it is to get alcohol. Because when you go around town, supermarkets always sell it. Some dairies sell alcohol. It's just so easy to get...Educate the justice system, the police, CYFs... (to) have more understanding for people battling with addictions and mental illness.”” (Craig, in-depth interview)

Craig encourages greater investment in support options for people with problematic substance dependency. He highlights the need for ongoing support in the community, post rehabilitation. The level and extent of support he is suggesting far exceeds that of current service offerings. He alludes to the need for social sector organisations to educate themselves properly, to be more trauma-informed about the true cause of people's substance dependency and traumatic events people have survived. He also advocates for a law change to limit people's access to alcohol, since this substance has had a significant and intergenerational detrimental effect throughout his life.

Piri also advocated that people experiencing homelessness need a range of wellbeing interventions.

“They need medical assistance. Access to all the medical help. Medical. Mental. Physical.” (Piri, in-depth interview)

His intention is that this wellbeing support be free and easy to access, as that has been his experience of health support received while with The People's Project.

6.4.3.1 Section summary – Adequate support with existing health and wellbeing issues

Participants highlighted the need for adequate and ongoing support of those suffering with existing health and wellbeing issues. Participants advocated for social sector agencies to adopt a trauma-informed understanding when supporting people. This meant not only seeking to avoid retraumatising their service users, but also understanding the significant and long-term health and wellbeing impact of both current and historic traumatic events. Support for duration of need is advocated, particularly post-medical intervention. Participants agreed that this type of support would have reduced the contribution these health issues made to raising their risk of single adult homelessness.

6.4.4 Adequate income and addressing barriers to work

Having access to adequate money gives you more housing options when in a housing crisis. Most participants felt that having an adequate level of income would have given people a greater ability to resolve their difficult housing situations themselves, without the help of a homeless service. At the

time of interviewing, all participants were beneficiaries, and all considered that having insufficient income contributed to their experience of homelessness.

When asked what resource or support would have made the most impact on various factors which contributed to her episodic experiences of homelessness, Brosh replied emphatically, and without hesitation:

“Extra money”. (Brosh, in-depth interview)

6.4.4.1 *How much income is enough?*

When asked how much would be enough to cover her food, rent, power, clothing, and bus fare, the items we together conclude to be the necessities of life for her, she replied:

“.. for myself, I’d say a good \$400 per week”. (Brosh, in-depth interview)

She is homeless at the time of interviewing but has been applying for rental properties costing \$240 a week, and upward. With modest power costs deducted (say \$30 per week), living on \$400 per week, we calculate she could have just over \$130 to spend on food, clothing, and transport per week, which Brosh feels would be adequate.

Sarah defines the amount of discretionary income she would like to have left after all her bills are paid:

“Well, to answer how much money is liveable, it’s a bit hard these days. ‘Cause I reckon once all my bills are paid, I’d probably say, easy-to-comfortable amount a week, in hand, after all that, probably be... \$100. Or over \$100.” (Sarah, in-depth interview)

Sarah feels having \$100 left after all essential household costs are paid would allow her to reintegrate into her community.

Craig talks about the amount of money he thinks would be sufficient to sustain his family of three; two adults and a child.

“Even with the benefits, just making sure that the families get everything that they’re entitled to. So, they need to increase the benefit. They’re not listening to any of the surveys. The surveys are saying that on average, the average New Zealand household needs at least \$800-\$900 (a week) and nothing’s happening about it. The minimum (hourly) wage (rate) needs to be about \$20. And nothing gets done about it.” (Craig, in-depth interview)

Craig concludes that the amount beneficiaries receive needs to go up. He is frustrated that in his estimation Government does not seem to be listening to the needs of the people. He refers to the

findings of a recent community consultation process that appears to have been ignored¹⁰. He is frustrated that families are not getting the financial help they need, through entitlements that they might be eligible for through Government agencies. In this sense, Craig is saying families need additional financial support from more responsive government organisations.

6.4.4.2 *Improved access to work*

Many participants saw increased access to paid work as a means of improving their state of income precarity. Participants said having work would mean people could earn enough money to have more choices when needing to relocate to alternative housing. All of the in-depth interview participants had worked previously, and most wanted to get back to work. However, there were many barriers to readily accessing work.

In Apples' comment, she identifies her criminal history as a barrier to being offered work and housing.

"You're unemployed. No, you're not going to get a place ... There's a lot of unemployment. They need to focus on the people that are unemployed. You get them jobs. Instead of ringing up overseas and getting everyone to come over here, taking their jobs. And when I do hustle for my money, they tell me to get a job. And I'm like 'how am I supposed to get a job?' I still can't get a job through those companies...where they hire people out to other jobs. I can't get that because of my criminal record. But I used to work for them..." (Apples, in-depth interview)

Apples identifies that people who have work are offered rental properties first. Therefore, not having work is a barrier to being able to access this type of housing. She is also implying that beneficiaries are discriminated against in the rental market. She notes there are several barriers to people getting work locally. One major barrier she has encountered is having a criminal record. She is frustrated that she has work experience and yet she is being over-looked by work brokers because of this record.

Apples also makes comments about her perception that migrant workers are taking jobs away from locals. These comments are representative of similar sentiment regarding refugees and migrants made by several participants. Often, participants made comments about the impact of refugees and migrants on the community at the same time as discussing a recent outpouring of support for the Muslim community after the Christchurch Mosque shootings¹¹. Most participants were quick to

¹⁰ A Welfare Expert Advisory Group was convened in 2018 to provide advice to the government on areas for reform in the welfare system. Meetings were held throughout the country and included consultation with beneficiaries. A report was produced including 42 key recommendations.

¹¹ The Christchurch mosque shootings involved two consecutive mass shootings which occurred at the Al Noor Mosque and the Linwood Islamic Centre in Christchurch on the 15th of March 2019. The terrorist attack was

comment that the Muslim community were deserving of national support. However, many added that they felt families of those slain received a much higher level of outpouring of public support, as well as a much larger amount of financial and other support from government, than most homeless people have received. Participants are therefore perceiving that people homeless are receiving an inequitable response from the New Zealand community-at-large, compared to others.

Mike comments about his attempts to ask passers-by for work while begging. He did this by indicating on a hand-made sign that he was looking for work.

“They (Work and Income) did say to go out and look for work. But I’ve tried. I’ve asked a lot of people that’s out there on the roads and all they ask is about my criminal record.” (Mike, in-depth interviews).

He too alludes to being declined work options due to his criminal convictions. In this excerpt, Mike is talking about being advised by Work and Income to try and find work as a means of improving his homeless circumstances. Mike does this by soliciting for work from the pavement, while also asking for money from passers-by.

Similarly, Brosh talks about the difficulty she has experienced accessing work.

“I just wish they’d be more (work) out there. I know there’s a lot of jobs. It’s just a matter of getting out there. Some, you’ve got to do a bit of training ... I’m more hands-on than with paperwork...Yeah, they said they’d pay \$10 a day if I could get to (name of town). I just thought, in the end, I get paid, it’s not worth it. Because I need that extra \$70 dollars to put on my food or pay extra bills.” (Brosh, in-depth interview)

In her interview she talks about her strong work ethic instilled by a hard-working grandfather. His family had ancestral land in several centres, which was cropped by extended family. In her case, she has been offered seasonal work picking fruit in another town. This town is over a hundred kilometres away from Hamilton. She does not have a car. There is therefore a cost for her in getting to where work is located. After considering her options she concludes that the cost of travel, coupled with the threat of potentially losing her benefit, outweighs the benefits to her of having extra weekly income.

Participants also made suggestions for supporting people on a benefit to become work ready. This included having opportunities to update their skills and capabilities, which in turn would provide an avenue for improving people’s sense of self-worth.

carried out by a lone gunman. Fifty-one people were killed, and 49 people injured. It was the deadliest terrorist attack in New Zealand history.

Ben talks about some of the benefits he enjoyed being part of a conditional welfare schemes that ran in New Zealand in the 1980's¹².

“...the people on the benefits, give them something to do. Bring in those P.E.P schemes. The last one I done I was in (name of town), working at (name of tourist attraction). All the decking out the front. That was only for the benefit. I loved it. It gave me something to do. It gave me a chance to update my skills. It gave me a purpose. ...I've still got a couple of photos at home. ...I like doing PD for that reason.... If you haven't got a purpose, then you just slip.” (Ben, in-depth interview)

Although Ben comments that he would rather be working for an income, he sees work-for-benefit schemes as a means of upskilling, as well as being an opportunity to provide people with a sense of purpose. Ben's most current work experiences have been accessed through a Labour Department work-scheme, and through the justice system while on periodic detention (P.D). Having work experience has given him a sense of pride, as evidenced by reference to the photo he still has, which reminds him of a time he enjoyed. He welcomed the opportunity to update his carpentry skills.

6.4.4.3 Section summary – Adequate income and addressing barriers to work

Having constrained income contributed to participants having less options when in housing crisis. Therefore, participants advocated for programs and policies which increase people's access to income. Many saw work as a means of achieving this. Most participants thought having increased income from working would likely act as a protective factor against homelessness, as well as giving people a sense of purpose and a means of social inclusion. Most participants had worked before and most wanted to get back to work. Yet there were multiple barriers to accessing work locally, including discrimination related to having a criminal history, lack of support to travel to where the work is, and lack of support to transition from the security of receiving a constant income on a benefit to the precarity of potentially insecure employment, such as seasonal work. Support to navigate these barriers was advocated.

6.4.5 Crisis response

Participants suggested a range of interventions to support these already homeless, so that they might avoid subsequent episodes of homelessness. Like recommendations made to interrupt pathways, crisis response recommendations unanimously centered around providing people with immediate

¹² Project Employment Programs (PEP) were subsidized work schemes initiated by government in August 1980. The programs ran for six years. Employers and community groups received wage subsidies for setting up limited term projects of community value. The scheme was designed to provide subsidized, short-term public sector employment for job seekers who were at risk of becoming long-term unemployed (Te Puni Kokiri., 2014).

access to shelter, then easily accessible, non-judgmental support to navigate the process of accessing adequate permanent housing. Ongoing support was advocated, to help people sustain their tenancies. Additionally, where desired, support was advocated to help people attend to the complex combination of background and other issues which contributed to their housing crisis, so that people might live their version of their best life (The People's Project, n.d.).

6.4.5.1 Improved access to information, non-judgemental support, and accommodation.

All in-depth interview participants had experienced episodes of rough sleeping within the last five years. Participants therefore unanimously highlighted the importance of providing immediate access to shelter for rough sleepers. When Ben was asked what he would do, as Prime Minister, to prevent or end homelessness in New Zealand, he replied:

“I’d have a lot of shelters and that for them, for people to go to, to go and park up”. (Ben, in-depth interview)

Ben has spent several spells in the local men’s night shelter. Although this accommodation option is often maligned, Ben stresses that having a place to go is better than having no place to go.

Many participants noted that they had experienced trouble finding the right help when a housing crisis loomed. Sarah talks about the difficulties she experienced when facing homelessness:

“...There’s not much agencies or anything that actually helps people in homelessness get support... I reckon if they had more agencies that won’t look at you and judge you and...yeah, just more agencies that are there, easy to look at, easy to get a hold of mainly...I was very self-conscious. I was running out of options. And there was no information or people to recommend other people to go and see. For our homeless people... listen to their stories. You know, like, everyone’s got a different story. But, at the end of it, like I said, it’s support, income, and information.” (Sarah, in-depth interview)

Sarah highlights the need for easily accessible information and support for those already homeless, as well as those who are “running out of options”. Sarah stressed that service providers need to be non-judgmental, and support needs to be client driven, as each person’s trajectory into homelessness is unique. She is advocating a one-size-fits-one approach to supporting people. Sarah adds that if there had been an organisation available to provide this type of guidance and support for her to access the resources she needed at the time she faced homelessness, there is a chance she might not have been reduced to living under a local bridge with her adult children.

Similarly, Rangitahi talks about the need for a respectful, collaborative, and trauma-informed approach to engaging with people who are already homeless. In this quote, she is explaining the way she was encouraged to engage with TPP.

“You can be honest with me. I can be honest with you’. That was the first thing that (case manager’s name) said to me...if I can help myself, then she can help me. And that’s what did it. Someone like TPP believes in a person like me; that’s a start. That’s power...You need to not be judgemental. You need to take a person for who they are. You never judge a book by its cover, do you?” (Rangitahi, in-depth interview).

Although initially reluctant to engage with yet another social sector agency, Rangitahi indulged this case manager because of the careful and respectful way engagement was approached. Like Sarah, Rangitahi reiterates the need for services to be non-judgemental in their approach to supporting people. Rangitahi indicates this is important because of the level of stigmatisation, institutional abandonment, and societal exclusion many single adult homeless have endured.

Once engaged and supported to find permanent accommodation, participants highlighted the need for ongoing support. Piri’s comments are representative of many who see support to sustain people’s tenancy as critical.

“First of all is accommodation. Put them into their own accommodation. The second thing would be to help them settle in.” (Piri, in-depth interview)

Piri explains that support to help people “settle in” could take many forms and depends on the level of need of the person involved. For some participants, this may mean helping people navigate setting up power accounts, assisting them to manage payment of rent and utilities, assisting them to be able to maintain their property, and helping them relearn the etiquette of being a reasonable neighbour. For others, this means helping people relearn to care for themselves, to manage basic personal hygiene, and to cook for themselves. Apples reiterates that the settling-in process can take time for some people.

“They’ve got to get used to what’s happening, so step by step. You can’t just put someone in a place and just go, “Oh yeah, you do this”. It’s got to be step by step.” (Apples, in-depth interview)

For Brosh, the settling-in process included wanting support to learn to cook for herself:

“Well one thing I’m not good at is cooking. So, I was kind of living out of the shop. But, you know, just certain foods, sausages, I can cook all that. I just don’t know how to cook a proper meal. It’s been a while.” (Brosh, in-depth interview)

Brosh’s comments serve to remind us that people who have been precariously housed or rough sleeping often do not have access to cooking facilities. They are therefore relegated to eating pre-cooked meals, or meals that can be eaten with little preparation and that do not require refrigeration.

Rangitahi provides a formula for calculating how much ongoing support someone who has experienced homelessness needs once housed. In essence, this is a one-to-one ratio: one year of rough-sleeping equals one year of in-home support.

“You take someone that’s been on the streets for 12 months... or 12 years. And then you take someone who’s been on the streets for 6 months...got to get used to it. So, that’s the support. So, this person that’s (on the streets) 6 months, we’d be supporting them 6 months.” (Rangitahi, in-depth interview)

Sarah gives us a guide to the frequency of contact needed:

“It would also be nice if like that social worker touches base, like once a week, or twice a week. Not once every month.” (Sarah, in-depth interview)

Sustained support post-housing is a common theme among participants. Vee reiterates that she has been left feeling abandoned by services in the past and that a lack of ongoing support contributed to poor biopsychosocial outcomes for her, including periods of rough sleeping. She advocates for a no-graduation policy from support services.

“I’ve got a home now, but I still need that...support by coming in (to TPP Office). I asked if I could still come, once a week... and she (her TPP case manager) said, “Absolutely”. Because I still need that. I don’t want to be left (unsupported) ...Because that’s what has always happened to me, as I was growing up, as a Ward of the State.” (Vee, in-depth interview)

Access to ongoing support, for duration of need, is therefore important for people to help them maintain their tenancies and well-being.

6.4.5.2 Section summary – Crisis response

Participants advocated for an obvious solution to homelessness, immediate access to shelter. They also advocated for easily accessible support for those homeless, or about to become homeless,

provided by services who are non-judgmental in their engagement, trauma-informed, and who genuinely understand the long journey many have taken into homelessness. Each person's journey is unique, therefore support needs to be tailored to the specific needs of the individual. Participants had welcomed support to access permanent housing. However, participants stressed that providing shelter on its own would not be enough to avert people from subsequent episodes of homelessness. To help rebuild institutional trust, participants recommended that support from government agencies and community support organisations post-housing be provided in an ongoing and intensive manner, for duration of need.

6.5 Chapter summary – qualitative data and results

Overall, in-depth interviews allowed for collection of a comprehensive set of data reflecting a broad range of opinions about what has contributed to, and triggered participants' various experiences and episodes of homelessness, both in Hamilton and throughout New Zealand. Participants spoke from various vantage points, both as being currently homeless, or as newly rehoused at the time of interviewing. While participants' life paths are distinctly their own, collectively the contributing factors, and triggers identified bore unmistakably common themes. Further, these themes reflected a chronological pathway, which started for all participants with adverse events in childhood. The main theme and subthemes identified will now be summarized in relation to the research aims.

6.5.1 Results support a pathways understanding of single adult homelessness.

Purposeful selection meant that all in-depth interview participants had experienced ACEs in their childhood. Participants strongly connected the disruption they had survived in childhood and adolescences with disruption they had endured throughout their lives, including later life housing instability and homelessness. Family violence in participants' childhood homes was often fueled by excessive alcohol consumption by caregivers and other household members. The traumatic events of their childhood and adolescence had largely gone concealed and any ensuing adverse health and wellbeing issues untreated. ACEs were largely swept under the rug of familial suppression, to avoid families coming to the attention of child protection services and to avoid family shame.

Family violence in participants childhood homes had however resulted in state intervention for most participants, and an out-of-home placement. This was often participants' first experience of homelessness. Being a survivor of ACEs in participants' childhood homes, and an out-of-home placement was the starting point of lives that might be characterized as chaotic, disrupted, and destabilized. These early-life traumatic events were also the catalyst for the start of disconnection from familial and kinship networks, and early involvement in the justice, health, and welfare systems.

This series of disruptive early-life events are often the precursor to single adult homeless pathways identified in other countries. Qualitative data therefore contributes to quantitative findings in supporting the development of a pathways understanding of single adult homelessness in Hamilton. It is noted however, that because the selected participants were survivors of a high degree of ACE's and lifetime disruption, these findings might not necessarily apply to the portion of the homeless population who have experienced one or two brief episodes of homelessness over their life course.

6.5.2 Other contributing factors.

Other factors were commonly identified by participants as additional elements which contributed to raising risk of homelessness. This included a lack of access to housing, a lack of support with existing health and wellbeing issues and a lack of financial resources.

Unsurprisingly, participants had sought the help of a homeless service primarily because they were unable to access affordable, safe, appropriate permanent housing without this help. An undersupply of affordable single-person housing and abundant demand for what housing was available, meant most private rental tenancies were over-subscribed with potential tenants. Additionally, there were many barriers to participants being offered a tenancy among the pool of potential tenants. Participants considered they had been excluded from being offered tenancies based on their status as ex-prisoners, beneficiaries, addicts, mental health patients and as people of colour.

The private rental properties participants were able to access did not qualify as a home for some people. These were mostly co-living style properties, which were more affordable, but had tenancy conditions and rules that left people with a sense of precarity in their housing status. For some, public housing was one of their few remaining housing options. However, access to public housing was also constrained and the process of acquiring a public house was protracted, fraught and in need of review.

Many participants faced homelessness feeling alone, without positive social supports to navigate the process and systems involved in finding an affordable, appropriate permanent home in Hamilton. Disruption and dislocation from familial supports started with ACEs, and out-of-home-placement for most participants. Social isolation was therefore identified as a very strong theme throughout qualitative analysis, a theme that may have been missed if this study had relied solely on quantitative data.

Participants' sense of being isolated from support when in housing crisis included a sense of abandonment by the many government, and other social sector and community agencies participants were connected with. Participants had developed institutional distrust in many government agencies

and community organizations. This had resulted from demeaning, unhelpful, and stigmatizing interactions over many years.

Existing health and wellbeing issues suffered had contributed to a raised risk of homelessness. The two most prevalent health issues were problematic substance use and mental health issues. Problematic substance use was framed as a coping mechanism by many participants. This health issue was implicated in early involvement in the justice system, in a breakdown in adult relationships and in the loss of last tenancies. Similarly, mental health issues, such as depression and anxiety, had developed early in people's lives. It followed participants from childhood into adulthood, and escalated to suicidality for some, under the pressure of impending or eventual homelessness.

Poverty had contributed to participants pathways into homelessness, by exacerbating their existing circumstances and limiting options when in personal crisis. Participants had low incomes and high debt. As a consequence, participants generally had limited access to adequate financial reserve when in housing crisis. Participants felt the amount of benefit income they received was too low to be able to afford rising accommodation, food and other costs of living. Institutional debt, often levied by the justice, welfare and tax agencies, further constrained income levels. Many were consistently left with very little money to live on, let alone to be able to afford to rent a place to call home.

6.5.3 Points of intervention: what resource is needed and when.

Participants identified three main domains of intervention; prevention in early-life to mitigate disruptive early-life experiences, interventions aimed at supporting people already drawn into a pathway to single adult homelessness and interventions aimed at supporting those who are experiencing an episode of homelessness. Crisis prevention measures were aimed at preventing subsequent homeless episodes.

Participants recommended intervening early once ACEs had occurred. A holistic approach was advocated, aimed at reducing family violence by supporting entire families. Where out-of-home placement was appropriate, participants advocated ongoing support of those under the care of the state, for duration of need.

Recommendations aimed at interrupting trajectories into homelessness included easily accessible support to tenant affordable, safe, and appropriate permanent housing. Currently untenanted housing in the community needs to be made available for renting. Local iwi needed to be involved in housing supply strategies, so that Māori are appropriately represented in the formation of housing solutions to homelessness in Hamilton.

Participants advocated for adequate and equitable access to appropriate and ongoing support for their existing health and wellbeing needs. Stigma around substance based coping strategies needs to be addressed. Participants highlighted the need for cross-sector adoption of trauma-based approaches to supporting people who are at-risk of, or already homelessness, particularly focused on supporting survivors of ACEs and out-of-home placement. This support needed to be underpinned by a genuine understanding of the lifelong impact of historic traumatic events, which may manifest as multiple biopsychosocial challenges.

With access to adequate income, many people felt they may have been able to resolve their own housing crisis. Participants felt they could increase their income most easily by being in paid employment. There were many barriers to them being offered work, including having a criminal history and their health and wellbeing issues. Therefore, supported employment schemes were advocated. Participants also advocated for work-based programs for beneficiaries that would provide an opportunity for people to upskill, as well as providing people with a sense of purpose, of belonging, and of self-worth.

Crisis response recommendations involved improving immediate access to shelter and then providing easily accessible support to help people tenant permanent housing. Once housed, participants advocated ongoing support for duration of need. This was needed to support people to address the other complex accumulation of factors which had contributed to their trajectory into homelessness, if desired.

Chapter 7. Discussion

This thesis set out with three objectives:

1. To determine what factors contributed to or raised the risk of single adult homelessness in Hamilton.
2. To determine if a pathway of common occurrences throughout people's lives raised the risk of homelessness, and what age any such pathway might have begun.
3. To consider critical points of intervention, where appropriate intervention may lower the risk of single adults becoming homeless.

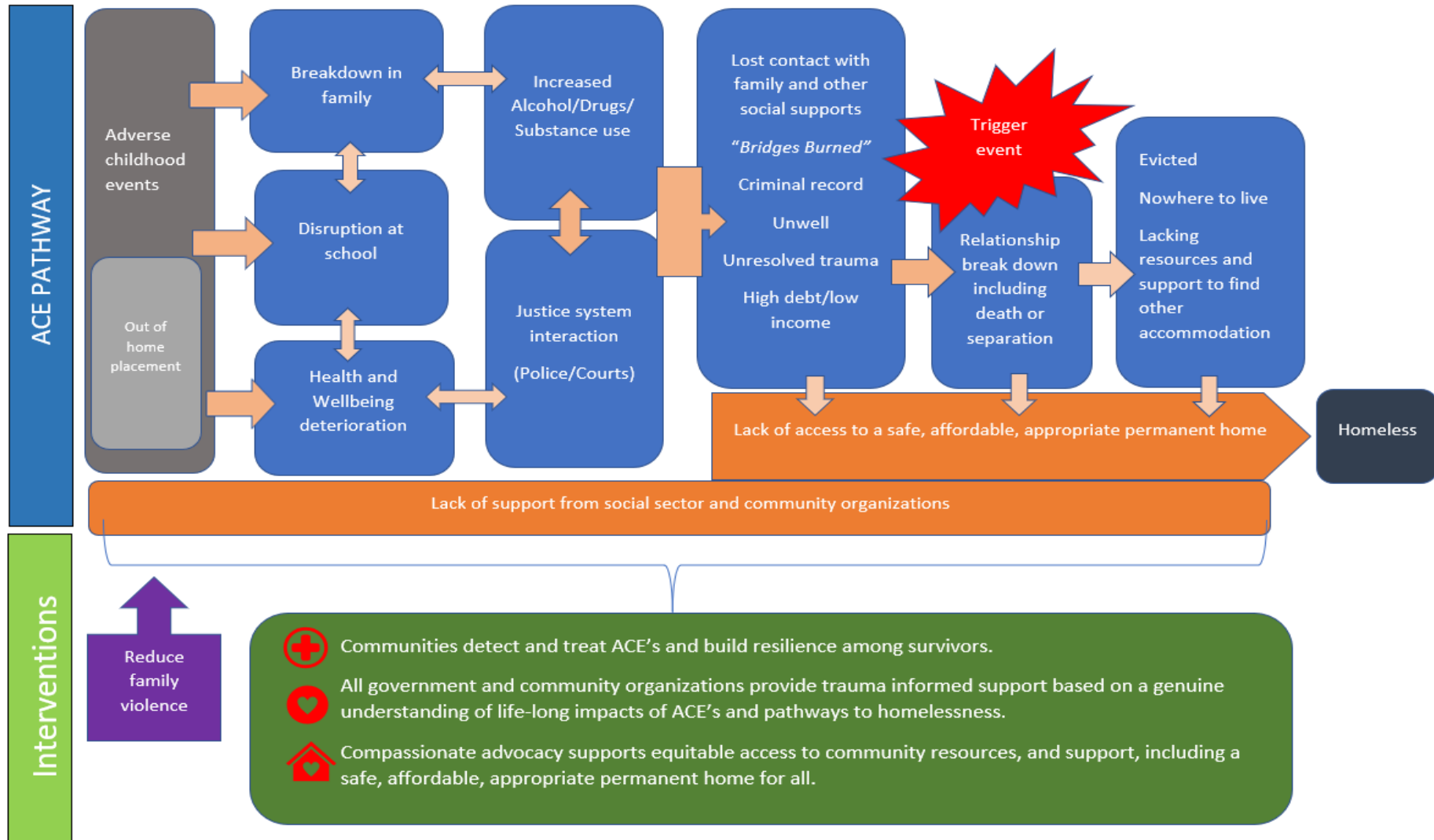
Results revealed a pathway to single adult homelessness in Hamilton, which is represented in Figure 2 in this chapter. Both quantitative and qualitative results confirmed a series of disruptive events over time, almost universally preceded by ACEs, and often resulting in an out-of-home placement in childhood and adolescence. These events had an accumulating impact throughout people's lives. These destabilising early-life events impacted people's wellbeing throughout their lives and contributed to disruption in later-life social networks. A dire lack of familial and other kinship support when in personal crisis contributed to participants having lowered resilience to life-shocks, such as a loss of tenancy.

Trigger events, most commonly a breakdown in a relationship, contributed to a raised risk of homelessness, either resulting in an immediate episode of homelessness or acting as a catalyst for a series of events culminating in participants finding themselves with nowhere to live. Additional structural and individual pressures exacerbated existing circumstances. This included constrained or inequitable access to adequate money, to adequate support from organisations they were connected with, and to a supply of safe, affordable adequate and permanent housing. This combination of contributing factors raised people's risk of single adult homelessness.

Both quantitative and qualitative results highlighted important points of intervention, where the right resource and support may have interrupted pathway into homelessness. Qualitative results provided important insights about the resources participants felt would have made a difference. Often this meant having access to resources that may have allowed people to resolve their own housing crisis, without the support of a homeless service.

This chapter summarises the findings presented and compares these results with extant literature and understandings of homelessness. This discussion will be presented in relation to the three objectives outlined at the beginning of this chapter. Research design strengths and limitations are then reviewed.

Figure 2 ACE pathway to single adult homelessness in Hamilton, N.Z. and points of intervention



A critical realism approach has at its heart a desire to arrive at recommendations for improvement of the circumstances of the people being studied. For this study to “count for something” for its participants, something must change. Policy implications are therefore presented before a conclusion to this thesis draws this study to a close.

7.1 Factors contributing to a raised risk of single adult homelessness in Hamilton.

The results revealed that a combination of individual and structural issues contributed to raising people risk of homelessness. Each of these elements are represented in figure 8 and will now be described in more detail.

7.1.1 ACE and Out-of-home placement contributing to disrupted early-lives.

Quantitative results showed that participants were almost universally exposed to traumatic childhood experiences, most from a very young age. This exposure was at a high rate, with half of the participants scoring 7 or more during ACE testing. As there has been no known comparable ACE testing among a cohort of single adult homeless in New Zealand, results were compared to ACE testing among an adult homeless cohort in the USA (Montgomery et al., 2013) and Canada (Patterson et al., 2014). This testing showed that participants ACE scores were significantly higher than ACE scores for these comparative cohort.

The high rate of ACEs experienced by TPP program participants in this study has been corroborated by additional data from other studies involving this population. This showed TPP program participants had high rates of reported and actual abuse in childhood, as recorded in historic child protection services administrative data. This was at rates vastly higher than a representative control group of non-homeless New Zealanders (Nevil Pierse et al., 2019). Research findings from this thesis corroborate these results and therefore joins a body of international and local evidence showing that, while not everyone who has experienced ACEs will become homeless, ACEs features disproportionately in the life histories of those experiencing homelessness (Suzanne Fitzpatrick et al., 2013; Montgomery et al., 2013; Nevil Pierse et al., 2019; Roos et al., 2013).

For nearly half of the participants in this thesis, ACEs preceded an out-of-home placement in childhood and adolescence as a Ward of the State or in other placements facilitated by child protection services. This involved time spent in foster homes, in boys’ or girls’ homes and in other facilities. Many experienced multiple placements while in state care (between 2 and 12) over multiple years in care (a median of 4 years). An out-of-home placement in youth, and a subsequent breakdown in family ties,

are common occurrences among people experiencing homelessness in other countries (Chamberlain & Johnson, 2013; Suzanne Fitzpatrick et al., 2013; Goering et al., 2014; Ravenhill, 2008; Shinn et al., 2007) and is considered people's first experience of homelessness by some authors, such as Rua et al (2019). Along with perpetuating a fractured relationship with familial networks, ties already compromised by ACEs, an out-of-home placement in childhood and youth is also associated with increased risk of poor health and wellbeing outcomes, particularly poor mental health outcomes, throughout a person's life (Roos et al., 2013, p. 275). Research from Australia has specifically advocated for programs that support teenagers who have been in state care and protection, because they are at greater risk of homelessness (G. Johnson & Chamberlain, 2008). Therefore, this research joins a body of evidence linking ACEs and an out-of-home placement with an increased risk of homelessness.

Other New Zealand research has noted that people's first homeless episode often starts with removal from their childhood family home and out-of-home placement, often within a state care environment (Rua et al., 2019, p. 11). From results in this thesis, it can be seen that this early separation from familial and kinship networks had a lifelong impact on people, contributing to participants having fewer people to turn to when facing later-life episodes of homelessness. The practices of New Zealand's child protection services have recently come under review due to public concern, particularly in relation to Māori children in state care (Radio New Zealand; Whānau Ora Commissioning Agency, 2020). Data from this thesis supports current calls for an urgent reduction in family violence and an alternative to removal of children from their kinship networks in order to support wellbeing outcomes.

In-depth interview participants had universally experienced ACEs, some at a very high level (e.g., ACE score 7 and 8). The majority had experienced both ACEs and an out-of-home placement. Participants articulated a clear link between the instability they had experienced in their childhood homes, an out-of-home placement during their formative years and disruption in their adult lives, including housing instability. Some commented that they simply did not know how to settle into a tenancy, or a house, in adulthood.

A pattern of transience had formed early, with some people moving from their childhood family home to foster homes, from foster homes to the street, to prison, to acute mental health facilities, to precarious and temporary accommodation (such as couch surfing), sometimes staying with other family members, and back to the street. Most participants had lived in at least four homes before the age of 16 years. Nearly half of all participants had left their childhood family home for good by age 16

years. This disruptive early life is portrayed in the ACE Pathway in Figure 2 as a cyclic flow of instability between home, school, the justice sector, and the health sector.

This pattern of transience continued into adulthood. Most participants (n=82) had experienced two or more episodes of homelessness in their life, mostly for less than five years in total. This pattern of transience is like that experienced in other countries such as Canada. A study conducted across five Canadian cities in 2013, involving 2,148 primarily single adult homeless people, showed that most participants had been episodically homeless, and for about 4.8 years in total in their lives (Goering et al., 2014). Therefore, the later-life transience experienced by thesis participants appears common among single adult homeless elsewhere. International research also shows transience is both a contributing factor to single adult homelessness and a consequence of single adult homelessness (Ravenhill, 2008). In the case of thesis participants, this transience had its roots in the disruption people survived as children in their childhood family homes.

Disruption in participants' childhood family homes probably contributed to them having a brief and disrupted primary and secondary schooling experience, with all participants leaving school at age 15 years. Most participants (n=71) had been truant from school. Half reported being badly bullied at school and half had been expelled or suspended. Transience is shown to impact children's education (Nooe & Patterson, 2010). Research from Australia has shown that many young people have their first experience of homelessness when they are still at school (G. Johnson & Chamberlain, 2008). In the case of thesis participants, half had experienced an out-of-home placement from an average age of 11 years. This was the same average age when many had run away from home for the first time and also when people first experienced being bullied at school.

During quantitative surveying and in-depth interviews, participants identified that the trauma they had experienced in childhood negatively impacted their wellbeing as adults. Many participants had received no formal support around this abuse. It had remained swept under the carpet of familial shame, partly due to family fear about coming to the attention of child protection services. The word "whakamā" (shame) was used by some participants in discussions about the effect of ACEs in their lives and their reticence to disclose their abuse to anyone, or to seek help. The prevalence of traumatic life experiences among populations, both homeless and housed, is probably underestimated because "such information is well protected by shame and secrecy..." (Felitti & Anda, 2014, p. 205). For this reason, ACEs has been referred to as the "silent wound" (Liang, 2020), often laying undetected, unhealed, and still painful. The relationship between adverse childhood experiences and poor social and health outcomes in adulthood often goes unmeasured and unrecognized.

Time does not heal the effects of ACEs; it merely conceals (Felitti & Anda, 2014). Participants talked about carrying the pain forward into adulthood, and about their efforts to dull this pain, often through self-medicating with various substances. The impact of this substance-based coping strategy will be discussed in the next section. Participants' early life trauma had shaped the way they chose to interact with others, including with individuals, government agencies and other organisations. Participants noted they felt consistently wary of others and lacking in self-confidence. This led some to avoiding asking for help at critical points.

7.1.2 Mental health and problematic substance use

Participants identified that their often life-long battle with mental health issues and problematic substance use had its origins in abuse, neglect and trauma survived in childhood and adolescence. Research has shown that there is a significant relationship between unaddressed or undetected ACEs, and a high risk of developing major mental illness, and problematic substance use (Felitti et al., 1998; Maté, 2012; Montgomery et al., 2013; Patterson et al., 2014; Roos et al., 2013; Taylor & Sharpe, 2008). Binomial testing compared the portion of thesis participants who reported being diagnosed with these comorbid health issues with another New Zealand study involving coroner's reports involving single adult homeless who had died (Charvin-Fabre, 2020). This test confirmed that the diagnosed prevalence among thesis participants was significantly higher than expected.

These health and wellbeing issues had developed long before people became homeless. Depression and anxiety symptoms started for most people (n = 92) from an average age of 18 years old. Problematic substance use also began in adolescence, with most (n=85) of the 87 participants with a substance dependency in adulthood reporting excess alcohol use from an average age of 18 years old, use of solvents and inhalants (n=70) from age 18 years and street drugs such as cannabis, synthetic cannabis and problematic use of prescription medication (n=70) from age 24 years. In qualitative data, participants linked ACEs they had survived and their ongoing experience of mental health issues and problematic substance use. These comorbid health issues were also implicated in a breakdown in participants' last relationship, which was in turn a trigger for the loss of many people's last tenancy. Additionally, mental health issues and problematic substance use formed the basis for discrimination when seeking alternative housing and work. Stigma and discrimination associated with these and other health issues affects individuals' health and recovery trajectories, adding additional pressures to those already socially marginalised and alienated due to being homeless (Mejia-Lancheros et al., 2021). This research therefore joins a body of evidence showing that unaddressed, or unsupported ACEs are strongly associated with persistent negative health and wellbeing outcomes for people (Felitti et al., 1998; Roos et al., 2013).

Many participants referred to their problematic substance use as a coping mechanism, a means of helping them manage the pressure of their current circumstances, as well as a means of attempting to mask the pain of past trauma. These findings therefore join an increasing body of literature calling for better understanding of substance-based coping strategies among homeless cohorts (Watson et al., 2016). Coping devices such as alcoholism and illicit drug use were leading contributors to multiple poor and complex biopsychosocial outcomes for participants, including involvement in the justice system, time spent in acute health facilities, and episodes of homelessness. Addictions were often merely psychoactive relief (Felitti & Anda, 2014; Maté, 2012) for many single adult homeless, a means of alleviating stress caused over prolonged periods of time, and often starting with ACEs in childhood. These are familiar patterns in literature from other countries and New Zealand (Suzanne Fitzpatrick et al., 2013; Gluckman & Lambie, 2018; Goering et al., 2014; Maté, 2012; Padgett et al., 2016; Piat et al., 2015; Tsemberis, 2015).

7.1.3 Estrangement from familial support and other kinship networks

Families, friends, and other kinship networks shoulder a large portion of the burden of homelessness in New Zealand, as most people homeless are doubled up, living in severely over-crowded housing with others (K. Amore et al., 2020; Atatoa Carr et al., 2018; Collins, 2010). However, for the thesis cohort, life-long disruption in participants' social networks meant this type of housing support was mostly unavailable. This is the very reason most sought the help of a homeless service. Additionally, estrangement from later-life family units and partners, sometimes due to a breakdown in relationship, or death of a life partner, contributed to participants being both single, socially isolated and facing homelessness feeling alone.

The reasons participants were estranged from family were evenly split between it being unsafe for them to go home and families and kinship networks feeling unsafe about contact with this family member as an adult. Previously described, this fracture in familial ties often had its roots in ACEs and an out-of-home placement in participant's childhoods. Substance-based coping strategies, people's mental health issues, their later-life associations, justice system interactions, and transience contributed to participants being excluded from familial and kinship supports.

Some participants defined homelessness as the absence of familial or kinship support when in crisis, without reference to having no shelter. This finding links with the work of other authors who concluded that being without shelter may have been the least of some homeless people's issues (Ravenhill, 2008). The contribution of a lack of social capital when in housing crisis is a major theme in this study. These findings therefore support an understanding that social exclusion and single adult homelessness need to be considered in tandem in New Zealand, which resonates with the work of

many authors, both in this country and elsewhere, such as Clapham (2007), Shinn et al. (2007), Ravenhill (2008), Nooe and Patterson (2010) and Straaten et al. (2018). Single adult homelessness might be considered the epitome of social exclusion.

Being estranged from familial supports can cause additional pressures for Māori who are homeless. In research about Māori who were homeless, some expressed a profound sense of whakamā (shame and humiliation) at being disconnected from the whānau (family) (Shiloh Groot & Peters, 2016). Similarly, some thesis participants who were Māori expressed that they were too whakamā to seek help from whānau when in crisis. Additionally, some felt whakamā that they had been turned away from help from family. Māori thesis participants rarely described disconnections from cultural ties as an influence on their homelessness. The silence around cultural strengths and cultural supports however was likely itself a consequence of this disconnection, suggesting a “hidden” pathway. This absence of commentary among thesis participants points to the need for ensuring supports are culturally safe and embedded in Te Ao Māori (the Māori world view).

7.1.4 Poverty

Participants had low incomes, high debt, little-to-no financial reserve, and little-to-no access to additional forms of legal or socially acceptable income producing opportunities. Having a constrained level of disposable income, sometimes as little as \$30 per week, limited participants’ options when in personal crisis. Participants were almost universally receiving welfare income (n=97). They concluded that their benefit income levels had not kept pace with the cost of renting and other essentials such as food. Some commented that one small increase in essential costs of living was enough to add significantly to their existing sense of precarity. Some were substituting their weekly income with provisions from food banks, and by attending free community meals. Some had resorted to survival shop lifting and survival sex to make financial ends meet. These survival behaviours are common among cohorts of single adult homeless in other countries (Suzanne Fitzpatrick et al., 2013; Ravenhill, 2008). Researchers from other countries have observed that people who have adequate income can usually avoid homelessness, even if they are experiencing personal crisis (Suzanne Fitzpatrick et al., 2000). Thesis results therefore corroborate the consensus finding that those living without an adequate income are at a greater risk of multiple poor social outcomes including homelessness (Boston, 2013; Suzanne Fitzpatrick et al., 2000; Hodgetts & Stolte, 2017; Rua et al., 2019; Shinn et al., 2007; Tanielu et al., 2020).

Participants had high estimated levels of debt, on average \$11,000 per person. Those involved in the feedback sessions unanimously concluded that this amount was probably an underestimate. By far the largest contributor to high debt levels were government departments. Over 63% of participants

estimated debt was institutional debt, owed to Work and Income mostly for welfare debt, advances or Child Support amounts collected by Work and Income, owed to Courts for fines and reparations, in Student Loans and in tenancy related debt owed to the government's public housing provider, Kāinga Ora/Housing New Zealand. One participant expressed a sense of loss of agency over his benefit in relation to the way government departments are able to make deductions from benefit income before the beneficiary receives the remainder. The call for responsible debt levying on the part of government departments was part of a recent report in the UK; the authors cautioning their government to ensure that inter-departmental debt deducted from benefits was not a driver of hardship and destitution (Bramley et al., 2020).

Participants saw work as one way that they may have been able to afford more housing options when in crisis. Nearly all of the participants had worked before (n=75) or had work related qualifications (n=17). This is not an unusual finding, as other research has shown that people homeless have work experience in their past. A Canadian study involving 2,148 mostly single adult homeless across five cities found that over 65% of participants had been employed in the past (Goering et al., 2014). This is contrary to popular stigmatising of single adult homeless as work-shy (Clapham, 2007).

Despite many being willing to work and having prior work experience, many participants had encountered multiple barriers to being offered work. Barriers included having a criminal record, having health and wellbeing issues and being a person of colour. These barriers are not unique to those who have experienced homelessness and are seeking employment (Poremski et al., 2016). However, research has shown that this cohort may have additional barriers to employment, such as worries about having to explain gaps in their work experience during episodes of homelessness, fears about continued substance use and fears about re-experiencing homelessness-related trauma.

In other countries, governments are being urged to ban criminal record checking to remove this as a barrier to both employment and housing (Lake, 2021). Several American states have enacted Clean Slate laws aimed at sealing certain qualifying criminal records. Additionally, there are current moves to include legislation in the American Fair Housing Act which would prohibit landlords from discrimination based on criminal conviction. This may lessen the cycle of those exiting prison to homelessness, counter racial inequality in housing security, and strengthen reintegration of this cohort into housed and working society.

Among thesis participants, being unemployed had also been a barrier to being offered private rental tenancies. These findings therefore link in with research from both New Zealand and other countries about the importance of supported employment services to help people with multiple barriers to get back into the workforce (Lockett et al., 2018; Poremski et al., 2016; Tsemberis, 2015). Authors such as

Poremski et al and Tsemberis conclude that programs aimed at reducing episodic homelessness should include supported employment services. Supporting people to access and sustain work has social and economic benefits including reduced welfare dependence, and reduced health service utilization. Having a higher income, and being part of the waged community, would also likely provide more options when in personal crisis, including a housing crisis. More disposable income, increased social capital, and less barriers to renting alternative accommodation, are a few benefits of working. Work is therefore likely a protective factor against single adult homelessness.

7.1.5 Systems failure

There is existing evidence that systems failure has contributed to homelessness in New Zealand (Shiloh Groot & Mace, 2016; Hodgetts et al., 2014; Lawson-Te Aho et al., 2019; Leggatt-Cook, 2007; Nevil Piere et al., 2019; Rua et al., 2019). Thesis findings therefore further corroborate this understanding. In-depth interview participants indicated they felt a high degree of institutional distrust and abandonment from the many organisations they had been connected with throughout their lives. Some who had been through an out-of-home placement in youth had experienced a sense of abandonment when aging out of care, feeling like they had been “tossed aside” to fend for themselves. Many felt abandoned on exiting prison and rehabilitation centres. A lack of organisational support at such critical points had contributed to episodes of homelessness for some. Some indicated a loss of institutional trust, which had built up over many episodes of inadequate interaction between participants and mostly government departments. This included being declined support for assistance with food and with emergency housing. Some participants indicated that there was a general ignorance among social sector workers about the traumatic lives many people homeless had endured. This had contributed to fraught interactions with these organisations.

Participants had endured stigma related to their appearance while homeless, their use of various substances as coping strategies (to manage often undiagnosed post-traumatic stress conditions and the precarity of their circumstances), a perceived lack of ability to navigate bureaucratic processes and their past justice system histories. Former prisoners are at a higher risk of homelessness than the general population, because corrections histories can result in discrimination when attempting to secure accommodation (Baldry et al., 2006). Any time spent in prison can also cause housing disruption, due to having to immediately relinquish a tenancy at the point of sentencing leading to incarceration (Nevil Piere et al., 2019).

Participants talked about episodes of racism experienced during interactions with the medical, justice and welfare systems, with real estate agents and with other community organisations. Existing literature has linked racism and homelessness in New Zealand, particularly as it relates to Māori who

are homeless and to both individual or personal experience of racism and systems failure (Lawson-Te Aho et al., 2019). Therefore, the findings of this research build on this understanding. Overall, however, despite a specific question designed to capture participant narrative about the over-representation of Māori homeless in Hamilton, surprisingly few participants commented about this. Some participants did make reference to a sense that being Māori precluded them from equitable access to community resources in general, including housing. A lack of comment may be related to a perception about the researcher's ethnicity. Despite the researcher having Māori ancestry, being of a predominately New Zealand European appearance may have been a barrier to the free flow of narrative about this topic. Alternatively, lack of comment may be an indication of internalised racism (C. P. Jones, 2000). Perhaps Māori participants had accepted negative messaging about their abilities and intrinsic worth, resulting in self-imposed limitations in their right to self-determination and equitable access to resources in the community. Furthermore, lack of discussion regarding racism may also stem from long-standing disconnections from the sociocultural supports provided by access to identity. Disconnection from whānau (family) structures, as described by these participants, including those that had experienced state care, is also associated with disruption of identity and cultural ties. In turn, disconnection from identity influences perception of racism (L. T. Smith, 2013).

Ineffective, sometimes dehumanising interactions with social services and government departments led some participants to avoid asking these organisations for help when in crisis. This type of experience has been noted in other local studies involving vulnerable cohorts (Shiloh Groot et al., 2008; Shiloh Groot & Peters, 2016; Rua et al., 2019). Institutional inadequacy in supporting vulnerable cohorts is a form of systemic social exclusion (Clapham, 2007; Straaten et al., 2018). Some participants had been denied resources at critical points and many felt abandoned by these organisations when at risk of homelessness. A lack of organisational support and understanding contributed to immediate episodes of homelessness for some. This study therefore corroborates the findings of a recent review of social service systems (New Zealand Productivity Commission, 2015) which concluded that some of New Zealand's most disadvantaged people have been inadequately served by these systems. The report concluded that people with complex needs often lacked the experience, information, or social supports to navigate social services equitably. Additionally, social services may lack a genuine understanding of people's lived experience (Rua et al., 2019), including an understanding that people are often survivors of a high degree of trauma and lifelong instability (Padgett et al., 2016; Tsemberis, 2015). This thesis adds to literature aimed at rectifying this deficit.

7.1.6 Constrained housing supply

The main reason people came to TPP for help is because they could not find alternative affordable or safe accommodation for themselves. A lack of access to housing was the prime presenting issue for people. There is consensus that New Zealand has a housing shortage (A. Johnson et al., 2018) and that a constrained supply of affordable housing contributes to homelessness. The issue of housing shortage is exacerbated for the single adult homeless in Hamilton because there appears to be a pronounced shortage of affordable and appropriate single person housing in this community (Brame, 2018). This includes both private rental properties and public housing. Of the total number of people throughout New Zealand waiting for public housing in September 2020, for example, 44% were waiting for a one-bedroomed property (Ministry of Social Development, 2020a).

Participants had experienced high competition for a limited supply of affordable single-person housing on offer in Hamilton. This is partly because there is a large student population in Hamilton (approximately 40,000 before COVID-19 restrictions from 2020 onward), with two large tertiary providers within the city (Brame, 2018). There are also many single people exiting two prisons in the region, most of whom may have lost their accommodation due to periods of incarceration (Baldry et al., 2006; Nevil Piers et al., 2019). Therefore, high competition for low-cost single-person housing evidenced in this thesis has also contributed to single adult homelessness in Hamilton. A lack of supply of single-person housing has also shown to contribute to single adult homelessness in other countries (Culhane et al., 2013).

Because of this lack of availability of appropriate, affordable housing, participants were often forced to accept renting cheap but substandard, mostly co-living style accommodation. While this type of housing provided shelter, and some with a sense of increased security (due to the level of scrutiny assisting in keeping away unwanted guests) other participants said a room in a complex was not the same as a home. It did not contribute to an overall sense of ontological security (Dupuis & Thorns, 1998; Giddens, 1991). It did not afford them the opportunity to attempt to reignite kinship networks due to physical constraints and rigid tenancy conditions. Participants were deterred from having friends and family to visit. One participant gave up her accommodation in this style of housing to return to the streets. This was due in part to issues with others in the complex, lack of space for visitors, the communal nature of the shared spaces, and a lack of privacy. The relegation of those with multiple barriers to renting substandard housing in boarding and co-living circumstances is well documented in homeless research from both New Zealand and other countries (J. T. Anderson, 2016; Shiloh Groot & Peters, 2016; A. Jones & Pleace, 2010; MacKenzie & Chamberlain, 2003; Ravenhill, 2008).

Many participants indicated that while supporting single adult homeless to access housing was critical, ongoing support was equally important to help stop people returning to homelessness when in personal crisis. Support was required to help people settle in, to assist them with their health and wellbeing issues, and to help access work and other meaningful activities. This support needed to be delivered in a trauma-informed and respectful manner. It was also required for duration of need. Facilitated access to permanent accommodation with ongoing support to help people sustain their tenancies is fundamental to the Housing First approach (Tsemberis, 2015). A person-centred, harm-reduction, and trauma-informed approach with support for duration of need is advocated. Housing First is an approach adopted and funded by the New Zealand government to alleviate homelessness (Ministry of Housing and Urban Development, 2020). This approach is also an important element in this country's first National Homeless Action Plan.

The overrepresentation of Māori among homeless cohort in New Zealand is linked to the enduring effects of colonisation (Lawson-Te Aho et al., 2019). There is evidence in thesis findings of experiences of institutional and personally mediated racism levied against Māori participants (C. P. Jones, 2000), as well as suspected but not articulated disconnection from sociocultural supports and cultural ties, which had contributed to many Māori participants feeling additionally isolated when facing homelessness. Local researchers have recommended adaptations to Housing First housing interventions incorporating Kaupapa Māori principles which may go some way to addressing the additional complexities some Māori experience while homeless and ensure that homelessness response is culturally safe in this country (Lawson-Te Aho et al., 2019).

Recommendations include adopting a Whanau-Ora (family wellbeing) approach, involving a shift away from individual intervention-driven provisions to a greater focus on family self-management and independence, based on building determinants which allow families to flourish (Te Puni Kokiri, 2015). Findings from this thesis however highlight the complexities a whānau-based approach may pose for some participants for whom separation from family is rooted in ACE's. There is a delicate nature to reuniting these families, particularly later in adulthood, with some participants seeking to avoid such a reunion based on these historic events.

Additionally, Lawson-Te Aho et al (2019) recommend applying principles of Māori cultural housing design to homeless solutions, which might result in collective, multi-dwelling styles of housing, perhaps built on ancestral land. Thesis participants advocated for Māori support structures such as Iwi (tribe) and Hapū (subtribe) to be included in the design of homeless solutions, including housing solutions, in Hamilton. This was particularly to support local Iwi tribal members who may be homeless.

Moreover, many participants (irrespective of ethnicity) felt socially disconnected from kinship networks. Therefore, a collective style of housing may help alleviate feelings of social exclusion.

A collective housing solution does, however, sit contrary to the scattered site housing approach recommended under some Housing First approaches (Tsemberis, 2015), which advocate that no more than 20% of formerly homeless program participants be housed in one complex or area. This approach encourages social inclusion, with other tenants in a housed community providing a normative context for neighbourhood behaviour (Tsemberis, 2010, p. 22). Scattered site approaches are also said to counter “ghettoizing” which might result from grouping similarly disadvantaged individuals with high and complex needs in one place. Findings from this thesis extend this view, with some participants cautioning against encouraging formerly homeless people to take up tenancies in co-living circumstances, often situated in collective, multi-dwelling housing, with communal facilities. Many thesis participants did not consider this style of housing to be a home, the co-living configuration often impinging on a sense of ontological security for many.

7.1.7 Summary of contributing factors.

Overall, the research findings fit with the broad consensus of understanding about the main contributing factors to single adult homelessness identified in research and other literature from both New Zealand and other countries. While lack of access to safe, affordable, appropriate, and permanent housing was the main reason participants presented at TPP for support, it was but one of an array of contributing issues people were facing. Traumatic events in childhood, an out of home placement and ensuing disruption throughout adolescence contributed to multiple poor biopsychosocial outcomes across the lifespan. Early separation from familial and kinship networks had a lifelong effect, contributing to participants having fewer people to turn to when facing homelessness. Estrangement from later-life family units and partners also contributed to participants being both single and facing homelessness feeling alone. Social exclusion was a significant contributing factor increasing the risk of homelessness in Hamilton. An erosion in institutional trust and a lack of organisational support at critical points, also added to the sense of social isolation. Systems failure therefore also contributed to a raised risk of homelessness in Hamilton.

Participants lacked access to minimally adequate financial resources which limited their options when in personal crisis. Participants had low incomes, and high debt, most of which was owed to government departments. Poverty had contributed to a raised risk of homelessness.

Mental health issues and problematic substance use were existing issues, having mostly first manifested in participants’ youth. Substance-based coping strategies contributed to estrangement from family and kinship networks, to discriminatory treatment when applying for rental properties

and work, the loss of tenancies and to a high rate of sustained involvement in the justice system. Any time spent in prison contributes to housing instability.

Discrimination, including racism, was experienced in participant's dealings with various government agencies and community organisations, with the health sector, and with landlords and real estate agents. Systems-level racism was described, as well as disruption from cultural identity, which limited some participant's expectations about equitable access to resources in the community, including housing.

7.2 Pathway to single adult homelessness in Hamilton.

Overall, results revealed a pathway to single adult homelessness, which is represented in the ACE Pathway in Figure 2, page 183. This pathway is made up of a set of occurrences, each of which happened for nearly half (45%) or more of the participants. Inclusion of age of first occurrence in the questionnaire allowed for an understanding of the chronology of these common events.

The ACE pathway is similar to homeless pathways identified in research about single adult homeless in other countries. Some typical homeless pathways were outlined in Table 2 in section 2.5. The ACE pathway identified from thesis data most closely resembles the Child Abuse Pathway identified by Ravenhill (2008). Ravenhill's research involved a large sample of homeless youth and adults across five cities in the UK. Ravenhill's Child Abuse Pathway identified ACEs as a precursor to a high incidence of post-traumatic stress, disrupted schooling, disrupted social networks, time in state care as children and in youth, and time in prison. Each of these events contributed to an increased risk of homelessness. Participants also commonly experienced low self-esteem, and a high prevalence of self-harming behaviours and problematic substance use. Participants' lives also commonly included a high incidence of violence, including domestic violence. Each of these elements are reflected in Figure 2 and among the other contributing factors discussed throughout this chapter.

The ACE pathway is also similar to the Youth to Adult pathway identified by Chamberlain and Johnson (2013) in Australia, primarily centred around experience of a traumatic childhood and adolescence. However, Chamberlain and other authors, make further differentiations between homeless pathways based on more specific groupings of common experiences. For example, those whose main contributor to their homelessness appeared to be problematic substance use or mental health issues were categorised separately by some authors. Another common category is those whose homeless episodes are mostly related to family breakdowns. Similarly, Suzanne Fitzpatrick et al. (2013), Piat et al. (2015), Woodhall-Melnik et al. (2018) and I Anderson and Tulloch (2000) show various subgroupings of contributing experiences. Further analysis of thesis data may have revealed variously differentiated pathways. However, the almost universal prevalence of ACEs among participants

suggests that in this case, traumatic events in childhood were the main catalyst contributing to chaotic life paths; one set of early-life experiences from which various differentiated, unique, and personal journeys permeated, all leading to an experience of homelessness for the participants.

The results of this study also suggest the ACE pathway represents a series of disruptive life events which increase people's risk of hospitalisation in acute mental health facilities, and time spent in substance rehabilitation facilities, mostly during people's adolescence. Similar patterns of disruptive early-life experiences have shown to contribute to young New Zealanders being drawn into the "prison pipeline" (Gluckman & Lambie, 2018). Therefore, the ACE pathway represents a set of early-life events that likely greatly increases people's risk of being drawn into pathways to multiple poor biopsychosocial outcomes, such as prison, rehabilitation, acute mental health facilities, and homelessness.

The ACE pathway reflects a destructive interplay among individual factors such as dislocation from familial and kinship supports, mental health issues, problematic substance use, high debt, low income, involvement in the justice system and transience (Piat et al., 2015). Individual risk factors are amplified by structural issues, such as a lack of housing, substandard housing, poverty, and unemployment (Isobel Anderson & Christian, 2003). Inequitable access to community resourcing is evidenced. Systems failures contributed (Nevil Pierse et al., 2019). People lost faith that the organisations they were part of would help them when facing a crisis. This includes a loss of trust in the welfare system, the justice system, and the health sector, as well as other community organisations. An erosion of trust in government departments and social sector organisations has been noted in other research involving these sectors in New Zealand (New Zealand Productivity Commission, 2015; Welfare Expert Advisory Group, 2019). Distrust is further exacerbated by discrimination and racism. Systemic stigmatisation and discrimination is a common experience for people who are homeless, both in New Zealand and in other countries (Shiloh Groot & Peters, 2016; Lawson-Te Aho et al., 2019; Mejia-Lancheros et al., 2021).

One of the strongest themes to come through in this research is that participants mostly faced the prospect of homelessness feeling socially isolated. They were either too *whakamā* (shy, humiliated) to ask family for help or they were estranged from familial and other kinship supports. Disruption in these links can be traced back to family violence in participants' childhood households and removal to out of home placements. This element is represented in Figure 2 as a loss of contact with family and other social supports, "bridges burned", denoting an inability to connect with family due to having worn out one's welcome in the past, and later-life breakdown in adult relationships due to separation, divorce, or death of a life-partner.

7.3 Points of intervention

The chronological nature of the ACE pathway, and the addition in this thesis of the timing of events, provides a clear road map of points of intervention across participants' lifespans. In-depth interviewing provided an opportunity for participants to detail interventions that had worked for them, and to discuss resources and support options they would have welcomed through their lives. These points of intervention will be discussed in terms of the three domains identified in analysis of results, namely: early points of intervention in a pathway to homelessness and other poor social outcomes; points of intervention when someone has already been drawn into this pathway; and points of intervention once already homeless, looking to prevent subsequent episodes of homelessness. The points and methods of intervention raised in this research will be compared to extant literature. A summary of the key recommendations is included in the interventions section of Figure 2.

7.3.1 Prevention and identification of risk

In-depth interview participants mostly started discussion about homelessness prevention from the point of needing to better support survivors of traumatic early-life experiences, as well as supporting at-risk families. Participants advocated for more easily accessible support and for safe and discreet methods of disclosing family violence and abuse. Additionally, participants advocated for positive adult role modelling for at risk children and youth and for better alternatives to out-of-home placement where possible.

Results also showed that most participants started life in what might be considered stable permanent housing (n=84), where care givers were in paid work (n=75). Having stable housing at this time and caregivers in paid work was not enough of a protective factor to prevent ACEs from ensuing. It is often assumed that providing families with adequate housing and sufficient access to income may contribute to preventing family violence occurring. However, this was not the case for most participants. These results build on findings from enquiry into the adequacy of welfare income in New Zealand (Kiro et al., 2019). This report showed that 240,000 children were living in households deemed to be living in poverty (with household incomes below a poverty threshold), and 40% of these children were living in working households. Therefore, some working parents in stable housing are still living in poverty, and these two elements, housing, and income, are not necessarily protective factors against ACEs.

The number one substance implicated in participants' experience of family harm as children was alcohol. Some advocated that the sale of alcohol needed to be restricted to lessen its impact as a

contributor to family violence. For some this advice was shared as both a victim of family violence in childhood, where alcohol contributed, and as one who had contributed to family disruption in their adult relationships, where problematic substance use played a part.

Participants' recommendations about ways to support families where ACEs have occurred are in line with recommendations from multiple government reviews of social service in New Zealand. Various reports have recommended early intervention for at risk children, youth, and families, as a means of circumventing people being drawn into pathways to multiple poor social outcomes (Gluckman & Lambie, 2018; Lambie, 2018; New Zealand Productivity Commission, 2015). There are issues identifying people at risk of poor future outcomes. An attempt by MSD to use predictive risk modelling aimed at identifying children most at risk of abuse by age five was challenged due to ethical and probably political concerns (Vaithianathan et al., 2013). There are organisations, such as Centrelink in Australia, however, who are identifying people at risk of homelessness in their client database (Scutella et al., 2017). Therefore, identifying vulnerable cohort in large systems databases is possible, although the integrity of such identification relies on open disclosure by service users. The depth of disclosure itself rests on the quality of the relationship between an organisation and service users. Once risk is identified, the type of intervention put in place is also critical, so that such screening for risk does more good than harm.

Participants' suggestions for homelessness prevention also closely aligned with family harm prevention guidelines adopted in other countries. One example is the following broad approach advocated by the Centre for Disease Control and Prevention (2019) in the USA. Policy supporting the following outcomes is recommended:

- Strengthening economic support for families.
- Promoting social norms that protect against violence and adversity.
- Promoting a strong start for children
- Resilience building among youth and parents.
- Positive adult role-modelling
- Connecting children and youth to pro-social activities, such as sporting activities.
- Intervening when ACEs have occurred and providing support for families.

(Centers for Disease Control and Prevention, 2019 p. 9)

Literature concludes that the responsibility for reducing family violence in a community cannot sit with one government department. The role and responsibility of intervening when ACEs have occurred must involve other community and social sector agencies, and often those already involved

with families (Felitti & Anda, 2014; Lambie, 2018). This can include midwives, doctors, and early-childhood centres. Quality childcare has shown to be a protective factor against ACEs (Walsh et al., 2019b). Other organisations such as family support services, child protection services, and schools have a part in detecting and supporting children and families at risk (Lambie, 2018; Ravenhill, 2008). Children often have their first homeless experience when in school (G. Johnson & Chamberlain, 2008). Therefore, programs that prevent teenagers who are homeless dropping out of school are advocated. Additionally, interventions need to target teenagers who have been in child protection services and in out-of-home placements as they are at a greater risk of homelessness.

7.3.2 Interrupting pathways

Many agencies and organisations had been involved throughout the lives of participants. These included child protection services, youth justice services, police, corrections, courts, hospitals, mental health facilities, rehabilitation centres, food banks, community meal providers and social welfare agencies. Existing research involving administrative data about a TPP cohort showed that program participants had interacted with government agencies including the welfare, justice and health sector at a much higher rate than non-homeless New Zealanders and for long periods of time (Nevil Piersé et al., 2019). Despite this level of interaction, spanning periods of up to 30 years, homelessness still ensued. Research from other countries has concluded that each point of interaction with these agencies and organisations is also a potential point of positive intervention in pathways to homelessness (G. Johnson & Chamberlain, 2008; Ravenhill, 2008). Homelessness is therefore a manifestation of systems failure, particularly a failure on the part of community organisations to intervene appropriately to avert people from homeless pathways.

Community organisations have a duty of care in supporting people they may have identified as being at risk, especially if people have been consistently presenting when in crisis. Further, existing research advocates a better co-ordinated community response to supporting people at high risk of multiple poor social outcomes including homelessness (Nevil Piersé et al., 2019). Without this co-ordination, people simply fall through the cracks between social sector and community providers into homelessness (Al-Nasrallah et al., 2005; Shum, 2021).

Participants felt that many organisations they were connected with appeared to lack a genuine understanding of pathway to homelessness. This lack of knowledge among social services has been noted in other local research (Rua et al., 2019). Without this information, many participants concluded that organisations lacked an understanding of a need for a trauma-informed approach to supporting people asking for help. This finding corroborates other research which has concluded that many social services fail to adequately account for the lifelong effects of trauma in the lives of their clients

(McKenzie-Mohr et al., 2012). Trauma-informed approaches to supporting people who are survivors of ACEs have been adopted and mandated by government policy in other countries (California Department of Health Care Services, 2020; House of Commons Science and Technology Committee, 2018). Trauma-informed practices have been implemented across health sectors in places such as England , Wales and Scotland (Couper & Mackie, 2016). Adopting a more trauma-informed approach across New Zealand’s social sector agencies and organisations may help rebuild trust between organisations and their service users and encourage people to ask for help when needed.

Participants advocated for improved and sustained support from the health sector, particularly for those with existing mental health issues and problematic substance use. Participants concluded that having appropriate and sustained support for these issues may have reduced the impact and contribution these health issues had when people faced a personal crisis. There was a call to health professionals and other social sector organisations to develop a better understanding of coping behaviours, such as substance use. Often coping mechanisms developed as a consequence of the traumatic events that had occurred in people’s early lives. There is a growing understanding in research and literature from other countries around reframing health behaviours such as problematic substance use as a coping behaviour (Maté, 2012; Watson et al., 2016). Health and social sector professionals who understand these health behaviours can then apply a trauma-based response to supporting people and can advocate for public health initiatives that provide more comprehensive and holistic care for people.

Participants advocated for improved access to income because having more money would have allowed people to have more options when in housing crisis. This finding is corroborated by other research which has concluded that people with access to an adequate income can often resolve their own housing crisis (Suzanne Fitzpatrick et al., 2000). Benefit incomes have not kept pace with inflation in New Zealand (Boston, 2013). A recent review of the adequacy of welfare income in New Zealand concluded that many people were living desperate lives due to seriously inadequate incomes while on a benefit (Kiro et al., 2019). Among participants, desperation included resorting to survival shoplifting and survival sex to get by financially.

Most of the participants had worked before and most wanted to get back to work. They saw work as a way of improving their financial circumstances as well as improving their self-worth by giving them a purpose. Being part of the waged community would also likely improve property renting prospects, as many had concluded that landlords favoured offering tenancies to those in work. This finding corroborates existing New Zealand research highlighting the importance of supported employment

programs to help reduce inequitable access to work for people with health issues and other barriers (Lockett et al., 2018).

Finally, people wanted improved and equitable access to affordable, safe, and appropriate permanent housing. As previously discussed, a lack of housing in the community, particularly affordable single person housing, meant people were relegated to accepting substandard housing options, living doubled up with friends and family, in emergency or temporary housing, or resorting to homelessness. Having access to a ready supply of affordable housing would have lowered the risk of people becoming homeless in Hamilton.

7.3.3 Crisis points

Once homeless, participants advocated for easily accessible support to navigate the process of finding the housing they needed. After being rehoused, they sought support to help maintain their housing and get on top of the many issues that had contributed to their housing crisis. In the process of finding housing, support was sought from social services for help to pay for rental bonds, for utility bonds, for support to furnish a property or for an assessment for public housing. The Productivity Commission concluded that people with complex needs, such as many single adult homeless, often require support to navigate social services equitably (New Zealand Productivity Commission, 2015). Single adult homeless in other countries have similarly advocated for specialist homeless services in a community, specifically services that help with navigation of social systems and who provide continuity of care once housed (Ravenhill, 2008). Providing support to access permanent housing and ongoing support post-housing is the basis of the Housing First approach to alleviating homelessness (Tsemberis, 2015). Given these participants were being supported by an organisation applying a Housing First approach, it is unsurprising that the elements of this approach have been recommended.

7.4 Study design strengths and limitations

The design of this study allowed for collection of both qualitative and quantitative data, representing a rich source of information about factors contributing to single adult homelessness in Hamilton. This section explores the strengths and limitation of the methodology that framed this research. Areas for future research are also highlighted.

7.4.1 Strengths

This study's design was aimed at collecting and presenting data about homelessness, a sensitive social subject, in a non-exploitive and empowering way for people, at the same time collecting evidence to achieve the research objectives. Adopting critical realism was the right approach for many reasons. Firstly, this worldview situates people with lived experience at the centre of this enquiry, as they are

the experts about this topic. This approach was communicated at engagement and was empowering for participants. Many were motivated to be part of the research because they wanted to be part of something that might result in positive change for people experiencing homelessness, or better still prevent homelessness occurring.

Secondly, this approach advocated collecting data from as many viewpoints and aspects as possible. The mixed method approach allowed for a collection of both quantitative data and qualitative narrative, along with field notes and reflexivity observations. This combination, which is integrated in the discussion of this thesis, provides rich evidence, informed by those with the most knowledge about homelessness. On reflection, it is doubtful that either the quantitative data or qualitative narrative alone would have provided sufficient evidence or insight into the full range of, or level of impact of, contributing factors identified. For example, in relation to the contribution that estrangement from familial and kinship support played in people's pathway to homelessness, the strongest themes about this element came from narrative data. Quantitative data played more of a support role in bringing this important element to the surface and supported appropriate enquiry for the qualitative process.

Meaningful and appropriate participant inclusion was achieved in all aspects of this research, including, framing, and validating the results (Martin & Kunnen, 2008). One-on-one feedback sessions allowed participants to be included in the synthesis of the results. Important insights from these sessions were included in analysis and changes were made to the wording included in the ACE Pathway diagram. Each feedback participant confirmed they could trace their own trajectory into homeless through the results presented, providing additional strength in validation.

A pathways approach netted an important understanding about people's trajectory into homelessness. One of the key elements of data collection was the inclusion of age that an experience first occurred, both in the ACE questions and the MEH questions. This allowed for a clearer chronological understanding of the series of common events. Collecting data solely based on prevalence may not have resulted in as clear a picture, nor the specific ability to focus on potential timely interventions. These data facilitated a clearer understanding of important points of potential and early intervention, involving the right resources or support, to interrupt entry or continued inclusion in, a pathway to multiple poor social outcomes, including homelessness.

7.4.2 Limitations, research challenges and areas for future research.

This research is limited to the study of a single cohort of single adult homeless in New Zealand and is based on a non-random sample from a singular homeless service, in one region of this country. Other regional contextual issues may not be reflected in these results. For example, Auckland has different social, cultural, and environmental influences. This includes greater ethnic diversity than Hamilton.

More Pacific people are homeless in Auckland than in other regions (K. Amore, Viggers, H, Baker, M, Howden-Chapman, P, , 2016). The voices of Pacific people are not included in these results. Therefore, more research is needed to test regional differences.

TPP has a Housing First approach to service delivery, and this is the context within which participants may have framed their view of recommendations for support of people experiencing homelessness. Including people from other services may have resulted in a more holistic understanding of recommended crisis support measures. For example, one way to add additional diversity to this understanding would be to interview single adult homeless engaged with Kaupapa Māori services (based on Māori principles and values).

Institutional trust built up between program participants and TPP staff over time provided for a context conducive to participants being willing to share information about their more difficult life experiences. An inclusive, non-judgemental approach to service delivery is part of the philosophical underpinning of a Housing First approach (Tsemberis, 2015). This element is primarily a strength for this study. However, the significance of the context of the research being a Housing First homeless service is not known, which affects the generalisability of research protocols. For example, participants may not have been as forthcoming if interviewed about their homeless experiences while in prison, while in a Transitional Housing services or an Emergency Housing setting. The influence of the TPP environment on information provided cannot be determined.

Along with understanding if there are important regional contextual contributing factors, and important variations in recommendations for intervention between various types of homeless service providers, more research is needed to understand if the ACE pathway identified applies to families and youth who are homeless, as participants were single adults without dependent children. That said, many had experienced homelessness in youth, some had experienced homelessness with their families, and many were parents themselves. Further research is needed to determine if the ACE pathway identified applies to these and other cohorts.

The questionnaire relied on each respondent's retrospective account of events, including their earliest recollection of familial disruption in their childhood home. There is some criticism regarding the accuracy of information gained from people's long-term retrospective recall (Bryman & Bell, 2015; Larkin & Park, 2012). However, research from New Zealand involving the 10-question ACE test, specifically testing the reliability of ACE recall among participants, concluded that retrospective and prospective measures of adversity showed moderate agreement (Reuben et al., 2016). Reuben et al. concluded that an individual's disposition may lead to bias toward under or overestimating some adversity, although variation in this study was modest.

There was insufficient evidence to determine the impact two large prisons and existing and historic acute mental health facilities in the region may have had on single adult homelessness in Hamilton. More information would need to be collected to determine if unsupported exits from these specific institutions contributed directly to homelessness in this region. Further, the questionnaire and methodology were not able to determine the influence of additional specific health conditions in pathways to homelessness. These conditions include Traumatic Brain Injuries and Foetal Alcohol Syndrome Disorder, conditions which are of interest to TPP staff based on their history of support. This may be because these conditions are complex to identify and diagnose in isolation. More research is therefore needed in these areas.

Participants commented that the questionnaire did not measure the impact of the death of other family members and significant people in their lives on their pathway to homelessness. A question was asked about the death of a long-term partner. However, people talked about the impact the loss of a child had on their lives as well as other important family members, such as grandparents. Future research should therefore include questions specifically testing the impact of the death of other influential and significant figures in people's lives.

There was insufficient local comparative data about the ACE prevalence among other homeless cohorts in New Zealand. To my knowledge there have been only three other studies using the 10-question ACE test carried out in New Zealand. One involves a general population cohort from the South Island (Reuben et al., 2016), one involves a general population cohort from three regions in New Zealand (Waikato, Northland and Auckland), and one involves a cohort of young children growing up in New Zealand (Walsh et al., 2019a). In the latter two studies, only 8 of the 10 ACE questions were used. Random sampling of a large cohort of New Zealander's, using measures such as the ACE test, as well as testing for lifetime prevalence of homelessness, would provide a national baseline about abuse in childhood among those ever homeless. This would provide valuable evidence to inform policy about reduction of family violence and treatment protocols and approaches for those identified as homeless.

Based on participant feedback, question wording in the ACE test limited the collection of responses about partner domestic violence in participants' childhood homes. The question asks about intimate partner violence perpetrated against a female caregiver. Participants reflected that sometimes these roles were reversed, and physical violence had been perpetrated against their male caregiver by a female caregiver. Therefore, data collected about inter-partner physical violence in participants' childhood homes is likely under-estimated.

Undertaking research in sensitive fields such as homelessness requires strategies that recognize the impacts of this type of research on researchers as well as participants (Martin & Kunnen, 2008, p. 71).

Researchers are open to being emotionally affected by the stories and experiences they hear during the research process. Martin and Kunnen (2008) note that this element of researching those who are homeless has received little attention in academic literature.

Although the details of the trauma people had survived was never requested nor discussion of details encouraged, participants often disclosed details about their abuse to the researcher. Often this was the first opportunity people had been given to talk about their abuse, and some treated the process as a form of therapy. Researchers such as Last (2020) document the potential for secondary traumatization of researchers. Support structures must therefore be an integral part of the research process (Martin & Kunnen, 2008). Debriefing was an essential part of each regular research supervisors' meeting during the data gathering phase for this thesis. My personal recommendation is that no more than three interviews per day be conducted with people, particularly if the 10-question ACE test is part of surveying.

The association between racism and colonization as it contributes to a raised risk of single adult homelessness is sparingly represented in this study, despite increased interest and research evidence in this area within related research. While some in-depth interview participants did comment about racism generally in their lives, and some questionnaire participants indicated they had been discriminated against based on race when viewing rental properties and while interacting with various social services, there was an absence of any strong themes about this in the data. This may be because questions were poorly tailored or that participants may have been resistant to disclosing their feelings to someone whose appearance is that of a New Zealand European. A lack of a strong theme around racism as it links to a raised risk of homelessness may also be a sign of ongoing fear, distrust, disempowerment, loss of cultural connectivity and identity, and the effects of colonization, both historic and ongoing (Pihama et al., 2014; L. T. Smith, 2013) . Participants may have felt their circumstances were their lot in life (C. P. Jones, 2000). The association between historic and ongoing colonization, racism and homelessness has been explored more fully by other New Zealand researchers in connection with homelessness (Shiloh Groot & Peters, 2016; Hodgetts et al., 2014; Lawson-Te Aho et al., 2019; Leggatt-Cook, 2007; Rua et al., 2019). Thesis results from this research neither adds to nor detracts from existing literature in any significant manner.

Overall, the data collected, both from in-depth interviews and questionnaires, reflect a broad range of opinions about what contributed to a raised risk of homelessness for people. Participants spoke from various vantage points, being both homeless and housed at the time of interview. Most had experienced multiple episodes of homelessness throughout their lives. Feedback sessions confirmed participants' views had been fairly and accurately portrayed in the results. The methodology used was

therefore robust in its ability to produce a large volume of data, and results which meet the aims of the research and the aspirations of the participants involved. The limitations and research challenges identified represent opportunities for future work to improve research processes, as well as highlighting areas requiring further research.

7.5 Implications

This study sought to provide evidence to inform and influence policy to help prevent single adult homelessness in New Zealand. To follow are policy implications arising from this study as well as implications supporting an image change for those single adult homeless in New Zealand.

7.5.1 Policy Implications

To lower the risk of single adults becoming homeless later in their lives, the following policy changes are advocated:

1. Reduce family violence

Family violence is a preventable problem (Lambie, 2018). Targeting a reduction in family violence would lower people's risk of succumbing to homelessness later in life, as well as prevent many other poor biopsychosocial outcomes for people. Programs need to support families at risk (Atwool, 2019; Gluckman & Lambie, 2018; Lambie, 2018), as well as support the building of resilience among survivors (Bethell et al., 2019). Interventions provided must be appropriate, effective, safe, and equitable. Poor investment in interventions that provide safe and nurturing childhoods have been estimated to cost around 3% of GDP (Bellis et al., 2019). This estimation does not include the long-term monetary cost of ACE-related ill health issues, its effect on social issues such as unemployment and crime-related costs such as imprisonment, nor its association with increased risk of homelessness.

Policy aimed at preventing family violence should include the following elements:

- Strengthening support for families, including economic support.
- Promotion of social norms that protect against violence and adversity.
- Ensuring strong starts for children, which paves the way for them to reach their full potential

(Centers for Disease Control and Prevention, 2019).

2. Detecting and addressing the impact of ACEs

Legislation is required aimed at working across health, human services, education, welfare, justice, non-government sectors and communities to detect and address the impacts of ACEs. ACE and protective factor screening is critical. Early intervention is key. However, detection and support of survivors of ACEs at any age is also important. Routine screening for ACEs by General Practitioners (a doctor qualified in general medical practice) is advocated (Felitti & Anda, 2014). This is due to associations between undetected ACEs and survivors with few protective factors, and a raised risk of later-life health and wellbeing complications.

Additional measures are required to support ACE survivors who experience an out of home placement in childhood and adolescence, in foster care, as wards of the state or in other care arrangements. This cohort have a raised risk of future homelessness (Chamberlain & Johnson, 2013).

Methods of detection and intervention must be appropriate, effective, safe, and equitable and provide for ongoing support of survivors. Program approaches must include offering holistic support to families of survivors. An example of a family-oriented approach is the Whānau Ora framework (Te Puni Kokiri, 2015). A family-centered approach would help mitigate the potential for intergenerational transfer of trauma (Atwool, 2019).

Detecting and addressing ACE's is a key preventative measure to reduce risk of future homelessness. This measure would also improve health and wellbeing outcomes for New Zealanders for generations to come.

3. Mandatory trauma-informed training for all social service employees.

Trauma-informed training must be provided to all social services. This will encourage an environment where people are not afraid to ask for help at critical points (Bellis et al., 2019; House of Commons Science and Technology Committee, 2018 ; Lambie, 2018; New Zealand Productivity Commission, 2015). Further, training must seek not only to equip staff to avoid retraumatizing service users, but also with a genuine understanding of the lifelong impact of historic trauma and pathways to homelessness. A sensitive, appropriate, safe, equitable and well-informed mechanism for identifying at-risk cohort is required, as well as a coordinated approach to supporting at-risk people across services (New Zealand Productivity Commission, 2015; Nevil Pierse et al., 2019).

4. Institutional debt reduction and monitoring

Institutional debt has been a contributing factor to single adult homelessness in New Zealand. Legislation is required to encourage responsible debt levying practices and prohibit government departments from collectively levying debt upon a citizen at a rate at which they are unable to sustain a level of wellbeing and equitable participation in a community. This measure will help avoid the deduction of government debt from people's benefits contributing to destitution in New Zealand (Bramley, 2020).

Legislation is required to support the long-term and equitable provision of the following resources (Nevil Piersse et al., 2019). These resources are needed to help people avoid homelessness and to stop people returning to homelessness:

1. Support to find a home – An adequate supply of safe, affordable, appropriate, permanent single-person housing would reduce the risk of single adult homelessness in our communities. However, providing housing alone will not solve homelessness for everyone. Support to help people find a home and sustain their housing is required. Housing First is a program already funded by the New Zealand government to alleviate homelessness. This program supports people who are homeless to access permanent housing, and connects them with supports they may need, once housed. Support is provided for duration of need. International examples of Housing First have demonstrated this approach has proven effective in supporting those in homeless crisis (Goering et al., 2014; A. Jones & Pleace, 2010; Padgett et al., 2016; Tsemberis, 2015). Therefore, legislation to adequately support the continuance and proliferation of this service approach is advocated.
2. Support to access work – People who have access to adequate income have more options in a personal crisis (Suzanne Fitzpatrick et al., 2000). Many people who are homeless have work experience and want support to return to work. Existing research from New Zealand and other countries has shown that supported employment allows those with multiple barriers to access and sustain work (Lockett et al., 2018; Poremski et al., 2016; Tsemberis, 2015). Housing First programs would benefit from incorporating supported employment interventions into their programs (Poremski et al., 2016), as such interventions have shown to improve quality of life, aid mental health recovery and reduce stigma and discrimination for socially excluded populations (Mejia-Lancheros et al., 2021) . Sustained employment has social and economic benefits including reduced welfare dependence, and reduced health service utilization (Lockett et al., 2018).

Additionally, policy and legislation are required mandating ongoing monitoring and evaluation of these programs to ensure program delivery remains appropriate, effective, safe, and equitable.

7.5.2 Other implications

People who are homeless in Hamilton have experienced stigmatization and discrimination, both systemic and personally mediated. This experience is common among homeless cohort, in both New Zealand and other countries (Lawson-Te Aho et al., 2019; Mejia-Lancheros et al., 2021; Rua et al., 2019). This is in part because homelessness suffers with an image problem (Kate Amore, 2019). The dominant view of single adult homelessness is that of personal failing, that people's circumstances are an outcome of bad choices (Clapham, 2007; Parsell & Parsell, 2012). Evidence from this thesis, however, confirm that those who found themselves with nowhere to live have mostly survived a lifetime punctuated with a high level of traumatizing and destabilizing events, which almost universally started with surviving ACEs and often an out-of-home placement in their childhood and adolescence. Perhaps the image of people experiencing homelessness should be reframed as that of Ngā Mōrehu, the survivors. The past and recent pathways to single adult homelessness in this thesis have been exposed as complex, inter-connected and a result of years of discrimination and stigmatization, sometimes exacerbated by prolonged poor treatment by government agencies. Results of this study serve to clarify a few misconceptions about single adult homeless in New Zealand, as follows.

One misconception is that people homeless in New Zealand are work-shy third or fourth generation beneficiaries who have contributed to their own circumstances by refusing to work (Lang, 2017). Participants reported having been berated by passers-by while rough sleeping, or while hustling, suggesting they seek employment as a means of alleviating their circumstances. Similarly, landlords have discriminated against people during the process of applying for rental properties because they are beneficiaries. Additionally, one participant reported that Work and Income have also suggested he seek employment as a means of alleviating his homeless circumstances.

Three quarters of the participants had either worked before (n=75), or had completed schooling or tertiary study, or trade qualifications (n=17). Other research involving single adult homeless has also shown that many people homeless had work experience (Goering et al., 2014). Most participants (n=75) remember their parents or caregiver having worked while participants were living with them as children and most participants (n=85) were brought up in what might be considered stable housing, sometimes owned by their parents, or in a dwelling on ancestral land. Many also recall their grandparents working hard and owning their own homes. Therefore, most participants had work ethic role modelled across two generations as children and most had themselves worked before.

Many wanted to get back to work. However, there were multiple barriers to them accessing work, including discrimination related to people's justice system histories (their convictions sometimes being many decades old), racism, and having various health and wellbeing challenges. At the time of interviewing, over half of the participants (n=56) were on a benefit related to having an injury, health condition or disability, being either on a Supported Living benefit or Jobseeker benefit with a medical deferral from working. Most people were simply not yet well enough to work.

Based on the findings of this research, the image of single adult homeless in New Zealand as work-shy third or fourth generation beneficiaries is ill-founded. Participants were mostly beneficiaries who wanted to get back to work but were unwell, due to injuries, health conditions or disabilities. The remainder were on a benefit type where they could work, however, having no place to live made seeking and maintaining work problematic. Additionally, people had many barriers to accessing work, such as their justice system histories and their perceived communication and literacy barriers.

7.6 Key findings

The key findings from this study show that the contributing factors identified as raising people's risk of single adult homelessness in Hamilton fit with the broad consensus of understanding about homelessness from other countries. The presenting issue for those engaging with The People Project for help was a lack of access to housing. Therefore, housing is a critical element in addressing single adult homelessness. But other measures are also needed to alleviate and prevent this issue.

Along with having nowhere to live, people felt they had no one else to ask for help. They had lost contact with family and other dependable kinship and friendship networks. The fracture in family ties had its roots in disruption and traumatisation during people's formative years, which often included an out-of-home placement through child protection services. Additionally, long-running relationships with a variety of government, social sector and community organisations had not acted as a protective factor. Homelessness still ensued. Social isolation was one of the strongest themes which surfaced from analysis. Participants often faced homelessness feeling alone. Single adult homelessness may be the ultimate manifestation of both social exclusion and systems failure. In this case, systems failure means a failure among social systems and community organisations to take action to prevent those known to be highly disadvantaged among their service users from falling into homelessness.

Along with having trouble finding alternative accommodation and having no one to turn to for help, people generally had no financial reserve to be able to afford alternative accommodation options when they lost their last tenancy. People had high debt and low incomes. A collection of government departments had contributed to this high level of debt. In a benefit money-go-round, people received

welfare income from one government department, only to have large portions of their money deducted to pay debts to other government departments, with the beneficiary receiving the remainder. Sometimes the remainder left people with insufficient money to make financial ends meet, let alone find and secure a place to call home.

Being without a house was the final pain point for many participants, the very end point in a pathway which can be characterised as disrupted and unstable. Multiple and complex biopsychosocial and other issues had accumulated over time. These often-existing issues added pressure to circumstances which culminated in homeless episodes. Health and wellbeing issues, particularly mental health issues and problematic substance use, were exacerbated by impending homelessness. Once homeless, these health issues showed further and serious deterioration.

The ACE pathway identified has similarities to single adult homeless pathway identified in other countries, despite potential contextual differences. There was almost universal exposure to ACEs. Results also highlighted the pervasive and life-long impact of unaddressed, unsupported, mostly undetected ACEs in participants' lives. This research therefore builds on an increasing body of work that shows that adverse childhood events, "swept under the carpet", can be the precursor to many detrimental outcomes for people later in life, including an elevated risk of homelessness.

Identifying a pathway to single adult homelessness in Hamilton provides opportunities to prevent homelessness. Many points of intervention were identified, with most relating to a point of interaction with government departments including health, education, welfare, justice, and other social services. These organisations therefore hold a duty of care to identify people at risk of poor social outcomes connecting with their services and to, at a minimum, offer non-judgemental, empathetic, culturally appropriate support and equitable access to resources, or referral to specialist services. Homelessness has resulted from a failure to act on the part of these and other community organisations, which may in part have been proliferated by a lack of a genuine understanding of homeless pathways.

Intervening early involves identifying people who are "at risk" of homelessness and other poor social outcomes, which has shown to be problematic. Past performance does not always predict future outcomes. At the same time, there is significant existing evidence that unaddressed, and undetected ACEs, for example, can contribute to lifelong detrimental biopsychosocial outcomes for people, and there is a high association between ACEs and a raised risk of future homelessness. Therefore, an increasing volume of evidence, along with well-established research, and endorsement by organisations such as the World Health Organisation, and the Centers for Disease Control and Prevention in the USA suggests that intervention is warranted. Additionally, those who have had an out-of-home placement in childhood or adolescences are at a higher risk of homelessness. Therefore,

early intervention after ACEs have occurred, and ongoing and intensive support of those who have additionally experience out-of-home placements in youth, are critical points of intervention.

Stopping ACEs occurring is a preferable focus. Preventing family violence would stem the flow of people entering the ACE pathway. New Zealand experts conclude that family violence can be prevented in this country (Lambie, 2018). In other countries, this starts with policy designed to reduce family violence (California Department of Health Care Services, 2020; Couper & Mackie, 2016; House of Commons Science and Technology Committee, 2018) and to detect, measure and ameliorate ACEs (Felitti & Anda, 2014; Gluckman & Lambie, 2018; Lambie, 2018). Such intervention must be intensive, mobilising family/whānau, friends and the broader community. Preventing social problems by intervening early, apart from being the morally appropriate response, is cost effective (Bellis et al., 2019) and can significantly improve lifelong outcomes for people (New Zealand Productivity Commission, 2015).

Despite social isolation from familial and kinship networks being a major contributing factor identified in this research, there were few recommendations made by participants about interventions to help mend broken ties with family, if this was desired. It is interesting to consider the state's role in this, as part of this breakdown involved state intervention. One lone suggestion involved providing housing that facilitated such healing by providing space in single person dwellings for familial visits. Supporting social reintegration is also part of the work of a Housing First service, which can involve supporting people to reconnect with family, if desired (Tsemberis, 2015). Additionally, the Whānau Ora approach is a “culturally grounded, holistic approach focused on improving the wellbeing of whānau (families) and addressing individual needs within a whānau context” (Te Puni Kokiri, 2015, p.9). Policies promoting adopting a Whānau Ora approach may be appropriate. Such specialist services may support people in this extremely difficult journey of reconciliation.

A key recommendation is the adoption of a trauma-informed approach to supporting people who are homeless, as well as people who are at risk of homelessness. This approach would include embracing a genuine understanding of the likely pathway people have taken into single adult homelessness. Consensus holds that this pathway will mostly include traumatic historic events which have had lifelong biopsychosocial impacts through people's lives (Felitti & Anda, 2014; Fitzpatrick et al., 2013; Patterson et al., 2014; Ravenhill, 2008; Roos et al., 2013).

It has been said that for those already homeless, a singular focus on lack of housing fails to fully grasp people's complex life journey (Rua et al., 2019; Tsemberis, 2015). This thesis has presented evidence that single adult homeless in New Zealand have often survived highly traumatic, chaotic, and unstable lives. Therefore, along with providing safe, sustainable, permanent housing, people's complex needs

must be properly addressed, in a trauma-informed and co-ordinated manner, across the many organisations people continue to be connected with (New Zealand Productivity Commission, 2015).

7.7 Contribution

This research provides new knowledge about pathways to single adult homelessness in New Zealand and identifies contributing factors which have raised the risk of people becoming homeless. Mixed quantitative and qualitative research methods allowed for collection of rich data about many aspects which contributed to people's experience as well as collecting important narrative evidence from those with lived experience about points and methods of intervention in pathways to homelessness. This study is well informed by those with lived experience. Meaningful and appropriate participant inclusion was achieved in all aspects of research, including validation of final results (Martin & Kunnen, 2008).

A unique set of data was gathered about traumatising in childhood, its impact across people's lives and its links to an increased risk of later-life homelessness. Results of this enquiry therefore provide information which would support considering multiple early-life points of intervention to help prevent homelessness in New Zealand (Ministry of Housing and Urban Development, 2020). Results have also provided an ACE baseline among a cohort of single adult homeless in New Zealand. Although the 10-question ACE test has been applied in other research such as the longitudinal Dunedin Study and the Growing up in NZ study, it has not been applied to understanding the prevalence of ACEs among single adult homeless in this country.

Overall, the objectives of this research have been realized.

1. A selection of contributing factors and trigger events which raised the risk of single adult homelessness in Hamilton have been determined.
2. A pathway to single adult homelessness was revealed. The earliest age that this pathway began for most people was determined.
3. Critical points of intervention were identified, where appropriate intervention would likely lower the risk of single adult homelessness in Hamilton.

The outcome of this research is therefore a collection of evidence facilitating a genuine understanding of people's journey into single adult homelessness in Hamilton, and how this pathway might have been avoided.

Despite contextual differences between countries, for example in types of welfare systems, and local challenges and constraints, the pathway and contributing factors identified bare similarity to those identified in other countries. This research therefore adds to international evidence that indicates the

importance of addressing the complex needs of those experiencing single adult homelessness, of which a lack of access to housing is one part of the solution.

7.8 Final word

The aspirations of many participants were that their involvement in this research would provide a method with which to record people's long journey into homelessness, in so doing, provide our community with a genuine understanding of single adult homelessness in Hamilton. People homeless are first and foremost our fellow men and women. Despite tough starts in life, sometimes the toughest start imaginable in New Zealand, and largely inadequate support throughout their lives, most have gone to school, worked, paid taxes, and taken part in various families, households, and communities. The impact of trauma from disruptive childhoods followed people into adulthood; and manifested as ill-health, as disrupted social networks, as multiple custodial lags, and ultimately as single adult homelessness. This was never a choice. In the words of one participant, "The last thing anyone wants to be is homeless".

People homeless are worthy of empathy, of dignity, of respect, of inclusion and of equitable access to our community's resources. They have equal right to receive great healthcare, to a permanent, affordable, safe place to call home, to education, to justice, to restitution for perpetrated acts, to freedom from the perils of systemic "double jeopardy". Single adult homelessness is a manifestation of systems failure, a failing of a duty of care on the part of government departments and community organisations to provide appropriate interventions at critical points for people known to be at risk of poor biopsychosocial outcomes. It is therefore the community's responsibility to redress this failing.

Through community collaboration, including 100 voices of experience, involving 101 hours of consultation, with the support of one homeless service, three population experts and one researcher, and guided by extant literature, many aspects of the unique, and yet familiar, journeys into homelessness have been recorded. The outcome is a document which will contribute toward a better understanding of single adult homelessness in Hamilton, along with providing information and recommendations about important points of intervention, to help prevent people being drawn into a pathway to homelessness.

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Appendix A Questionnaire information sheet

Research Title - Lost Points of Intervention in Pathways to Homelessness in Hamilton, NZ

Who is the researcher?

My name is Carole McMinn and I have worked with The Peoples Project since October 2014. I am also a part-time university student at the University of Waikato.

What is this research about?

We don't really know all of the reasons why people become homeless in Hamilton. My research is about finding out from those who have been homeless **what things caused or contributed to people becoming homeless in Hamilton.**

Who do I want to talk to?

I believe the experts in understanding homelessness are those who have been homeless. So, I want to talk to **people who have experienced homelessness in Hamilton** who have been helped by The Peoples Project.

What would you be asked?

You will be invited to **share your story** about your journey into homelessness. I respect that your story is unique and personal, and there may be some very sensitive parts. There are some tough questions, so I want to be up front about what I'll be asking.

Early Childhood Experiences

Research from other countries shows that for some people who end up homeless, their journey started in their childhood. Studies have shown for example that abuse in childhood can make some people 700% more likely to form an addiction to drugs or alcohol in their later life, and their addiction can then go on to contribute to them becoming homeless. Researchers have developed 10 questions that ask about some very personal and sensitive things about abuse and neglect people may have experienced in childhood. These ten questions are included in my research.

Contributors and causes

There is a lot of research from other countries about what people have said caused or contributed to them becoming homeless. But we don't know if the same things are happening in Hamilton. The questionnaire includes questions about whether causes identified from overseas, and some identified by The People's Project, were part of your journey or not. If there are other things not on the list, you can add them.

The questions are mostly 'yes' or 'no' questions, asking if experiences were part of your journey or not, and at what age you might have had these experienced. The questionnaire should take about 45 minutes to complete. You have the right to refuse to answer any question. You can bring a support person with you to questionnaire sessions. You can ask for help to complete the questionnaire. If completing the questionnaire makes you feel stressed, embarrassed or emotionally unwell, you can receive support and be referred to free counselling services or to the free doctor through The People's Project.

Will other people know who you are or what you say?

You can choose if you wish your answers **to remain anonymous**. You can choose to provide your name and contact details if you wish to be part of further in-depth interviews about your experiences and about homelessness in New Zealand.

In what special circumstances could my confidentiality will be breached?

A researcher holds a 'duty of confidentiality' which includes not passing on data which could identify a participant to anybody without that participant's consent. Please note, however, **researchers have a responsibility to report to the relevant authority any actions or planned actions discovered or disclosed (told to the researcher) during the course of research which they believe are likely to result in serious or immediate harm to others.** This includes acts involving child abuse and criminal activity.

Research data given in confidence may be ordered to be released to a court as part of criminal proceedings.

The researcher may make a referral to the relevant authority if a participant reports having recently been **a victim of a crime or reports being at immediate risk of serious harm.** In this case, the participant will be consulted before any referral is made.

How will the survey process work?

There will be a number of research sessions held at The People's Project office at 24 Garden Place, Hamilton on Fridays throughout 2019. You can let the researcher know which session you will be attending, and if you would like help completing your questionnaire.

What will happen to your information?

The questionnaire answers from everyone will be put together and the results will be included in the research. Nobody's individual information will be identifiable in the results.

The researcher will report back to all interested participants about the results of research, so you can see how you have added to our understanding of homelessness in Hamilton. The results of this research may be published in magazine articles, books, or used in presentations to interested groups or hui. A presentation of the findings of this research will be held and all research participants will be invited. You can tell me at that meeting if I've got the results right in your view.

Will you be asked to sign anything?

Yes. You will be asked to complete the consent form attached. This is a standard requirement in research. Your consent will be kept separate from your completed questionnaire, so your answers remain anonymous.

What if you feel you have been treated unethically during this research?

This research project has been approved by the Human Research Ethics Committee which is part of the University of Waikato. Any questions about ethical conduct during this research can be directed to them at:

University of Waikato, The Whare Wananga o Waikato, Private Bag 3105, Hamilton 3240 or
Email: fass-ethics@waikato.ac.nz.

What do you need to do now?

Complete the attached consent form and let the researcher or one of The Peoples Project team know if you'd like to participate and we can arrange a questionnaire session that suits you.

Thank you for sharing your story.

Researcher contact details:

Carole McMinn: The Peoples Project, 24 Garden Place, Hamilton.
M: 027 809 2376 (text is best) or by email: Carole.McMinn@wisegroup.co.nz.

Appendix B Questionnaire Consent

UNIVERSITY OF WAIKATO
FACULTY OF ARTS & SOCIAL SCIENCES

Description of Project: This research aims to try to find ways to prevent homelessness in New Zealand. I am interested in asking people who have experienced homelessness what caused, contributed to or triggered their experience.

PARTICIPANT CONSENT FORM - Questionnaire

Name of Participant: _____

I have read and understood the information sheet or had the information sheet read and explained to me. 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.

While completing the questionnaire, I understand that I do not have to answer any questions I do not feel comfortable answering.

When I sign this consent form, I will retain ownership of my questionnaire responses, but I give consent for the researcher to use my responses for the purposes of the research outlined in the information sheet.

Tick [✓] the appropriate box	YES	NO
<i>I wish to receive a copy of the findings.</i>	<input type="checkbox"/>	<input type="checkbox"/>

Participant :

Signature :

Date :

Contact Details :

Researcher : Carole McMinn

Signature :

Date :

Appendix C In-depth interview information sheet

Research Title - Lost Points of Intervention in Pathways to Homelessness in Hamilton, NZ

Who is the researcher?

My name is Carole McMinn and I have worked with The Peoples Project since October 2014. I am also a part-time university student at the University of Waikato.

What is this research about?

We don't really know all of the reasons why people experience homelessness in Hamilton. My research is about finding out from people who've experienced homelessness in Hamilton what things caused or contributed to them becoming homeless. I want to know **what type of help or intervention people think would have stopped them ever experiencing homelessness and when that help would have been welcomed**. I want to know why people think more and more New Zealanders are experiencing homelessness, and what they think can be done about it

Who do I want to talk to?

I believe the experts in understanding homelessness are those who have experienced homelessness. So, I want to talk to people who have experienced homelessness in Hamilton who have been helped by The Peoples Project.

What would you be asked?

You will be invited to **share your story** about your experience of homelessness **in more depth** and **give advice about how to change things to end homelessness in New Zealand**. Building on your survey responses, I will ask you questions about the following topics:

Early Childhood Experiences

If people have experienced traumatic events in their childhood, I will ask if people consider these experiences contributed to their journey into homelessness and how.

Other contributors, triggers and causes

From the things you've identified in your survey as contributing to your experience of homelessness, I'll ask you what you think was the most important cause or trigger, why and what intervention you think might have stopped this causing your experience of homelessness.

Homelessness and interventions in New Zealand

I will ask why you think homelessness is increasing in New Zealand and what type of help or interventions would stop people ever experiencing homelessness.

Over-representation of Māori among people experiencing homelessness

Māori are over-represented among people experiencing homelessness in New Zealand. I want to ask why people think this is and what we should be doing about it.

The interview will take **no longer than one hour**. I will audio record the interview. The interviews can be held at The Peoples Project, in your home or perhaps in Kakariki House. You can bring a support person with you. You may choose to answer the questions in Te Reo. You would have the right to refuse to answer any question and to ask me to turn off the voice recorder or stop the interview at any time. I will bring you a typed copy of the interview to check, change and sign off. You can withdraw your interview responses at any time up to four weeks after you have been interviewed. You can do that by telling me or any of the Project staff that you no longer want to be part of the research.

Withdrawing from the research will in no way affect your ongoing support from The Peoples Project. If completing the interview makes you feel stressed, embarrassed, or emotionally unwell, you can receive support and be referred to free counselling services or to the free doctor through The People's Project.

Will other people know who you are or what you say?

No. You will choose a fake name to protect your identity before our interview. I will take all possible care to protect your privacy. You and I will be the only people who know what information came from which person.

In what special circumstances could my confidentiality will be breached?

A researcher holds a 'duty of confidentiality' which includes not passing on data which could identify a participant to anybody without that participant's consent. Please note, however, **researchers have a responsibility to report to the relevant authority any actions or planned actions discovered or disclosed (told to the researcher) during the course of research which they believe are likely to result in serious or immediate harm to others.** This includes acts involving child abuse and criminal activity.

Research data given in confidence may be ordered to be released to a court as part of criminal proceedings.

The researcher may make a referral to the relevant authority if a participant reports having recently been **a victim of a crime or reports being at immediate risk of serious harm.** In this case, the participant will be consulted before any referral is made.

What will happen to your information?

The information will be analysed, and the results will be included in my research. Nobody's individual information will be identifiable. I may use some direct quotes from you, but only with your permission. You will never be referred to by your real name in my report.

I will report back to all of the participants interested in the results of my research, so you can see how you have added to our understanding of homelessness in Hamilton. The results of this research may be published in magazine articles, books, or used in presentations to interested groups or hui. I will have a presentation of the findings and you will be invited. You can tell me at that meeting if I've got the results right in your view. After the research had been finalised, your information can be returned to you or confidentially destroyed.

What if you agree to participate and then change your mind?

You can change your mind at any stage before the interview and up to four weeks after the interview. You can do this by either letting me know or by telling, texting or emailing anyone from The Peoples Project staff.

Will you be asked to sign anything?

Yes, a consent form. This is a standard research requirement.

What if you feel you have been treated unethically during this research?

This research project has been approved by the Human Research Ethics Committee which is part of the University of Waikato. Any questions about ethical conduct during this research can be directed to them at:

University of Waikato, The Whare Wanaga o Waikato, Private Bag 3105, Hamilton 3240 or
Email: fass-ethics@waikato.ac.nz.

What do you need to do now?

Let me or one of The Peoples Project team know if you'd like to participate and we can arrange an interview time and place that suits you.

Researcher contact details:

Carole McMinn: The Peoples Project, 24 Garden Place, Hamilton.

M: 027 809 2376 (text is best) or by email: Carole.McMinn@wisegroup.co.nz.

Appendix D In-depth interview consent

UNIVERSITY OF WAIKATO
FACULTY OF ARTS & SOCIAL SCIENCES

Description of Project: This research aims to try to find ways to prevent people experiencing homelessness in New Zealand. I am interested in asking people who have experienced homelessness what caused, contributed to or triggered their experience, what intervention would have stopped them ever experiencing homelessness, and when that intervention would have been welcomed.

Name of person interviewed:

I have received a copy of the Information Sheet describing the research project and a copy of this signed consent. 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 up to four weeks after the interview.

During the interview, 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 have discussed the representation of my identity within the research and choose for my identity to be protected through the use of a pseudonym (fake name).

Please complete the following checklist. Tick [✓] the appropriate box for each point.	YES	NO
<i>I wish to receive a copy of the interview recording.</i>		
<i>I wish to view the transcript of the interview.</i>		
<i>I wish to receive a copy of the findings.</i>		

Participant :	Researcher :	Carole McMinn
Signature :	Signature :	_____
Date :	Date :	_____
Contact Details :	Contact	027 809 2376 (text is best)
	Details :	_____
		Carole.McMinn@wisegroup.co.nz

Appendix E In-depth interview topics



Research Title:

Lost Points of intervention in pathways to homelessness in Hamilton NZ

Research Aim:

To find out what has caused people to experience homelessness in Hamilton

To find out from the experts (people who've been homeless) what interventions/help would stop people ever becoming homeless.

Research Rights:

Please ask me to explain any question if it doesn't make sense to you. You have a right to decline to answer any question and to ask me to stop recording this interview at any time. Your answers to these questions will remain anonymous. I will be the only one typing out our conversation. I will return the typed transcript of our conversation to you for checking. You can ask me to delete or correct any part of it. You can also ask me to remove your transcript from the research completely up to four weeks after you have signed off the final transcript. Withdrawing your transcript in no way affects your ongoing support by The People's Project. You are welcome to answer in Te Reo and I will have your transcript translated.

Your wellbeing is important:

If answering these questions makes you feel stressed, embarrassed or emotionally unwell, let the researcher or other TPP staff member know and we can refer you to a doctor or counsellor for help.

Date of interview:

Place of interview:

Participant Pseudonym:

Topic 1: Contributors and triggers to homelessness

What are all of the things you think contributed to you experiencing homelessness before coming to TPP for help?

Which is the main or most important thing?

What intervention, help or resource would have stopped this thing/these things contributing to you experiencing homelessness?

When should this help/intervention/resource been available?

Topic 2: Prevalence of adverse childhood experiences

(If ACE): Your survey results show that you experienced adverse childhood experiences/trauma in childhood.

Do you think the traumatic things you experienced in childhood and/or while growing up had any negative long-term effects on you, or were part of the reason you became homeless? Any relevance to health issues today?

If, yes, how?

If yes, what intervention, help or resource would have stopped these experiencing contributing to you to becoming homeless?

When should this help/intervention/resource have been available?

Do you think it would be helpful/make a difference if agencies like WINZ, like Prisons, knew you'd had a traumatic childhood or life?

Topic 3: Systemic and other structural causes and interventions in New Zealand

The census data tells us that there is an increasing number of people experiencing homelessness in New Zealand.

Why do you think this is?

If you were Prime Minister, what would you do about homelessness?

Topic 4: Over-representation of Māori among people experiencing homelessness

Māori are over-represented among people experiencing homelessness in New Zealand.

Why do you think this is?

What do you think we need to do about it?

Thank you for sharing your story and advice

Appendix F Questionnaire

TPP Structured Interview Questionnaire



What causes homelessness in Hamilton?

Version 3.5 – 2019

<p><i>If answering these questions makes you feel stressed, embarrassed or emotionally unwell, let the researcher or other TPP staff member know and we can refer you to a doctor or counsellor for help. You may decline to answer any question.</i></p>						
DEMOGRAPHICS						
Participant identifier number:		Current housed status:	Housed		Homeless/not housed	
Gender	Male Female or describe your gender					
Date of Birth and Age	Day	Month	Year	Age		
What is your relationship status?	Single	Separated	Divorced	Defacto		
	Married	Widowed	Civil union	Declined to answer		
Which ethnic group or group(s) do you belong to – mark as many of the groups which apply to you	NZ European Māori Samoan Cook Island Māori Tongan					
	Niuean Chinese Indian Other, please write _____					
	Don't Know Declined to answer					
If you answered more than one ethnic group in the previous question, what is your <i>main</i> ethnic group, that is the one that you mostly identify with?	NZ European Māori Samoan Cook Island Māori Tongan					
	Niuean Chinese Indian Other, please write _____					
	Don't Know Declined to answer					
If Māori, what iwi/ hapū do you identify with?	Iwi			Hapū		
	Don't know Declined to answer					
Which town where you born in?	Declined to answer					
Which region have you mostly lived in?	Waikato	Tick	Other	Specify		
If you are <u>not</u> from Hamilton, why did you come here?	Declined to answer					
If you are <u>not</u> from Hamilton, when did you arrive here?	Declined to answer					

LENGTH OF TIME HOMELESS		Declined to answer
Q	<i>How long were you homeless (without a home, including couch surfing) in the time just before coming to TPP for help?</i>	The number of years, months, weeks, or days
	<i>How many times have you experienced homelessness or being without a home in your life?</i>	Tick/circle one of these options: Just this once 2-5 times 6-10 times More than 10 times
	<i>How long in total in your life have you been homeless/with a home?</i>	The number of years, months, weeks, or days
YOUR DEFINITION OF HOMELESS		
<i>Briefly describe what being homeless means to you.</i>		

The next set of questions ask about experiences you may or may not have had during your childhood, up to the age of 18. It might be hard to remember details from your childhood, but please try to answer from what you can recall. There is space to record if you can't remember and space to record if you wish to decline to answer.

EARLY CHILDHOOD AND YOUTH					
<i>Between the ages of 1 and 18 years of age:</i>	Yes	What age did this start/happen?	No	Can't remember	Declined to answer
1 Did a parent or other adult in the household often swear at you, insult you, put you down or humiliate you or act in a way that made you afraid that you might be physically hurt?					
2 Did a parent or other adult in the household often push, grab, slap, or throw something at you or ever hit you so hard that you had marks, were injured or had to go to hospital for treatment?					
3 Did you often feel that no one in your family loved you or thought you were important or special or your family didn't look out for each other, feel close to each other, or support each other?					
4 Did you often feel that you didn't have enough to eat, had to wear dirty clothes, had no one to protect you or your parents were too drunk or high to take care of you, or neglected to take you to doctors or left you alone to take care of yourself and other siblings?					
5 Were your parents ever separated or divorced?					
6 Was your mother, stepmother or caregiver often pushed, grabbed, or had something thrown at her or was sometimes or often kicked, bitten, hit with a fist, or hit with something hard or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?					
7 Did you live with anyone who was a problem drinker or alcoholic or who misused prescription drugs or used street drugs?					
8 Was a household member depressed or mentally ill or did a household member attempt suicide?					
9 Did a household member go to prison?					
Was a parent or guardian involved in a gang?					
10 Did an adult or person at least 5 years older than you ever touch you inappropriately or have you touch their body in a sexual way or try to or actually have sex with you?					
How many homes did you live in before the age of sixteen?		Number			
What age did you leave school?	Age				
What is your highest school or other qualification? (e.g. trade certificates, NCEA qualifications, Degrees)					

Parents – Housed
Work

		Yes	No	Declined to answer	Can't remember	
Q	<i>Were you ever living in foster care through Child Youth and Family (Oranga Tamariki) or made a Ward of the State?</i>					
	What age did that first happen?	Age →				
	What age did you leave foster care?	Age →				
	What is the total number of years you were in foster care?	Number →				
	How many foster homes did you live in, in total	Number →				
Q	<i>What age did you leave home for good?</i>	Age →				
Q	<i>Before you were 16 years old, did any of these apply to you and at what age?</i>	Yes	No	Age first happened	Declined to answer	Can't remember
	I ran away from home and stayed away for more than one night					
	I was truant from school a lot					
	I was suspended or expelled from school at least once					
	I was badly bullied by other children					
	There was sometimes not enough to eat at home					
	I didn't get along with my parents, step-parents or care-givers					
	My family was homeless					
	I shared a bed with others, slept on the floor or in a room that was not a bedroom, such as the lounge, garage or shed					
Q	<i>Did you experience any of these situations <u>with your family</u> when you were a child? (Under 16 years old)</i>	Yes	No	Age this first happened	Declined to answer	Can't remember
	Sleeping rough/sleeping on the streets or in a vehicle					
	Staying with friends or relatives because we had no home of our own					
	Staying at a hostel, camp ground, or back packers because we had no home of our own					
	Staying in Emergency Accommodation paid for by MSD/Work and Income					
	Staying at a Women's Refuge					

PHYSICAL HEALTH					
	<i>Do you have any of the following <u>diagnosed</u> health problems?</i>	Yes	No		Declined to answer
	Dyslexia				
	Disabilities connected with arms, legs, hands, feet, back or neck such as Arthritis			Specify	
	Learning disabilities			Specify	
	Difficulty seeing (other than needing glasses to read normal print)				
	Difficulty hearing				
	Skin conditions/allergies			Specify	
	Chest/breathing problems, asthma, bronchitis			Specify	
	Heart/high blood pressure or blood circulation problems			Specify	
	Stomach, liver, kidney or digestive issues			Specify	
	Diabetes			Specify	
	Anxiety, depression, schizophrenia, bipolar disorder, Post traumatic stress disorder or other mental health condition			Specify	
	Alcohol, drug, glue, inhalant or other substance dependencies			Specify	
	Epilepsy				
	Migraines, frequent headaches, head injury			Specify	
	Cancer			Specify	
	Stroke				
	Foetal Alcohol Syndrome				
	Other serious physical disability or illness (please specify)				

Q	<i>Do you have any of the following <u>diagnosed</u> health problems? (continued)</i>	Yes	No		Declined to answer
	Rheumatic Fever				
	Tuberculosis				
	Hepatitis				
	HIV				
SOCIAL INCLUSION					
Q	<i>Have you ever had a problem with the following?</i>	Yes	No		Declined to answer
	Trouble with reading or writing or understanding written documents?				
	Trouble communicating with others?				
	Have you ever felt discriminated against, including racial discrimination?				
	If so, please describe what happened				
ARMED FORCES					
Q	<i>Have you ever spent time in the armed forces, the Army, Navy or Airforce?</i>	Yes	No		Declined to answer
	If yes, how many years did you serve?	Number of years?			Declined to answer

JUSTICE SYSTEM						
Q	Have you ever experienced any of the following?	Yes	Age this first happened?	No	Declined to answer	
	Been a victim of a violent crime or domestic violence before becoming homeless					
	Been a victim of violence, assault, robbery or abuse while on the street					
	Been to prison					
	If yes, which prison/s (including Borstal)?	List names of all prisons				
	How many years in total have you been in prison?	Number →				
SOCIAL CONNECTION						
Q	Have you ever experienced any of the following?	Yes		No	Declined to answer	
	Divorced or separated from a long-term partner					
	A long-term partner died					
	Been part of a gang					
	Lost contact with family					
	If yes, what is the main reason you lost contact with your family?					
PREVIOUS HOUSING						
Q	Since the age of 16, have you ever lived in a place that you would regard as a settled home?	Yes		No		Declined to Answer
Q	Which of these best describes the last house you lived in before becoming homeless?	Tick if applies				Declined to answer
	A private rental property where I was a tenant or a boarder					
	A Housing New Zealand Property where I was a tenant					
	Temporarily staying in a house with a friend, relative or partner where I was <u>not</u> a tenant or boarder					
	Something else	Specify				

HOUSING CONTINUED				
Q	As an adult (18+) have you ever experienced any of the following?	Yes	No	Declined to answer
	Slept rough, lived on the streets, in a garage, shed or in a vehicle			
	Stayed with a friend or relative because you had no home of your own			
	Stayed at a hostel, refuge, night shelter, back-packers or in other emergency housing because you had no home of your own			
	Lived in supported housing with mental health or corrections services such as Keys/Pathways Housing or with Anglican Action			
Q	Thinking about the last place you lived, were any of the following the reasons why you had to leave?	Tick any that apply		
	90-day, 28 day or 42-day notice to leave			
	Lost job/couldn't find work			
	Relationship problems/family breakdown			
	Couldn't pay rent			
	Couldn't pay power and gas			
	Rent too expensive			
	Evicted, 24-hour notice to leave			
	Went to prison			
	Problem with benefit			
	Problem with landlord			
	Over-crowding			
	Asked to leave			
	Left care			
	Thrown out by parents/care givers			
	Home was repossessed			
	It was unsafe (including domestic violence)			
	Methamphetamine contamination of property			
	Problems with alcohol or drugs			
	Other (Please describe)			

INCOME				
<i>When you were homeless, did you receive money from any of the following?</i>	Tick if applies	Name of benefit		Declined to answer
A benefit, ACC or Government paid superannuation				
Paid work (including cash jobs)				
Friends or relatives				
A charity or church				
Begging/Hustling/Busking				
Illegal activity such as drug dealing				
No income received at all				
Have you ever had sex or engaged in a sex act in exchange for money or for things like food, drugs or somewhere to stay?	Yes			No
Have you ever shoplifted because you needed things like food, drugs, alcohol or money for somewhere to stay?	Yes	No	Declined to answer	
Do you have difficulty budgeting your income?				
WORK & STUDY				
<i>Which of these statements best fits your life experience?</i>	Yes	No		Declined to answer
I have spent most of my adult life in steady, long term jobs				
I have spent most of my adult life in casual, short-term seasonal work				
I have spent most of my adult life unemployed				
I have spent most of my adult life as a student/in education				
I have never worked				
I've spent most of my adult life caring for others including elderly family members or children.				
Have you ever had a period in your life when you were unable to work because of long-term sickness or injury?				
If yes, what sickness or injury was that?				

DEBT					
Q	At the time you were homeless, did you owe money to any of the following?	Yes	Approximate amount \$	No	Declined to answer
	Power or gas companies				
	Banks for loans, credit card debt, overdrafts, fees				
	Hire purchase companies				
	Mobile home retailers/trucks				
	Instant finance companies/pawn shops/Cash Converters				
	Previous Landlords				
	Housing New Zealand				
	A gang e.g. for drug purchases or loans				
	Friends or family				
	Work and Income				
	Student Loan				
	Court fines and reparations				
	Have you been through bankruptcy, insolvency or no asset procedures?				
	Have you ever been to tenancy tribunal or do you have a tenancy order against you?				
OTHER CAUSES OF HOMELESSNESS					
Please list any other things you think caused you to become homeless not already covered in this questionnaire.					

Phew! The End! Thank you for sharing your story.

Date completed:

Place where completed:

Survey completed by: Participant

Support Person

Researcher

Other

(specify)

Participating in further research – In-depth interviews

I am seeking further advice from people who have experienced homelessness in Hamilton about *ways to end homelessness*. I would particularly like to talk to people who have experienced the following:

- Trauma in childhood or youth or experienced foster care
- And/or been involved with many social agencies such as prison, rehab or any mental health facilities.

If you meet these criteria and would be happy to discuss some of your answers to this survey, and your experience of homelessness in more detail, please write your name and contact phone number or details below. Please note, your answers to this questionnaire will remain private and confidential.

Name: _____

Contact Details: _____

What causes homelessness in Hamilton?

Please tell us *your* story

If you have experienced homelessness in Hamilton, and are working with The People's Project, we'd welcome your advice and participation in this research project.

What is this research about?

We don't really know all the reasons why people experience homelessness in Hamilton. The experts in understanding homelessness are those who've been homeless – people like you.

What's involved?

You will be supported to complete a questionnaire of mostly yes and no answers. This will take about 45 minutes. Your answers will be completely anonymous (no one will be able to identify you because of your answers).

What's in it for you?

Sharing your experiences can help us try to change things, to stop people ever experiencing homelessness in the first place.

You will receive a small koha to acknowledge your time and effort in sharing your story.

How can I be a part of this?

Ask Carole from The People's Project for more information or text her on 027 809 2376.

THANK YOU!



Appendix H Permissions log

Page number	Details of in-copyright material	Date permission requested	Permission granted for print thesis	Permission granted for digital thesis	Conditions
18	The Truth About ACEs infographic	4 May 2019 (email)	Yes	Yes	Credit notice identifies Robert Wood Johnson Foundation as the copyright owner. Format of acknowledgement provided.
64	Multiple Exclusion Homelessness extended survey	3 May 2018 (email)	Yes	Yes	Reference original work of (Suzanne Fitzpatrick et al., 2013).

From: Wesolowsky, Oriana <owesolowsky@rwjf.org>

Sent: Saturday, April 13, 2019 6:45 AM

To: Carole McMinn <Carole.McMinn@wisegroup.co.nz>; ReprintPermission <ReprintPermission@rwjf.org>

Subject: RE: Contact RWJF: Reprints, orders, permissions or logo requests

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Thank you for your request dated 4/5/19 to reproduce *The Truth About ACEs Infographic*.

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If anyone expresses an interest in using materials from this publication, have them get in touch with me and I would be happy to discuss granting permission.

Please let me know if you have any other questions,

Thanks!!

Oriana

From: Johnsen, Sarah <S.Johnsen@hw.ac.uk>
Sent: Thursday, 3 May 2018 10:45 PM
To: Carole McMinn
Subject: RE: Research references - Lost points of intervention in journey's into homelessness.
Attachments: MEH_CensusSurvey_Final.docx; MEH_ExtendedSurvey_Final.docx;
MEH_InfoSheet2.doc; MEH_study_poster.pdf

Hi Carole

Thanks for the feedback on the blog. Glad you liked it!

I am also delighted that you found the MEH work useful – and **of course we'd be happy for us to use (or adapt) our research tools**. I have attached the census survey questionnaire and the extended interview guide. Please note that the latter was scripted into CAPI which does all the filtering and routing automatically – it can be very difficult to navigate on paper! You may need to adapt some of the language to suit the context. I've also attached an info sheet for participating services and poster used in census settings just in case they are useful. Good luck with it all – and please don't hesitate to get back in touch if you'd like further detail re how we used / interpreted anything.

If you want to keep in the loop re our publications or other things that we find interesting at our end – perhaps sign up to receive notifications via our blog <https://i-sphere.org/> or twitter @isphere_hwu. We post details of almost all our new publications and other work we like on those!

All best,
Sarah