



# **Slipping Through the Cracks**

## **A Study of Homelessness in Wellington**

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## **Disclaimer**

The content of this report are the views of the authors and do not necessarily reflect those of He Kainga Oranga, Housing and Health Research Programme, or the Department of Public Health, Wellington School of Medicine and Health Sciences.

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*"If I could change the emotional climate of New Zealand by 1% I'd die happy."*

- James K Baxter

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# **1. Abstract**

Over the past two years the experiences of homeless individuals have come to the attention of the Wellington public through the media and policy changes. The result of this attention has focussed the Wellington City Council, Downtown Community Ministry and Regional Public Health on developing a homelessness strategy for Wellington. To do this they have asked 5<sup>th</sup> year medical students, under the supervision of the Housing and Health Research Programme at Wellington Medical School, to assist.

The aim of this paper was to determine the major pathways leading into homelessness, and to identify gaps in the existing service provision and prevention.

For the purposes of this study the definition of homelessness was a "lack of adequate, secure, affordable and suitable housing which results in rough sleeping or use of dwellings for people with no fixed address". This was derived from Chan, 2005 [1].

The study was performed using three methods: a literature review of previous research, thematic analyses of 30 interviews of experiences of homelessness and 25 agency interviews.

The study revealed many common pathways that were associated with or lead to homelessness. The major pathways identified were Family Situation (Driven), Discrete Event (Dropped) and Natural Progression (Drawn). Agency and service gaps were divided into three groups. The main gaps in primary prevention were alcohol and drug services, gambling services, mental health services, community education, youth and Māori specific services. The secondary prevention gaps were based around the lack of accommodation and the tertiary gaps were found in inter-agency service coordination and a lack of 24-hour drop-in centre.

Overall the voice of the homeless people agreed with the gaps identified in the services provision. It is important that this voice is heard when developing the homelessness strategy in Wellington.

## 2. Background

On 30 June 2003, a well-known member of the Wellington community died [2]. Robert Jones had lived, homeless, in Wellington's inner city, spending much of his time living in the Town Belt, for the previous two decades. His death made newspaper headlines nationwide and drew political attention to the issue of homelessness in Wellington City, which had previously been percolating quietly in the background. There had also been concern raised more broadly about homelessness in New Zealand [3-5]. At the same time, Wellington City Council was in the process of reviewing their Public Places Bylaw, which included a provision that banned camping in public places, including the inner city. Whilst the focus of the Bylaw was on the wider issue of public places, and unrelated to the concurrent events involving the homeless population, the timing drew a negative community reaction [6, 7]. As Council looked for a suitable response to gather information about the actual problem and work towards a solution, the Mayor established the Homelessness Taskforce, which was chaired by a City Councillor and had representation from a wide range of organisations and agencies. The result of the Taskforce was a report provided to Council and a Homelessness Strategy developed and implemented. One of the early outcomes of the political attention was a significant financial contribution by the Wellington City Council (WCC) to establish Project Margin, a project managed by the Downtown Community Ministry (DCM) on behalf of WCC. The aim of Project Margin was to obtain and maintain sustainable accommodation for those in the homeless population who were at 'greatest risk'. In parallel to these community events, the Department of Public Health at the Wellington School of Medicine has been recently developing a research focus on housing need [8-10].

Housing has clearly been identified as a determinant of health in numerous studies [11-18]. People with experience of homelessness may have specific health needs [19-24]; and the homeless population itself is heterogenous, meaning that different health service responses may be varyingly efficacious dependant on how well targeted they are to



particular groups within the homeless population [25, 26]. There is evidence that health practitioners' views of what might constitute a housing solution for their clients are not always in accord with what their clients may desire as a solution [27], indicating a need to gain greater understanding of the homeless population and to listen to what they are saying about the services they see as useful in ameliorating their circumstances. Although there are a number of studies that have looked at various demographic characteristics of homeless populations overseas [28-30] there have been none so far in New Zealand, and surprisingly little has been published internationally on pathways into homelessness [31-35].

It was in the context of recognising a paucity of literature on homelessness, particularly within New Zealand [22, 36-38], and in view of the broader socio-political context, that DCM, WCC, Regional Public Health, and He Kainga Oranga (The Housing and Health Research Programme at the Department of Public Health, Wellington School of Medicine) have collaborated in the current research. This document is intended specifically to contribute to the development of a Wellington City Public Health Strategy for Homelessness being developed by Regional Public Health and other agencies.

To inform this strategy development we aimed to explore the following questions:

- What are the common pathways into homelessness in the Wellington Region?
- What services are currently available to the homeless and do these meet the needs for effective prevention and support?

We have taken two separate approaches to answering these questions. Our first approach made use of a set of interviews conducted by DCM in November and December 2004. These interviews were analysed qualitatively to identify common pathways into homelessness in the Wellington region, and the views held by participants on services available to them. Where common themes were identified within the Wellington

homeless population we searched the literature to identify overseas programmes and how these had responded to the same issues.

Our second approach was to interview a range of service providers in the Wellington Region to identify what services these organisations provided in the area of homelessness. Our intention here was twofold: firstly, we intended to provide an indication of the range of services that are available; secondly, we wished to identify any obvious service gaps. By identifying deficiencies our hope has been to indicate where resources may be directed in future. We also wanted to identify common perceptions amongst agencies of deficiencies in catering to the homeless population.

Our definition of homelessness was derived from Chan [1]; "Lack of adequate, secure, affordable and suitable housing which results in rough sleeping or use of dwellings for people with no fixed address". An ancillary goal of this project was to advance a definition of homelessness that might be useful for statistical purposes in terms of counting the homeless population in Wellington (and to this end provide a basis for measuring the efficacy of interventions). The difficulties of finding an acceptable definition of homelessness, which is a necessary precursor for future cross-sectional studies, is reviewed in Chan's report.

*"I didn't feel like I was slipping through the cracks. I felt like I was being stomped down through the grate"*

- 41-year-old male

## **3. Methods**

### *3.1 Homeless Interviews*

We had initially intended to conduct a series of interviews with people who have experienced homelessness in the Wellington region. However it became apparent that the Downtown Community Ministry (DCM) had already conducted 30 in-depth interviews in November 2004 with a number of self-identified homeless individuals. We elected therefore to make use of this extensive and yet to be analysed resource.

DCM had previously sought ethical approval to conduct these interviews from the Wellington Regional Ethics Committee (see Appendix A). The intention in conducting the interviews was to establish the reasons given by the interviewees for the causes of their homelessness; what they thought of current services for the homeless in Wellington; and, finally, what additional services they regarded as being potentially useful.

Opportunistic and snowball sampling techniques were employed in the recruitment of participants. Notices were placed in the DCM office advertising the project and inviting self-identified homeless people, or people who had previous experience being homeless to present to the DCM offices during the period of the interviews. Participants were reimbursed \$25 for their time. Participants were supplied with an information sheet (see appendix B). Interviews were conducted with individual participants over the course of approximately one hour by DCM staff. Staff used an interview guideline, which utilised open-ended questions (see appendix C).

The interviews were audiotaped, and transcribed to text by an independent contractor. DCM staff reviewed the transcripts to remove any information that would identify the interviewee. The transcripts were then analysed by four 5<sup>th</sup> year medical student researchers.

We conducted an inductive thematic analysis of the interviews. Each researcher read a sample of interview transcripts; we then met and reviewed these within this group to ensure validity and reliability. As a result of this, a number of common themes were identified, and these are shown in Table 1 (a copy of the coding document is attached as appendix D). Two researchers working independently then thematically coded each interview transcript. Any thematic coding discrepancies found were then discussed by the researchers, and if required a further independent researcher was involved. This method increased reliability as a consensus was reached regarding appropriate themes for each transcript. This also increased validity, as it made sure that all relevant themes were included. A total of 21 transcripts out of the 30 were double-read.

**Table 1 - Common Themes identified in interview transcripts**

Theme
Alcohol
Childhood abuse
Debt burden
Difficulty budgeting
Drugs
Family breakdown/instability
Foster families
Frequent moving/change in housing
Gambling
Gang involvement
Institutional care as a child/adolescent
Lack of schooling/education
Mental health issue
Negative beliefs about self/self-image
Prison as adult
Relationship breakdowns
Social isolation
Traumatic parental death

Trouble communicating with others
Trouble with Police
Unemployment

The meaning of each common theme used during the thematic coding is described below:

#### Alcohol

The use or abuse of alcohol appeared to contribute to the development or maintenance of the homeless state.

#### Childhood abuse

The interviewee identified a history of physical, emotional, or sexual abuse during their childhood or adolescence.

#### Debt burden

Debt owed to other people or agencies appeared to precipitate or sustain the condition of homelessness.

#### Difficulty budgeting

The interviewee described a pattern of having difficulty, or failing, to manage their income in order to provide for their basic needs (e.g. food or housing).

#### Drugs

The interviewee identified a history of use or abuse of drugs (other than alcohol or tobacco).

#### Family breakdown/instability

The story given by the interviewee presented a picture of an unstable family situation, or the breakdown of the family unit, during their childhood or adolescence. This includes elements such as family fights, violence or abuse within the family unit, parental relationship breakdown, or runaway behaviour.

### Foster families

The interviewee indicated a history of being in foster care during their childhood or adolescence. Does not include institutional care (such as boys' homes or borstals).

### Frequent moving/change in housing

Where the interviewee indicated a pattern of frequent changes in housing, or shifts between cities, either in their adult life, or as a child or adolescent.

### Gambling

Gambling appeared to be related to the development or maintenance of the homeless state.

### Gang involvement

The interviewee described an involvement with an organised gang (for example Black Power or the Mongrel Mob) at some point during their life.

### Institutional care as a child/adolescent

The interviewee described being in institutional care during their childhood or adolescence. This includes placements in boys' homes, borstals, prison, or a psychiatric institution.

### Lack of schooling/education

The interviewee identified a pattern of poor achievement at school, truancy or a lack of educational qualifications.

### Mental health

The interviewee had either a diagnosed psychiatric condition, or gave a suggestion of having one (for example stating that they had a problem with anxiety, or heard voices in their head).

### Negative beliefs about self/self-image

The ideas raised by the interviewee indicated a pattern of negative self-belief, or a negative self-image.

### Prison as adult

The interviewee gave a history of having been in prison during their adult life.

### Relationship breakdowns

The interviewee described a relationship breakdown, which resulted in, or was associated with, them becoming homeless.

### Social isolation

The ideas raised in the interview suggested an element of social isolation (for example stating that they would rather be by themselves, or did not like interacting with other people).

### Traumatic parental death

The interviewee described the death of a parent or caregiver, which appeared to have significant impact on their life, and was implicated in them becoming homeless.

### Trouble communicating with others

The interviewee described difficulty in communicating with other people socially, or difficulty communicating their problems to an agency, in order to gain support.

### Trouble with Police

The interviewee described getting in trouble with, or having difficulties interacting with the Police. This may or may not have resulted in them going to prison.

### Unemployment

The interviewee described either unemployment as a barrier to them becoming housed, or unemployment as a precipitating factor for their homelessness.

Any other miscellaneous themes identified were also noted.

If the sex, age or ethnicity of the interviewee were mentioned, these were noted.

An attempt was made to identify specific factors that led to the maintenance of the homeless state, but it was found that many stories were too complex to adequately and reliably categorise these factors. It was difficult to establish the temporal relationship of factors in the individual's life-story.

Any interesting quotes were noted and these were used to help illustrate and give voice to the participants.

After reading through the transcripts and conducting the inductive thematic analysis, the main common pathways that appeared to lead to homelessness were identified. Using this typology of pathways, each transcript was categorised under one or more of these pathways, and their story was summarised.

In order to illustrate and contextualise the main pathways into homelessness, we then constructed a generic story for each main pathway, which incorporated elements of several individual stories.

Some transcripts included the interviewees' views regarding services around Wellington. These perceptions were also noted and summarised. Comparison between the agencies' and homeless peoples' views were made.



### *3.2 Agency Interviews*

A selection of agencies was made based on previous work within He Kainga Oranga. In addition, we used a snowball sampling technique by seeking referrals to other agencies from the agency interviews we conducted. We attempted to be inclusive and robust in our selection of agencies. We attempted to interview agencies working directly in the field and also agencies whose policy areas or fields of activity might directly or indirectly relate to pathways associated with homelessness. We accept that we may inadvertently have omitted agencies that may wish to contribute to the field of homelessness and make an open invitation for comment on the content of this report.

Key Appointments were arranged by telephone and an interviewer visited each agency (with the exception of two agencies who were interviewed over the telephone). Agencies were supplied with an information sheet describing the project (see appendix G). At the interviews the participating agencies were provided with a 'show card' (see appendix H). Interviewers structured their interviews on the basis of an interview guide (see appendix I). Ultimately 25 agencies were interviewed (for a list of these agencies see appendix J).

With the interviews we attempted to establish each agency's definition of homelessness and compare it with our own definition. The intention of this was also to advance a definition to the agencies working in the homelessness field in order to gain some acceptance of a definition that might be of some future use in measuring the homeless population and thus measuring the efficacy of interventions.

The second goal of these interviews was to establish the functions of each of these agencies, particularly in relation to the homeless population. In order to apply a public health model to this analysis we divided services into primary, secondary and tertiary interventions.

We defined primary interventions as those interventions that were intended to prevent individuals becoming homeless. Primary interventions were in turn divided into:

- a. High-risk approaches targeting those who are known to be at risk of becoming homeless.
- b. General approaches targeting the whole population.

Secondary interventions were defined as interventions intended to get individuals out of homelessness.

Tertiary interventions were defined as those interventions aimed at helping people live with the consequences of homelessness.

We asked agencies to categorise their services as falling into one or more of these categories.

The third intention of the agency interviews was asking each agency to identify the perceived gaps in servicing the homeless in the Wellington region.

Finally, we sought referrals from the agencies we interviewed to other agencies within the Wellington region.

Four medical student researchers conducted most of the agency interviews, although others of our number conducted additional interviews. Notes were made of each interview and were transcribed later by the interviewer. These notes are included in appendix J of this document.

On the basis of the notes that were made from these interviews we made an inventory of services available in the Wellington region. Additionally, we compiled a list of gaps in services for the homeless as identified by the agencies. This list of gaps forms the basis of a number of recommendations made at the end of this document.

## 4. Results

### 4.1 Homeless Interviews

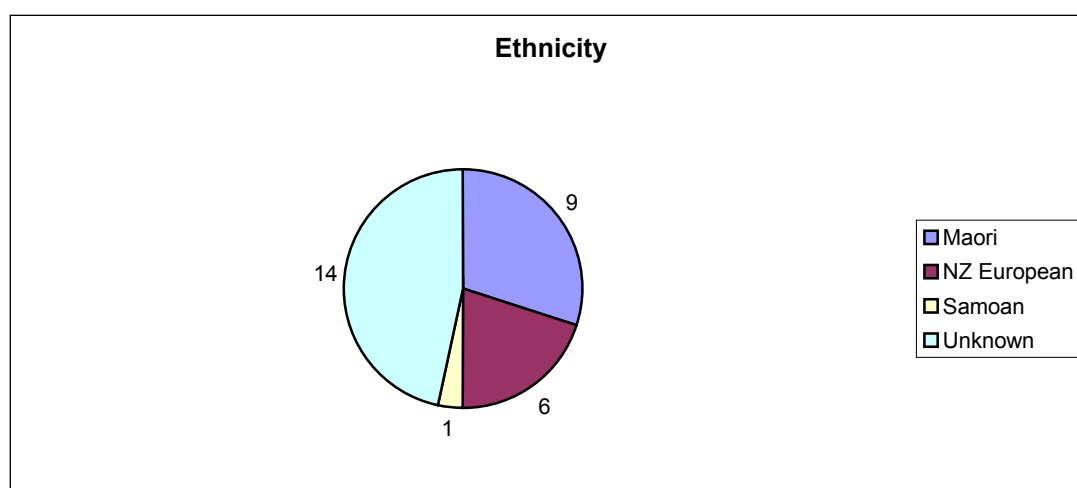
#### 4.1.1 Demographics (Appendix E)

Total number of interviews analysed: 30

**Gender:** 29 male, 1 female (97% male)

**Average age:** 36.5 years (range 17-51 years)

**Ethnicity:** 9 Māori  
6 NZ European  
1 Samoan  
14 unknown

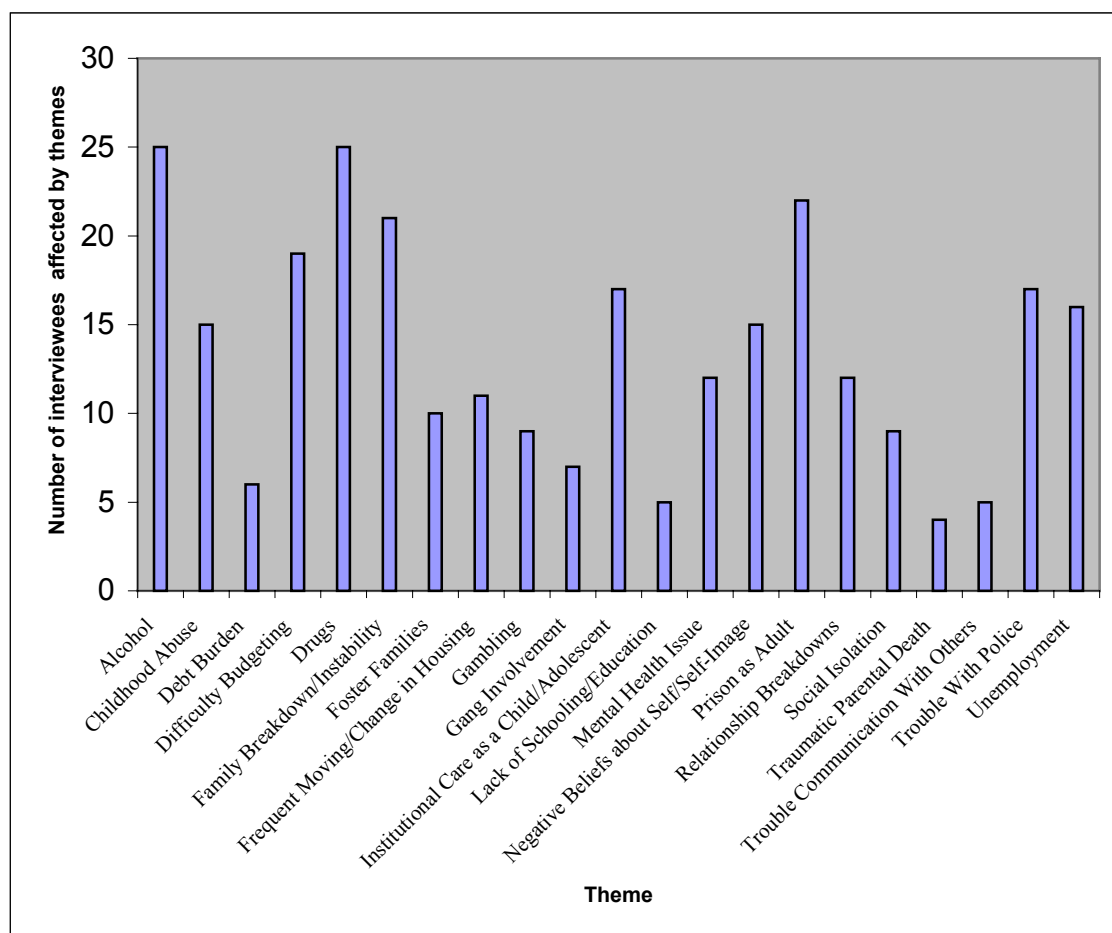


**Figure 1: Ethnic Classification of Interviewees**

**Table 2: Ethnic Classification of Interviewees by Percentage**

	All Interviewees (%)	Interviewees of known ethnicity (%)
Māori	30	56
NZ European	20	38
Samoan	3.3	6.3

#### **4.1.2 Themes:** (Appendix D & E)



### **Figure 2 – Number of Interviewees affected by themes**

Figure 2 shows the number of interviewees that reported being affected by each theme. Alcohol and drugs were the most common themes, followed by being in prison as an adult. It is to be noted that the information in this graph only reflects this group of interviewees, as our research was not a quantitative census of homeless people in Wellington.

### **Table 3 – Raw data of themes identified in interviews**

The following page (Table 3) is the raw data regarding themes arising from the interviews. The letters represent each interviewee and the themes they identified with.

[illegible]

#### **4.1.3 Common Pathways – ‘Driven, Dropped, Drawn’ (Appendix F)**

As a result of the inductive thematic analysis, three main, broad pathways into homelessness – Family Situation, Discrete Event, and Natural Progression - were identified as being common to most participants in the interviews.

##### 1. Family Situation (‘Driven’)

This pathway began with common events such as parental break-up, family instability, domestic violence, or parents addicted to alcohol or other drugs. This often led into foster care, institutions such as boys’ homes or borstals, then to alcohol and drug use, unemployment, crime and prison.

Nineteen stories were found to fit in this pathway.

##### 2. Discrete Event (‘Dropped’)

This pathway covered people who had a single discrete event, which acutely precipitated homelessness. This includes people who were suddenly made unemployed, had traumatic relationship breakdowns, a traumatic parental death, or an acute mental health episode.

Nine stories were found to fit in this pathway, although two of them were also included in the ‘Driven’ pathway.

##### 3. Natural Progression (‘Drawn’)

This pathway included people who may have come from a relatively stable family background, but had behavioural problems, may have been expelled from school, gotten into crime, started hanging out on the streets, and lost contact with family.

Three stories were found to fit in this pathway.

Although we believe these classifications accurately represent the major, broad pathways by which the participants became homeless, there was one interviewee who did not fit this classification.

Below, we present three generic stories illustrating the possible pathways into homelessness, which incorporate elements of a number of different



interviews. We wrote generic stories instead of using an actual interview to protect the confidentiality of the participants.

#### **4.1.3.1 DRIVEN (Family Situation)**

Mr B is a 35-year-old Māori male. He has been homeless on and off for most of his life.

Mr B was born in Auckland. His parents were not married; he lived with his mother and saw his father once a week. At four years of age, he was removed from the care of his mother, and placed in a foster home. He experienced physical violence in this setting, and only stayed here for six months.

He was placed in the care of relatives of his mother, and began school at five. He experienced learning difficulties and did not enjoy the school environment. At home he was causing trouble and misbehaving. By nine he was a regular truant at school, and was often running away from home. He was found stealing from the relatives he lived with, who decided they could no longer cope, and placed him in institutional care.

He moved through three different institutions and borstals until the age of 15. He now reflects that his trouble with alcohol, drugs and violence started in boys' homes, due to improved access.

*"It introduced me to a lot more drugs and that. More variety because of the other people that were there that had other problems, and lots of drugs...there's a lot of stuff there that you can get, that started me in the downward spiral"*

- 35-year-old male

At 15 he ran away with some friends from the boys' home, and began squatting in abandoned houses. He moved to Wellington six months later in search of employment.

He became involved with gangs at the age of 17, during which time his alcohol and drug habits became more serious. He was involved in several violent attacks, and was arrested and imprisoned at 18-years-old.

He served a two-year prison sentence, and was released in 1980. He found the experience of release more difficult than the prison time itself.

*"You need somewhere where you can come out and go that's safe for a couple of weeks, so you can get your feet back on, you can have a look out the door, you can come to places to get help, and from there you can get your house or whatever. You see, we've got nothing – we come out and we go straight to the streets. So what we do – we get our Steps To Freedom, we blow it, then we come to places like this to get a food parcel or whatever, and that's it – we stop, we turn off, we don't go any further"*

- 40-year-old with long experience of homelessness

He spent his release grant on clothes, tobacco, alcohol and a few nights accommodation in the Night Shelter. Once this money was gone he felt his only support came from the Work and Income NZ Unemployment Benefit. He did not receive any assistance to find accommodation or employment after his release.

Over the next few years he worked in several casual jobs, but found his criminal record was a barrier to gaining permanent employment. His alcohol and drug addictions continued through this time, and most of his income was prioritised on these things. He was kicked out of several flats as he was often unable to meet the rent.

*"I can't save at all. All my money goes on to addictions. That's my number one priority in life"*

- 35-year-old male

From the age of 25 to 32 he served several short prison sentences, mostly related to his drug habit. Each time he was released he returned to homelessness, and had to sleep rough on a number of occasions.

He has had no serious relationships during his lifetime, and feels this has to do with his inability to trust people, which has stemmed from his unsettled childhood.

He has problems with low self-esteem, and often feels useless and if he is 'missing something'.

He currently wants to get a job, but finds his addictions and criminal record major barriers to achieving this. No one will take a chance on him. He also would like to get a house, but is realistic about this:

*"Something that I could just call home, eh. Doesn't have to be flash or anything, just so long as I have the key to lock and unlock the door"*

- 32-year-old male

#### **4.1.3.2 DROPPED (Discrete Event)**

Mr L is a 50-year-old Pakeha male. He had been homeless for ten years.

Mr L had a stable upbringing and childhood, no behavioural problems, and achieved education up to a School Certificate level.

He worked in several jobs, mostly in the transport industry. He was financially comfortable, and happy with his job.

He had three long-term relationships, and married at the age of 26. He and his wife had two children, both of whom moved overseas after completing school.

At the age of 40, Mr L lost his job due to a downsizing of the business he had worked fifteen years for. He was given a modest redundancy package, but this did not last long due to mortgage repayments on the family home. He tried to secure another job, and attended several interviews, but the positions were inevitably given to younger people.

After two years of unemployment, and existing on the Unemployment Benefit, there was strain on the couple's marriage. The relationship deteriorated further, and Mrs L kicked Mr L out of the family home.

This left Mr L, at 43 years of age, with no job, no marriage, and no home. He stayed with friends for a few weeks, but eventually had to leave. He moved into a room in a boarding house.

Mr L started spending his days drinking heavily at the local pub and gambling. He found that his benefit could no longer cover his lifestyle and his board payments, so left the boarding house to sleep rough. He felt like he only had himself to worry about, and a place to sleep was a luxury he did not really need, especially when the place he was paying for was unsatisfactory.

He lost all sense of self-worth, as his whole sense of identity was associated with his job, home and marriage. He felt low self-esteem was a barrier to getting anywhere. Over the past year he has slowly started to improve this, and is finding getting access to help much easier:

*"I mean, you can help out with things like food parcels like you guys do, and that's good and practical help. But something's got to be done to make the person start to feel good about themselves, cause that's what I learned. Once I started to learn about feeling good about me I could approach other people and get help from you guys and other organisations"*

- 40-year-old male

#### **4.1.3.3 DRAWN (Natural Progression)**

Mr R is a 41-year-old Māori man, homeless since his early teens.

Mr R grew up in the outskirts of Invercargill and had a very stable childhood and loving parents. His family were working middle class and financially comfortable.

He started getting into trouble at an early age; playing truant at school, running away and stealing cars. His siblings had no behavioural problems, but his friends were a major influence on his actions.

His family tried to help him and never sent him to a boys' home or any other institution.

In his teen years he began using drugs and alcohol. He had huge problems with anger at everyone and everything. He got into some trouble and was sent to family group counselling.

He left home in his teenage years to move to the city with friends. During this time they all survived on the benefit and lived together in old houses. Parties, alcohol and hard drugs ruled their lives. He lived as a street kid for several years.

He got into trouble with the police and was sent to prison, this recurred several times throughout his adulthood. He feels prison is useless in that it does not teach any life skills or help people to improve their situation.

*"In prison it's all done for you and you're not taught a lot of skills"*

- 40-year-old male

-

He moved to Wellington and has had several experiences flatting, but these have ended due to financial issues (secondary to addictions and unemployment), or due to his anger management problems. He feels that because of his troubled youth, he failed to learn how to relate to other people or how to manage everyday life situations.

His lack of education and job skills, plus no work experience, make it difficult for him to gain employment.

His lack of life skills is compounded by lack of communication skills. He has found getting help from agencies very challenging and frustrating:

*"I think it's ridiculous because they are prepared to give me a couple of hundred dollars a week to do nothing and yet we have some ideas and they won't support them"*

- 45-year-old male

He is currently building a support network around him. This includes contact with his family who still want to help him.

*"What I'm doing now is building up a network around me because I haven't got one..."*

- 40-year-old male



#### **4.1.4 Services Gaps - View from the homeless**

The interview asked participants about being homeless in Wellington. Participants were asked for their perception of services available to them in Wellington, how good these services are, and the barriers to them being housed or remaining housed.

It is important to note that these perceptions only represent the group that was studied and should not be used to represent views of the entire homeless population in Wellington. Furthermore, not all participants commented on the services mentioned and comment was generally only noted if the person had a particularly strong positive or negative opinion.

##### **4.1.4.1 Childhood services**

Participants identified poor childhood services as a major contributor to homelessness.

Prior to organised childhood interventions many participants lived in unhealthy environments; with family dysfunction, abuse and insecurity. This lifestyle can result in long-term learned patterns of negative behaviour and/or persistent anxiety.

*"I think the primary reason [for homelessness] is that the first 3-4 years of a child's life is the most important. If you muck any of those years up, between 1-4; their school life or their home life is not in balance, that's one of the directives for the monsters to come in"*

- 45-year-old male

Once in foster or institutional care, some participants suffered abuse or were exposed to violence, alcohol and drugs.

*"It introduced me to a lot more drugs and that. More variety because of the other people that were there that had other problems, and lots of drugs...there's a lot of stuff there that you can get, that started me in the downward spiral"*

- 35-year-old male

The majority of those interviewed described frequent changes in housing situations during their upbringing.

*"I was always bounced around different homes and different schools"*

- 30-year-old male

As a consequence of both of these experiences, a number of interviewees identified long-term sequelae: poor life skills; trust issues; no sense of belonging; and a strong dislike of authority figures and societal systems.

*"Where do I fit into society? I don't fit in and no one told me how to fit in, they just wanted to pawn me off to any family that would take me. And I tell you what, none of them wanted me"*

- 31-year-old male

#### 4.1.4.2 Social Support

Several people identified lack of social support networks as a reason for becoming homeless or for maintaining homelessness. Participants stated that this was due to their disruptive childhood living situation, or lack of belonging to a safe community. One man spoke about an injury that stopped him working and mentioned that support would have helped him.

*"Because I haven't had the support of family or friends or that, the injury I had I could've overcome. I could have worked through it"*

- 30-year-old male

*"What I'm doing now is building up a network around me because I haven't got one, haven't got friends that I grew up with from teenage years, and relationships that I had as an adult, they haven't continued. With me personally I see it with a lot of other people; being homeless is because they are very alone and they do things on their own or they are very lonely people. They don't reach out, don't go to organisations continually – maybe call them once or twice...but don't make full use of what is available"*

- 40-year-old male

One man specifically identified feeling isolated from 'normal' society.

*"They're not going to let me into the local bowling club and be buddies with them in middle class areas"*

- 35-year-old male

Another person thought that being homeless was good for him as it gave him social networks that he had not had before.

*"It [being homeless] wasn't a bad experience, it was like a good experience for me"*

Interviewer: What was good about it?

*"Feeling part of something. Because I was in the same place as them and having to say the same things to each other and there wasn't anything else to talk about other than what you actually do"*

- 26-year-old male

#### 4.1.4.3 Night Shelter

When asked about the Night Shelter, there were many negative responses. These tended to focus on lack of security for possessions, the condition of the shelter, and unsupportive policy such as strict lock-down times.

Living in the shelter was also identified as a barrier to gaining employment, as there is no way to be contacted whilst residing there.

One interviewee compared the Wellington shelter to the Christchurch shelter; he stated the Christchurch shelter was integrated with other services, such as counselling and medical services, and a soup kitchen. The service is free, but despite this well staffed in his opinion.

*"I do know guys here I have spoken to...and I've said 'you know there is a night shelter down there' and they've said 'I would rather sleep out here', and that's bad"*

- 40-year-old male

*"My annoyance with the one here in Wellington is you need to have something available for guys to do...you need to give the guys a bit of responsibility and a bit of access to doing laundry, because you have been sleeping in your clothes and sometimes that's all you have got. Making them feel like a person, not saying like 'Ok, it's 9 o'clock and we're going to lock the door, you can't go outside for a cigarette"*

- 40-year-old male

#### 4.1.4.4 Work and Income NZ

There were several comments made about the advantages of Work and Income paying rent and power before the rest of the benefit was paid.

Unfortunately, many found that the remaining income was often unrealistic and difficult to live from.

The Work and Income Benefit payments were identified as the only ongoing support after release from prison.

One participant identified the frustration of receiving a weekly benefit but being unable to affect change in how social welfare operates; financial support is no good on its own.

*"They must think I'm a mushroom, because they feed me shit and keep me in the dark all bloody day"*

- 34-year-old male

*"I think it's ridiculous because they are prepared to give me a couple of hundred dollars a week to do nothing and yet we have some ideas and they won't support them" (on Work and Income not listening)*

- 45-year-old male

*"I will go back to getting \$35 a week in the bank, in the hand, you know, after those things are paid [rent and bills]. So it's like five bucks a day, which most people couldn't imagine, they just couldn't...imagine going into a supermarket and spending less than that, see what it gets you"*

- 41-year-old male

#### 4.1.4.5 Council Housing / Housing NZ Corporation

The majority of those interviewed who currently occupy council housing were happy to have something of their own.

*"It's [flatting] a whole new way of life, I'm really enjoying it...I've got no intention of going back on the street."*

- 51-year-old male

Some tenants felt the quality of their accommodation was poor, but they realised the limitations of housing services.

*"I've got a left-hand corner of my window, you know, like I get to see a square little bit of sky to make out whether its blue or grey"*

- 41-year-old male

One participant had the opinion that the council housing was adequate for the present, but that he was working towards something better.

*"I want to improve my accommodation and my standard of living, and I can only see that through education"*

- 51-year-old male

It was stated that a council house would feel more like a home if there were practical things provided, for example furniture.

*"Mayor gave us flats to stay in... and they chucked us into flats with no furniture, nothing and we only stayed 2 days and then we were back on the streets again"*

- 37-year-old male

Even with housing provided, barriers to this becoming a home were more often associated with emotional rather than physical needs.

*"Home's not the building that's around you; it's what's inside you, its how contented you feel about yourself, or secure"*

- 35-year-old male

Many participants said that they had problems with budgeting and practical living skills, and that this would be a considerable barrier to them remaining housed.

#### 4.1.4.6 Prison and Support

Few comments were made on the difficulties of imprisonment itself; rather the focus fell on problems after release. Participants believed that time in prison could be better used teaching life skills and coping mechanisms for use in life outside.

*"In prison it's all done for you and you're not taught a lot of skills. It's a lazy environment; you sit back and have the attitude that you'll still get fed and all that sort of stuff so it's not very helpful. If you are very angry and you've got a lot of problems, you step back outside and you're in the same situation and nobody's feeding you and no ones looking after you...they don't actually give you a skill or any training"*

- 40-year-old male

From interviewees' perspectives, there needs to be intermediate support and accommodation before becoming self-sufficient after release.

*"We do need halfway places, because if you come out of prison, doesn't matter if you've been in there one week or ten years, you need that. You can't come out and fit in. You have to come out and slowly get back in"*

- 40-year-old male

The Steps To Freedom, while helpful, were often misused, lasting no longer than a few days.

*"You see, we've got nothing, we come out, and we go straight back to the streets. So what do we do – we get our Steps To Freedom, we blow it, then we come to places like this to get a food parcel or whatever, and that's it. We stop, we turn off, we don't go any further"*

- 40-year-old male

NB: The authors understand there have been recent changes to the prison release system.

#### 4.1.4.7 Mental Health Services

One participant had strong views on the mental health services in Wellington. He found moving here created a barrier to access as he was not from the area and there was no record of him, preventing him from getting support.

*"When I first came here [Wellington] I needed someone to talk to, and they [mental health services] were like, 'well we can't really deal with you because you've been out of the system for too long'. Basically you've got to do something drastic to see someone...I ended up taking an overdose just so I could see them, and I nearly died"*

- 30-year-old male

#### 4.1.4.8 Addictions

Addictions to alcohol, drugs and gambling were frequently mentioned. They were identified both on the pathway to homelessness and as maintaining factors.

*"I can't save at all. All my money goes on to addictions. That's my number one priority in life".*

*"I think I'm on the streets because I stayed on the streets because of my addictions and the fears and paranoia that goes with it".*

- 35-year-old male

Participants were very vocal in their opinions on addictions, and saw them as a major contributor to the problems of the homeless community. They want Wellington-based interventions to prevent this problem.

*"You want to stop it, you don't want anyone else to go through it"*

- 45-year-old male

*"If I didn't have a habit, I would love it. If I could turn back time to when I was 15, I would never pick up the needle and never put heroin in my arm. If I could turn it around, if I knew that sort of shit, because believe me, having a habit ain't fun"*

- 40-year-old male

Addictions were identified as a major barrier to improving one's life situation.

*"I've got to get off the alcohol before I do anything serious (about my life)"*

- 44-year-old male

#### 4.1.4.9 Having a Say on Services

In participants' opinions, a major problem in the current system lies in the failure to listen to the voices of those it is trying to help.

*"Sometimes things are set up for homeless people with all the good intentions...but I think the people need more input"*

*"Sometimes it's a case of not being listened to"*

- 45-year-old male

There is the opinion that service groups need to go out and talk to homeless individuals to find out what they need, and what would be effective in helping them.

*"I'd like to see a big survey done with addiction people and there might be some new work scheme arranged"*

- 45-year-old male

A large proportion of participants identified self-esteem issues as a barrier to change. This factor is currently not adequately addressed by service providers on the whole.

*"I mean, you can help out with things like food parcels like you guys do, and that's good and practical help. But something's got to be done to make the person start to feel good about themselves, cause that's what I learned. Once I started to learn about feeling good about me I could approach other people and get help from you guys and other organisations"*

- 40-year-old male



*"If you're not willing to put yourself in a position to change then no one is going to change it for you"*

- 51-year-old male

One person emphasised the importance of the involvement of the wider community in developing strategies to deal with homelessness.

*"At the end of the day it all comes down to the community backing it up"*

- 37-year-old male

#### 4.1.4.10 General Opinions

*"I think you make it a lot easier for people who make life hard for themselves"*

- 50-year-old male

A general lack of service integration was identified by many of the participants. They felt that getting help from one agency was often limited due to lack of inter-agency communication. One person described major problems with linkups between services; often services have no idea of the bigger picture of that person's life. An improvement in housing may not necessarily improve one's life situation when not coupled with other changes.

*"If I move into my flat, I also want a job. I don't want to have a flat and be on the benefit, because then all you get is another bill"*

- 34-year-old male

*"You can't just give somebody a house full of food, and maybe rent paid for a while, and hey – problem solved. Because that's not how we got to where we are, there was a whole list of things that happened"*

- 40-year-old male

People who were satisfied with a service often put it down to advocacy in the service. One person felt that he wanted to change his life and have access to his entitlements, but did not fully understand how this could be done until DCM showed him and *"put it all together."*

*"It's a vicious circle - you haven't got the will or someone to mentor you and bring you out of that tailspin"*

- 51-year-old male

A suggestion proffered by a number of participants worked with the idea of a case manager or inter-agency advocate to improve access and awareness of services.

*"See, if you have people with anxiety problems like I do, and I mean, if I can't get it out on one go, and I go like say to [service provider] and they start throwing me around from floor to floor, I'll walk out you know. Because if I don't know what I need or what I want, then they don't know and I might as well go"*

- 40-year-old male

Problems dealing with bureaucracy and paperwork were identified as barriers to accessing support services and getting a flat. One man had his identity documents stolen, and as a result, has had considerable difficulty with entitlements to services. This problem may not have resulted had a caseworker system been in place.

An interesting comment made by one participant was regarding the ethnicity of arresting officers in the Police. He felt that Māori or Pacific Islander officers have a better way of dealing with alcoholics on the street, and they relate to homeless people better. At the moment the majority are Pakeha in his view.

There was also a suggestion for an agency where homeless people could go to get support and counselling if something has happened to them. They do not like to go to the Police, but need someone to talk to who

might be able to make suggestions. This would be a way of dealing with problems without using drugs.

## 4.2 Agency Interviews

### 4.2.1 **Definitions and Frameworks**

The definition used in this study was widely accepted by the agencies that were interviewed. It should be noted that this definition only identified one area of homelessness and did not include those on the brink of homelessness (incipient homelessness).

The public health prevention model was accepted for the context of this study. However, agencies felt they fell into most of the categories making it hard to categorise them. Another problem encountered was the wording of the primary prevention definition. One agency thought it that the phrase 'high-risk' should have been 'high-risk individuals' instead.

### 4.2.2 **Gaps in primary prevention:**

These gaps were identified in relation to services that could prevent high-risk populations becoming homeless:

#### 4.2.2.1 Alcohol and drug services

*"I've got to get off the alcohol before I do anything serious (about my life)"*

- 44-year-old male

This was an identified gap with most agencies. There are no residential rehabilitation services in the Wellington area. There was an identified need for more alcohol and drug counselling in Wellington. One agency felt there was a need for more Māori women counsellors for Māori men who have sexual abuse history and do not feel comfortable with male counsellors.

#### 4.2.2.2 Gambling intervention services

*"I'm finding gambling a problem...you lose all your money"*

- 24-year-old male

Gambling and debts were often identified by the agencies as a pathway into homelessness. There is a lack of intervention services that help those people with gambling problems in Wellington. A number of people with experience of homelessness were found to have significant debt and there is lack of budget services to help advocate and educate these clients about paying off debt. One area that was identified to be lacking was an Asian-specific Gambling Intervention counsellor, as there is a high proportion of Asians in Wellington with gambling addictions.

#### 4.2.2.3 Mental Health services

Mental Health covers a broad spectrum of disorders ranging from anxiety to axis-I psychiatric disorders. A large population of people in Wellington fit into this spectrum and there are limited resources to manage them. Therefore there are a number of gaps in the mental health services. There was an identified lack of mental health services for those with complex needs, such as dual diagnosis.

#### 4.2.2.4 Community education and awareness

Most agencies commented on the public perception of the 'problem' of people living on the streets and the difficulties this perception creates. It was felt that if there was increased awareness of why people may become homeless and what they can do to help, the stigma of homelessness may decrease. The public perception of addressing the homeless 'problem' needs to be shifted from 'getting them off the streets' to accepting peoples' choice to live on the street, with the full support that they deserve as a member of society.

#### 4.2.2.5 Māori specific services

Around one-third of the participants in the interviews used by this study identified themselves as Māori. This would suggest an over-representation of Māori in the homeless population. Some of the agencies interviewed as part of this project indicated that there is a lack of services that address the needs of Māori in an appropriate cultural context. There is a lack of Māori specific services in most areas especially A&D, gambling, youth and mental health services.

#### 4.2.2.6 Transition from CYFS care to community agencies (17-18 years)

A gap in service provision was identified in the co-ordination between CYFS and the wider community social agencies at the time when a child reaches the age of transition between them. At 17, a child is no longer the responsibility of CYFS, and yet is not eligible for some important services until they are 18 (eg. Social Housing.) This is a critical point of intervention, as during this window, one could fall into homelessness, especially those young adults with complex needs. There is a need for a process to ensure there is a continuity of support when a young person is handed over from CYFS to a community agency.

### **4.2.3        Gaps in secondary prevention:**

In this study we have identified a serious lack of housing and beds available in Wellington for those who are homeless or those with inadequate accommodation. This can be broken down into three areas of need: Emergency accommodation; Supported accommodation; and Sustained accommodation.

#### 4.2.3.1    Emergency housing

Emergency housing is seriously lacking in Wellington and this was reinforced by most of the agencies interviewed in the study. The group identified as being most lacking in access to emergency housing were those with alcohol and drug addiction problems, and those with dual diagnoses. The dual diagnosis group refers to people with addiction and mental health issues. Behaviours related to substance abuse and mental health issues often make these people ineligible for all emergency housing currently available in Wellington.

The other groups identified with a need for more emergency accommodation included women, single males, sex workers, mental health consumers and youth with addictions and/or mental health issues. There is a limited range of emergency accommodation options in Wellington to meet special needs of a changing homeless population. There is a definite increase in the number of females with experience of homelessness in Wellington, which is consistent with overseas trends [39].

#### 4.2.3.2    Supported accommodation

There is a definite lack of supported accommodation in Wellington. Many agencies and self-identified homeless people interviewed talked of a lack of transitional housing, bridging the huge leap between emergency accommodation and living in a private home alone, with limited assistance. A lot of these people with experience of homelessness have never lived in a 'normal house' where they have observed the skills of cooking, cleaning and 'normal' social interaction with others. Agencies that do provide this type of service, such as Easy Access Housing, expressed concerns about the limited supply of such accommodation in

relation to the huge demand for supported housing in Wellington. This need was especially identified for the population of ex-prisoners needing help with re-integration into society and housing.

#### 4.2.3.3 Suitability of options for sustained, affordable housing

Presently in Wellington there is a serious lack of suitable and affordable accommodation options for those that are presently homeless or on the brink of becoming homeless. Agencies identified that it was especially difficult for single men to obtain suitable accommodation as a lot of the social housing is set up for families. They commented that single men were offered bed-sits or single rooms in hostels but these options are limited in number and involve living in close proximity to a broad cross-section of people. Again, the problem arises for those with addictions, behavioural or mental health problems in terms of their suitability for this housing.

#### 4.2.3.4 Other: Residential Rehabilitation Services

The agencies felt that a big gap in Wellington was the lack of any residential rehabilitation services. A number of rehabilitation services around New Zealand have recently closed down, including Bridgehaven, increasing the severity of this gap for those with serious addictions.



#### **4.2.4        Gaps in tertiary prevention:**

##### 4.2.4.1    Co-ordination of services

The study showed that there are a large number of services already in Wellington doing a really good job in their specific areas. However, a lack of a co-ordinated strategy between all these services was seen as a barrier to creating a greater force for helping those who are homeless. Some agencies commented that if all the services combined their resources and energies, they could help provide for the needs of the homeless population in Wellington more efficiently. The main gaps in co-ordination were between community agencies and Government departments.

##### 4.2.4.2    Work and Income NZ access

*"Social welfare gave up on me"*

- 24-year-old male

Most of the people with experience of homelessness in the study were receiving benefits. Most receive an Unemployment Benefit, which is inappropriate for their needs. While many agencies described the meagre income many are left with after paying off debts such as court fines, and difficulties with getting a bond together, Work and Income NZ is legislatively limited in the assistance it can provide with the Unemployment Benefit. The majority of assistance covers housing costs, of which they have none to claim. Most are not able to access food grants or the Special Benefit due to inability to provide the evidence required qualifying for these. The most appropriate benefit for most of those with an experience of homelessness is the Invalids Benefit, which is paid at a higher rate than the Sickness or Unemployment Benefits and only renewed every 52 weeks. The IB is for health conditions expected to last two years or more, which includes mental health and addiction issues. The barriers to receiving this benefit seem to be stigma and the co-operation of health providers. Understandably, some GPs retain these clients on a Sickness Benefit as it allows them to see the client regularly (every 12 weeks). However, most of the homeless clients on this benefit do not renew it in the due day, and the problems of a lapse in income

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ensue. For these reasons, the successful maintenance of those with an experience of homelessness on the appropriate benefit would probably require the co-operation of an inner-city PHO with Work and Income NZ.

The second Work and Income issue is the use of advocates. Many of the Wellington homeless population use an advocate or agent to deal with Work and Income for them. This arrangement works best for both parties: the people with experience of homelessness generally do not like to go into Work and Income, only as a last resort; and Work and Income Case Managers generally find it easier to communicate with agents. However, the function of Case Managers is not only to provide the appropriate benefit, but also to bring in other services that the client may need. Work and Income have strong links with health and community services and can bring them into the office when the client is there. If the person with experience of homelessness uses an agent, the Case Manager never gets to see the client and cannot assess them for the Development Assistance they may be eligible for.

#### 4.2.4.3 Boredom/Place to 'hang out'

A gap identified by both the agencies and the people with experience of homelessness in this study was not having a safe, allocated place to 'hang out' and socialise (a gap created by the 'loss' of Glover Park.) This was also coupled with the problem of boredom. The agencies identified that boredom constitutes a huge issue for the people, and highlighted the lack of places for homeless population to go during the day that were not of 'public nuisance'. A lack of programmes offering opportunities for the constructive use of their time was also noted.

#### 4.2.4.4 Addiction and Mental Health Services

Services overall for addictions and mental health in Wellington are few and those that do exist are thinly stretched. Addiction and mental health issues were identified by agencies as common pathways into homelessness; therefore they felt there needed to be more services available for the people with experience of homelessness. The agencies felt there was a lack of cultural specific services for people with experience of homelessness, especially for those who are Māori. There was a definite

gap in services for young people with addiction and mental health issues. People with dual diagnoses (those with both mental health and addiction disorders) were identified as a group that are heavily affected by the lack of funding for services in these areas. The Mental Health Blueprint indicates that 14.5 Full-Time Equivalent (FTE's) workers ought to be employed in the dual diagnoses field in Wellington to meet the current demand; it is currently served by 0.5 FTE's [40].

## **5. Discussion**

### *5.1 Homeless Interviews*

#### **5.1.1 Demographics**

We are unable to comment on whether the demographics of the participants in this study accurately reflect that of the general homeless population in Wellington. There is no previous literature published on the demographics of the homeless population in New Zealand, and this presents an opportunity for future study.

Only one female was included in the interviews we analysed. This may result in an under-representation of the views of the females with experience homelessness. It is possible that there may be differences in pathways for males and females.

The mean age of our interviewees was 36.5 years. Anecdotally this is probably representative of the general homeless population (personal communication Phil Walker, DCM).

There was limited ethnicity data recorded with the interviews, however of those who recorded ethnicity, a large proportion (56%) were Māori.

### **5.1.2 Themes**

The inductive thematic analysis yielded a number of common themes that were associated with homelessness. The most frequent themes identified in the interviews were: alcohol and drugs; having been in prison as an adult; and a background of family breakdown or instability. Many participants also described difficulty in managing their finances, unemployment, and having been in institutional care as a child or adolescent. This is in accordance with other overseas studies [39] [34] [41].

Our data is suggestive that alcohol and drug problems have a high prevalence within the homeless population which is in accordance with overseas studies [42] [28]. It is essential that services are available for people with experience of homelessness who wish to address these problems. However many participants noted that it is up to the individual to make a decision for themselves as to whether they have a problem, and whether they need help.

Many participants described a background of having been in prison as an adult, for a variety of offences. In many cases it was difficult to determine whether having being in prison was a cause of homelessness in itself, or an effect of being homeless. Often, it is probably a combination of the two. Most of these people described leaving prison and moving straight back to the street. This pattern presents a problem for the Corrections service, and society in general. It appears that most of these people simply left prison and fell straight back to their original position or worse.

A large proportion of the participants interviewed had a background of family breakdown or instability. It is likely that this is a key factor in the pathway towards becoming homeless. Family breakdown or instability can encompass a number of different scenarios including being kicked out of home, parental split, domestic abuse, or poor intra-family relationships and communication. This is a huge problem, and something that society in general has to address. The importance of a stable, loving family as a key preventative factor against the development of homelessness cannot be overstated. It is evident that a large amount of the homelessness in the Slipping Through the Cracks, a Study of Homelessness in Wellington

Wellington region stems directly from the breakdown of the stable family unit. This factor reinforces the importance of having an effective Child, Youth and Family Service.

The difficulties with basic life skills relating to budgeting and management of finances among many interviewees were clearly apparent. A large number of participants described situations where they had been unable to manage their money, such that they had been unable to pay for rent or food. A group prioritised income for supporting their addictions rather than directing it at housing. A lack of budgeting skills seemed to lead to recidivism back into the homeless state for those who had managed to become housed.

Unemployment appeared extensively among those who were interviewed. Only a small group were employed, usually casually. Most interviewees described a desire to get a job, and this was often described as a pre-requisite for them moving into a flat. Many stated that they felt unable to move into housing while they were on a benefit, as it was too difficult to manage rent money in addition to their other expenses. The fact that a large proportion had been in prison confounded the problem of unemployment. Many described being unable to get a job specifically because of their criminal history. A criminal record certainly appears to be a factor in maintaining homelessness, due to the inability to get a job. This barrier may be open to solutions, perhaps through government work schemes.

Many participants described being in institutional care as a child or adolescent. In the majority of cases, this was a result of the breakdown of, or complete lack of a stable family, as described above. Of concern, many of those who had been in institutional care as a child or adolescent described being physically, emotionally or sexually abused while being 'cared for' by these services. This mainly appeared to be a factor in those who were aged in their 30's or older, and we hope that this culture is no longer present in New Zealand institutions.

In addition to counting the incidence of specific themes, we also made an attempt to record other significant life factors contributing to moving along the pathway towards homelessness. These factors were not identified within our specific thematic coding list (appendix D). This list included quite a range of factors, as most study participants had a complex progression to homelessness. However certain themes, common to two or more participants, could be elicited. These included: early difficulties or misbehaviour in the school setting; poor parent-child relationships in an otherwise stable family; the death of a close relation; anger and anger management problems early in life; significant injuries leading to unemployment and other life difficulties; lack of general life skills; lack of support network and subsequent discovery of the feeling of belonging within the homeless community; and chronic seasonal work leading to homelessness in the periods between employment.

Single individuals cited the following problems as major contributors to their homelessness: lack of official documents (for example, Identity documents) and other bureaucratic barriers; difficulty getting references; mixing with the wrong people; and supporting the drug habit of a partner. While these factors were not recorded as significant causes of homelessness within our study, they are important to note, as our study population may not be representative of the general homeless population. For this reason we cannot assess whether these factors are important contributors to the pathway into homelessness within the wider homeless population.

It is evident that there is not a single theme solely responsible for causing homelessness; multiple themes interact in a complex way, and result in an individual with little sense of self, a general lack of life skills, and difficulty accessing help.

### **5.1.3 Common Pathways**

All but one of the participants interviewed loosely fitted into one (or occasionally two) of the typology of pathways identified.

The majority of the group (19 out of 30) we studied were classified into the 'Driven' pathway (Family Situation). This reinforces anecdotal beliefs held by many agencies who interact with homeless people. To us, it cements the idea that for most, a stable and loving family is an essential element in the normal social development of an individual. There is support in the literature that early childhood and family events such as poverty, residential instability, and family problems may be antecedents to becoming homeless [34].

The 'Dropped' (Discrete Event) pathway covered 9 of the 30 people interviewed. The number of people whose homelessness could be accounted for by a single precipitating event was higher than we expected. All of the life events that precipitated homelessness for people in this pathway are experienced by many thousands of people in the New Zealand population each year. These include events such as relationship breakdowns, death of a family member, injury, or acute psychiatric incident. This could lead one to the conclusion that there may be something different about the majority of the population who can cope with these challenges and continue a relatively normal existence, compared with a population for whom the same challenges result in disintegration of their lives. While our study identified some perhaps understandable features in early life, such as initial psychiatric instability or some instability in family, many could be explained as having poor coping strategies for dealing with stressful life events, which was unidentified in the interviews conducted.

Three of the group interviewed were classified as being 'Drawn' (Naturally Progressed) into homelessness. Common to each of these participants was an early history of behavioural difficulties, despite a relatively stable and safe family environment. This could be characterised by a person whose behavioural problems led to an impact on schooling and general life, so that they were living on the streets from an early age, and slowly

progressed from there to adult homelessness. Again we can only hypothesise that there is some intrinsic difference in these people, which leads to serious behavioural problems, independent of family environment. The age at which this difficult behaviour began (for many, around the age of ten) may indicate the influence of peers and the onset of puberty with its associated disruption of hormonal and social equilibrium.



#### **5.1.4 Service Gaps**

Participants gave their general opinions on the overall service provision in the Wellington region. They made remarks on specific agencies such as Night Shelter, Work and Income NZ, Council Housing, Housing New Zealand Corporation and Prison. They also commented on childhood services, lack of social support, and the necessity of having a collective voice as the homeless community.

Although there were many negative views projected, we need to bear in mind two things. Firstly, the participants are only a small sample of the true homeless population. And secondly, these negative views are perceptions and experiences, and do not necessarily give a true picture of the service.

Most comments made on services identified problems in those currently operating, but a number of potentially helpful suggestions were given. A major focus of ideas was the integration of existing services into a model that allowed collaboration between all the agencies to provide a comprehensive approach to solving problems. The identification of integration as a future goal strongly corresponded with the ideas provided from those people currently working in service provision.

*"I just make sure that I eat and am alive the next day"*

- 24-year-old male

## 5.2 Agency Interviews

### **Recommendations**

*For all that has been, thanks.*

*For all that will be, yes.*

Dag Hammerskjöld (1905-1961)

These recommendations are aimed at creating a more co-ordinated service approach for homeless people in Wellington. We want to acknowledge the amazing work that already takes place in Wellington and hope these recommendations will help enhance the many good features that already exist.

#### **5.2.1 Primary Prevention:**

##### **- Preventing the transition into homelessness for those at risk -**

The following recommendations are based on the framework of the five strategies from Ottawa Charter [43].

##### **5.2.1.1 Building Healthy Public Policy**

A comprehensive public health approach would cover all three levels of homelessness prevention. This encompasses policy to prevent homelessness, focussing on those at high risk of becoming homeless, or as a general population approach. Homelessness represents an end-point for many factors that can go wrong in a life, and there is no policy that could prevent all of these. No matter how well our strategies for secondary and tertiary prevention work, homelessness is an issue that will never disappear, and our policy needs to be sufficiently robust to prevent those about to become homeless or newly homeless from falling through a gap.

*"One more eviction, one more addition to the household or one more person made redundant could result in a chapter of unknown personal disasters leading, perhaps, to homelessness" [38]*

This action needs to include all the agencies involved with pathways into homelessness. The efforts of Regional Public Health, Wellington City Council and DCM to convene this inter-sectoral group represent an attempt to build healthy public policy in this area. This process needs to be resourced in a way that ensures it is sustained. There is also a need to ensure central Government involvement. A recent effort made in this area is the New Zealand Housing Strategy [44], released on May 5, 2005, which addresses the spectrum of housing in New Zealand, of which homelessness is at an extreme end.

#### 5.2.1.2 Strengthening Community Action

A concern of all agencies was the public perception of the 'problem' of homelessness. An overseas study conducted by a Los Angeles Mission in 1995 surveyed 1500 individuals by telephone to find out their perceptions about homeless individuals [45]. This survey showed that 94% of respondents thought that homeless individuals could become "productive and self-sufficient". Many of the participants (19%) were also unaware of agencies and services to prevent homelessness and help those who became homeless. This demonstrates a gap in community understanding and education.

If service provision is to move towards a more comprehensive, harm-reduction model, that respects the homeless experience and supports homeless where they are, public education will be needed. Melbourne City Mission [46] provides a local model for community awareness and fundraising campaigns. They run a vast range of efforts to engage the community, including an annual 'Winter Sleepout'; a fundraising event which aims to create some sense of empathy in the public, with the message 'Homeless, not Helpless.' Their campaigns look to promote awareness that homelessness is a complex issue; solutions are not as easy as simply providing a house.

We found that this lack of understanding of homeless issues extended to the police. Considering the high level of involvement of the police with the homeless population, it is particularly important to address education in this sector. It was suggested that homelessness should become part of Slipping Through the Cracks, a Study of Homelessness in Wellington

the curriculum for police training. While this suggestion was made in regard to police training in particular, training aimed at creating a better understanding of homelessness should be extended to many other mainstream organisations, including Health.

The other important part of strengthening community action is ensuring involvement of homeless in all levels of planning and implementation of a homelessness strategy. The homeless population will always be our most valuable resource for evaluating how useful any of our ideas will be [37].

#### 5.2.1.3 Developing personal skills

Services that teach life skills in areas such as budgeting, relationships, training and employment, are important in the development of personal skills to prevent homelessness, especially high-risk populations. In the interviews with those with experience of homelessness, the lack of such skills came up as both a factor in the pathways to homelessness and a barrier to getting out of homelessness.

#### 5.2.1.4 Reorienting Health Services

Filling the huge gap in mental health and addiction services, which most agencies reported, would do a lot towards preventing homelessness. Our interviews supported this need, with a high burden of mental health and addiction issues in the study participants. Although other issues may lead to and surround these problems, we can look at these as critical intervention points. In strengthening addiction and mental health services, we would be acting at all levels of prevention i.e. supporting the homeless, and those at risk of becoming homeless.

#### 5.2.1.5 Creating supportive environments

*"We are pilgrims on a journey and companions on the road.  
We are here to help each other walk the mile and bear the load."*

- from 'Brother, Sister, let me serve you' by Richard Gillard (born 1953).

A society should be judged by how well it looks after its members who are most at need. A comprehensive public health approach to homelessness

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addresses all the determinants of health - peace, shelter, education, food, income, social justice and equity. A homelessness strategy acting at the three levels of prevention would provide a strong framework for creating a Wellington that fully supports its homeless community.

## **5.2.2 Secondary Prevention:**

### **- Helping people out of homelessness -**

Studies in Auckland and Christchurch conducted by Smith, Kearns and Abbot examine the problem of homelessness and serious housing need, especially in the case of those with mental illness [37], [38], [36], [22]. All of these studies have identified that safe, affordable housing is needed as individuals are currently “trapped by housing costs”[38].

With the desirability of living in the city comes the high cost of housing. This creates the problem of a serious lack of housing stock for social housing providers. The homeless who want housing in Wellington are generally unwilling to move into the suburbs, as it would mean leaving their friends and moving to areas less hospitable to being homeless, should they return to spending time on the street. The agencies interviewed in this study came up with a number of recommendations for the different levels of housing needs in Wellington and we have attempted to present this in a Transitional or ‘Staircasing’ Model.

#### **5.2.2.1 Emergency Accommodation**

The first model of intervention is for emergency accommodation with decreased criteria for eligibility e.g. ‘wet hostel’. One overseas group in Toronto, Canada has made their shelters ‘wet’ [47, 48]. In this shelter the bottle of alcohol is removed from the individual when they enter the shelter but “returned the next morning” [47]. This shelter is also linked to a hospital programme that is aimed at treating the homeless individual’s medical problems as well as their drug addictions. Another shelter in Canada has also started a harm-reduction programme for alcoholics where they are only served alcohol hourly, from 7.30am until 10.30pm [49].

At present, Wellington’s emergency accommodation only allows those homeless people who do not have addictions or severe behavioural or mental health issues to stay the night. Most agencies thought there needed to be a hostel where homeless people who were intoxicated could spend the night. This hostel would have a support staff but there would be less rules and regulations. They felt that there needed to be beds for

those that did not meet the criteria because of their severe behavioural problems and mental health issues.

The other population group for whom there is a severe lack of emergency accommodation are the young homeless population in Wellington. They often do not meet the age criteria for other housing services and therefore need a place to sleep where they feel welcome and safe.

The Wellington City Council is currently looking at models of wet centres and 'drop-in centres' from other overseas models such as the Wet Day Centre Research project in the United Kingdom [50].

The amount of emergency accommodation for single female and single male groups was also found to be lacking in Wellington. Single sex hostels or shelters were suggested to accommodate these two groups to provide protection for those who currently often cannot get a bed.

#### 5.2.2.2 Supported Accommodation (intermediary)

The second step in this intervention model is more supported accommodation. It was identified that the step from emergency accommodation to sustained accommodation is huge; there needs to be an intermediary process. The agencies commented that there needed to be housing situations where support was available to teach tenants how to clean, cook, find work and gain general social skills. One idea was a boarding style accommodation with 'wrap-around services' to support people in their everyday needs. There would still be independence and autonomy for these people but the services would be available if need arose.

#### 5.2.2.3 Sustained, affordable accommodation with more options

This is the ideal endpoint for those that have progressed along the continuum of eventually obtaining long-term accommodation. There are already a number of agencies providing houses in Wellington at lower than market rental prices, however as mentioned earlier, there needs to be more houses available. The other issue is having more options of housing. There are a lot of houses available for families but not many

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appropriate options for single men or those people with serious addictions, mental health, or serious behavioural issues.

#### 5.2.2.4 Other: Residential Rehabilitation Services

This was identified as a major gap and therefore there needs to be a centre in Wellington where people can be admitted to 'dry out'. Ideally, this would be a centre that people with addictions will seek out. With an inter-agency approach (described in Tertiary prevention), anyone who expresses the desire to detox could be referred these facilities.

#### 5.2.2.5 Other: Dual Diagnosis Services

There is evidence from overseas studies that those people with experience of homelessness and with a dual diagnosis need specific dual diagnosis programmes [25]. To meet the demand for these services, expanding the dual diagnoses workforce in Wellington from 0.5 FTE's to 14.5 FTE's (as identified in the Mental Health Blueprint [40]) would be advisable.



### **5.2.3 Tertiary Prevention:**

#### **- Addressing the needs of the current homeless population -**

##### **5.2.3.1 Co-ordinated Inter-agency Comprehensive Approach**

*"A journey of a thousand miles must begin with a single step."*

- Lao Tze 600 BC

The first step: Ownership of the problem and strategy needs to be taken. An agency would take the lead role, to co-ordinate - the 'tip of the umbrella' of service provision. This is a necessary point to form bonds between Government and the team of service providers, particularly for the all-important issue of funding.

The second step: Involvement of the homeless. It is so important that the homeless, and former homeless that have been helped by services in the past, have a strong voice in all levels of planning and application of any strategy for homelessness [51].

##### **5.2.3.2 Co-ordinating human resources**

A mobile team including: Work and Income NZ Case Manager

Social Worker – from a community agency

Health Officer

The team would provide income protection (including access to appropriate entitlements), needs analysis for community services, and health care requirements. A mobile team would overcome much of the barrier of access to services such as Work and Income and reduce the needs for advocates, which may go some way to improving access to Development Assistance for use of services for areas such as addictions and mental health. A social worker could provide the necessary support for organising how the various agencies required would work around this individual, providing a 'wrap-around service'. A health officer would be required to assess health, give medications, arrange for hospital admission if necessary, in much the same way as the outreach service from Te Aro clinic works now.

The primary aim of this team would be to ensure the person with experience of homelessness is safe on the street and their basic needs are met, supporting them where they are. With time, and continued support, the aim would be to get this person to a point where they feel they could make a decision about housing. At this point, a Housing Officer (from HNZN or Wellington City Council) would be brought into the team, and they would work together to support the person with experience of homelessness in achieving self-sustainability. Ideally, in the future, there will be a range of accommodation options available, so they can be 'staircased' from supported accommodation to suitable private housing.

This system would provide comprehensive care for the individual. It is a step to providing greater co-ordination and continuity of support. It promotes a 'patient-centred' approach, which may provide the best chance of creating sustainable changes in lives of homeless people. While a drop-in centre would be ideal (see below), even if the planning started immediately, it would be a long time before this could be established. This does not mean that we should wait until then to start implementing any strategies for increased inter-agency co-ordination. This strategy is just one idea. Only when we start a co-ordinated approach will we identify the most pressing gaps and therefore where policy changes may need to occur. Also, it will probably be much easier to get funding for human resources (that we already have in various agencies) to come together than it is to have funding allocated for 'bricks and mortar'. This means positive changes to service provision for the homeless population can begin sooner.

A model of such an approach currently in its early stages in Wellington is the Multi-Agency Prisoner Reintegration Process, which also needs to be integrated into a homelessness strategy. This process involves a needs assessment performed by a Case Manager, who then aims to co-ordinate all the services to meet each individual's needs.

#### 5.2.3.3 24-hour drop-in centre

A centre with involvement of all agencies for the homeless population, including:

- Showers, lockers, food
- Social workers (Case Managers), Health workers, Work and Income representation, Housing representation
- A&D service
- Gambling service
- Mental Health service
- Counselling

The approach of this centre would be one of harm reduction, providing a safe place for the homeless to hang out and get help if they need it 24 hours a day, 7 days a week. Basic needs such as showers, food and lockers would be available. In order for this service to reach those most at need, it must be able to accommodate active substance abusers, with a policy of harm reduction not exclusion. This is the group who falls through a large gap of services currently available in Wellington. The strength of the centre would be having a multi-disciplinary team of people working together in the same place, overcoming many problems of access. However, the danger of having all services in one physical place is that it easily becomes another institution. A centre encompassing all the services above would have to be enormous. The model above, therefore, may have to be seen as a theoretical one. In practical terms, it would be most important for the core agencies to run the centre and maintain strong links with other services. The idea would be that these services come into the main centre, rather than the homeless people being sent to them. Evolve (Wellington Youth Service) (Appendix J4) provides us with a small model of this kind of centre already running successfully in Wellington, although it is not a 24-hour service.

From the main centre other programmes could run including education and training programmes, employment options and life skills. Such a programme would certainly require a 'staircasing' approach and involve strong community and agency support networks. One suggestion is a Group Work Scheme for community projects, where a bus leaves Slipping Through the Cracks, a Study of Homelessness in Wellington

everyday for those that want work. Some kind of intervention is certainly required to combat the problem of boredom.

#### 5.2.3.4 Urban Marae

To fill the gap in Māori-specific services, an Urban Marae model has been suggested. Such a setting could see better delivery of services to homeless in a culturally appropriate framework, and forge a sense of belonging to a community and their culture. The Urban Marae could be similar to the 24-hour drop-in centre. The Marae would uphold all the normal Marae traditions of tapu and noa and be a central point for Wellington homeless agencies to provide services specific to Māori, or those who identify with Māori culture. As well as a central point for homeless services, the Marae could provide daily activities such as Te Reo classes, cooking classes and other useful courses to help homeless people function in the general community. The most important function of the Urban Marae would be to help Māori homeless strengthen their sense of belonging to a community. This could be done by retracing their whakapapa with the help of Kaumatua that work on the Marae. In some cases this may have a negative impact on the individual, therefore they could create whakapapa based around the Urban Marae, in a similar model to the one used at Te Whare Marie (Wellington Māori Mental Health provider).

#### 5.2.3.5 Youth services

There is a real need to provide services specifically for young people with an experience of homeless, as they tend to not want to use the services that are generally available, such as the Night Shelter or Soup Kitchen. Currently, the only service they use regularly is Evolve, which is only open during the day. It would be unrealistic to expect these young people to fit into the model of recommendations we have proposed, as their needs are very different. There is a need to adapt each of the recommendations to make them appropriate for the youth, particularly for accommodation, case management, and the 24-hour drop-in centre. As this group represents a large part of the future homeless population, our intervention with them is of great importance.

*"Homelessness is an ongoing issue that demands our ongoing attention and continual action."*

Melbourne City Mission

#### **5.2.4 Summary of Recommendations**

**Primary prevention recommendations** are based around the Ottawa Charter. In this document, five action plans are outlined, and each action plan should be addressed when further developing the homelessness strategy.

**Secondary prevention recommendations** are based around the theme of accommodation. These include features such as access, support, affordability, and rehabilitation.

**Tertiary prevention recommendations** surround the idea of co-ordination of current services. It also looks at possible facilities such as a 24-hour drop-in centre for those already on the street to help deal with the consequences of being homeless. Another possible facility is an urban marae. Youth-specific services would also be of great value.

## *5.4 Study Limitations*

This was a large study performed in a small amount of time. Because of the time limitation it was not possible to interview all the agencies that have an input into the welfare of the homeless population. This time limitation also meant that more than the four members originally allocated to this job performed the agency interviews. A result of this is that there is a large variability in questioning style and technique, however, analysis of the agency interviews showed that all required themes were covered adequately by each interviewer.

Another limitation acknowledged is the amount of data derived from the homeless interviews. Our study group analysed the interviews that had been conducted by another group. This meant that there was a lack of control over the data that was collected and there were some questions that were not asked that would have been helpful to our study.

To prevent bias in the interpretation of the homeless interviews they were double-read separately and where conflict arose there was discussion by the subgroup analysing the interview to come to a conclusion. Overall there was a good consensus. However, due to time limitations only 21 of the 30 interviews underwent this double-reading process.

The data derived from the interviews may be limited due to the time period since the services described were those that existed some decades ago. For example complaints about the CYFS services are not necessarily relevant to today as they represent the history of the service rather than current practice.

Within the interviews themselves, the study was limited by the self-selection of the interviewed people with experience of homelessness. This selection process may limit the generalisability of our findings. In particular, there has been some suggestion that our sample under-represents homeless people with a current psychiatric disorder. It is possible that members of this population may have been less inclined to

participate in this study because of decreased confidence and difficulties in articulating their particular circumstances. Another area that may be under-represented is the number of women and young people included in the study. Women might be a particularly difficult homeless population to identify and therefore cater to. Young people or the newly homeless may have had less contact with DCM and therefore been omitted from the sample. Anecdotally, the sample represents the *chronic* homeless well although mental health service consumers appear to be under-represented. There does appear to be high representation of Māori in this population, but this may be due to over-representation of Māori in the homeless population [52].

Since no previous studies have been undertaken that identify the demographic characteristics, or indeed count, the Wellington homeless population, it becomes difficult to generalise from our sample to the broader homeless population. To perform a quantitative survey of this nature would depend on being able to quantify the homeless in the region, which in turn requires a statistically useful and acceptable definition of homelessness; this was an ancillary goal of the current study and informed our decision to include a definition of homelessness in our agency show card to gain some idea of a definition acceptable to agencies working in the field. In addition to possibly under-representing homeless people who are currently psychiatrically symptomatic, it is possible that our sample misrepresents the true homeless demographic in other unrecognised ways.

Our study is a qualitative one. It was undertaken to assist in the development of a public health strategy. The homeless interviews give a snapshot of homelessness in Wellington and their opinions on the agencies working in this area. The interviews with agencies identified gaps and helped to develop interventions. This means that the quantitative data included in the study should not be used to draw quantitative conclusions.

## *5.5 Recommendations for Further Studies*

### **Enumeration**

Further research for methods of 'counting' the homeless population is needed.

### **Incipient Homelessness**

Whilst our study looked at rough sleepers and people with no fixed address, there is also a much larger population that experience serious housing need (which could be considered a form of homelessness). It would be interesting to study the characteristics of this population, as well as to develop strategies targeted at preventing them from becoming truly homeless.

### **Health**

Our study identified alcohol and drug problems of the homeless people in Wellington. Unfortunately we did not look into the general health status of these people. This would be interesting and helpful in developing strategies directly targeting the improvement of their health and health delivery services.

### **Public Perception**

As mentioned in our study, strengthening community action can be an important tool for preventing homelessness. In order to do this successfully, we need to find out how the public perceive homelessness in Wellington.



## **6. Conclusion**

The main pathways into homelessness that were identified in this study were Family Situation (Driven), Discrete Event (Dropped) and Natural Progression (Drawn). These three pathways may be useful for understanding the aetiology of homelessness in Wellington. They may also provide focus for further development of strategies for the primary prevention of homelessness.

The gaps in service provision identified by the agencies were consistent with those identified by the homeless people who were interviewed. The major gaps included childhood services, emergency accommodation, Work and Income Benefits, adequate and affordable social housing, prisoner reintegration services, mental health and addiction services, and youth services. It is important to point out that services currently exist in many of these areas. The collective view following feedback from individuals and agencies was that in many cases, due to the caseloads having to be carried by these services and the limited resources available to them, the end result is that effectively there is a gap in these services.

An important issue that we identified was the difficulty of giving homeless population a voice on the issues that affect them. It is a challenge to the agencies involved in developing such initiatives as a homelessness strategy to ensure that the voices of those affected by homelessness are heard.

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## Appendix A:

### Ethics Approval Communications for Homeless interviews:

From: Self <[director@dcm.org.nz](mailto:director@dcm.org.nz)>  
To: [claire\\_yendoll@moh.govt.nz](mailto:claire_yendoll@moh.govt.nz)  
Subject : Ethical approval for Downtown Community Ministry  
Date sent: Mon,04 Oct 2004 15:44:08 +1300

Dear Claire

Further to your conversation with Chris McCarrison this is to check with you whether we need to get formal approval to conduct a small research project amongst our client group.

Basically we are interested in the reasons why people become homeless (or have difficulty sustaining accommodation) as this group represents the bulk of our clients. We anticipate that the only health related question we are likely to pose is “do you identify as having an A&D problem?” and if the response is “yes” then we would explore how that affects their homelessness and/or whether they have been able to access services to assist them address their A&D issues.

Hope this gives you sufficient information. Please give me a call if you require anything else from us.

Yours sincerely

Stephanie McIntyre  
Director- Downtown Community Ministry  
Tel:3855602

---

Subject: Ethical approval for Downtown Community Ministry  
To: [director@dcm.org.nz](mailto:director@dcm.org.nz)  
From: [claire\\_yendoll@moh.govt.nz](mailto:claire_yendoll@moh.govt.nz)  
Date sent: Fri, 26 Nov 2004 11:51:10 +1300

Dear Stephanie and Chris

Thank you both for the information you have provided the Ethics Committee with relating to your research in Homeless people.

The Acting Chair considered the outline of the research and the questionnaire you provided. He made the following comments:

Formal ethical approval for this research is not required. The nature of the alcohol and drug question may be deemed to involved collection of health information according to the definition used by the Operational Standard for Ethics Committees but it is my considered opinion that these are more in the nature of an audit. The primary focus of this project is sociological one.

Please let me know if this e-mail is sufficient for you to begin your research or if you require a formal letter containing this information.

Regards

Claire Yendoll  
Administrator Wellington Regional Ethics Committee  
Sector Policy Directorate- Strategic Funding and Development  
Sector Policy Directorate  
Ministry of Health  
DDI: 04 496 2405

<http://www.moh.govt.nz>  
[mailto:Claire\\_Yendoll@moh.govt.nz](mailto:Claire_Yendoll@moh.govt.nz)

## Appendix B:

# Downtown Community Ministry is researching the causes of homelessness

*Have you ever lived on the streets or been homeless?  
If so, are you willing to take part in this research?*

### Some information about the interviews:

- You will be **paid \$25** for your interview.
- The interview will be with Phil and Stephanie.
- If you identify that alcohol, drugs or gambling have affected your housing, then you will be invited to take part in a follow-up interview with Phil and Chris (Chris is an Alcohol and Drug specialist).
- **Interviews will be taped** but all tapes will be destroyed, or returned to the participant after the research is completed.
- Interviews will be totally **confidential and anonymous**.
- No personal details or names will be used in the report that will be written at the end of the research.

## INTERVIEWS WILL BE HELD AT DCM EVERY MONDAY

---

*Please fill this consent form and give to a staff member.*

Date:.....

I ..... (name)  
consent to take part in the DCM research on homelessness.

Please tick the boxes below:

- ☐ I have had the purpose of this research explained to me
- ☐ I understand that my name will remain confidential and anonymous
- ☐ I understand that my participation in this research is entirely voluntary and that I may withdraw at any time before the compilation of the final report
- ☐ I understand that I will be paid \$25 at the end of my interview
- ☐ I understand that my tape will be destroyed or returned to me at the end of the project

Signed:.....



## Appendix C:

### Project Margin Research Questions

#### Section one: Biography

This questionnaire is to help us to find out from you how best we can support you into housing. Your input is vital for us to provide a client centred service.

1. How long have you been homeless (night shelter, sleeping rough etc)
2. Was this just in Wellington or other centres as well?
3. When was the last time you felt you had a home?
4. Where were you born?
5. Where did you spend your childhood, teenage years?
6. Were you ever in an institution- such as a residential family home, foster care, remand home, borstal or prison?
7. Was this as a child, teenager or adult?
8. What happened to cause you to end up living on the streets?
9. Have you ever had a house or flat?
10. How long for?
11. What happened?
12. If you had an option, what type of accommodation would you like?
13. What's stopped you from getting a house in the past?
14. What are the things that make it difficult for you to keep your flat now?
15. How easy is it to get support?
16. Where do you get support?
17. If you wanted to change your life what (if any) of these issues might hold you back?
  - a. Alcohol and drug abuse/ dependence problems
  - b. Gambling problems
  - c. Criminal history
18. Is there anything else you would like us to know about your experience of being homeless/ your housing problems that we haven't already talked about?

**Appendix D:****Thematic Coding for Homeless Interviews**

Theme	
Alcohol	
Childhood abuse	
Debt burden	
Difficulty budgeting	
Drugs	
Family breakdown/instability	
Foster families	
Frequent moving/change in housing	
Gang involvement	
Institutional care as child/adolescent	
Lack of schooling/education	
Mental health issue	
Negative beliefs about self/self-image	
Parents homeless	
Prison as adult	
Relationship breakdowns	
Social isolation	
Traumatic parental death	
Trouble communicating with others	
Trouble with Police	
Unemployment	
Others (add as required):	

**Interesting Quotes**

--

## Appendix E:

	A	A2	B	B2	C
Transcriber's name	Claire, Cath	Daisy, James	Daisy, Claire	James, Cath	Claire
Sex	M	M	M	M	M
Age	24	40	37	40	31
Ethnicity	part-M	Samoan			Maori
Alcohol	1	1	1		1
Childhood Abuse		1	1	1	1
Debt Burden					
Difficulty Budgeting	1	1	1		
Drugs	1	1	1	1	1
Family Breakdown/Instability		1	1	1	
Foster Families					1
Frequent Moving/Change in Housing					1
Gambling	1	1			1
Gang Involvement	1	1		1	1
Institutional Care as a Child/Adolescent	1			1	
Lack of Schooling/Education	1				
Mental Health Issue		1		1	1
Negative Beliefs about Self/Self-Image			1	1	
Prison as Adult	1		1	1	1
Relationship Breakdowns			1	1	1
Social Isolation					
Traumatic Parental Death					
Trouble Communication With Others					1
Trouble With Police				1	1
Unemployment	1		1		
Others	1 school difficulty difficulty getting references lack parental support	1 truancy domestic violence	1 dad alcohol self esteem	1 Difficult relationship with family Head trauma	1 angry at society
	C1	C2	D		
Transcriber's name	Cath, James	Claire, Cath	Cath, Claire		

Sex	F	M	M
Age	40	44	32
Ethnicity			
Alcohol	1	1	1
Childhood Abuse			
Debt Burden			1
Difficulty Budgeting	1	1	
Drugs	1	1	1
Family Breakdown/Instability	1		1
Foster Families			
Frequent Moving/Change in Housing			1
Gambling			
Gang Involvement			
Institutional Care as a Child/Adolescent			1
Lack of Schooling/Education			
Mental Health Issue	1		
Negative Beliefs about Self/Self-Image		1	1
Prison as Adult	1		1
Relationship Breakdowns		1	
Social Isolation			
Traumatic Parental Death	1		
Trouble Communication With Others			1
Trouble With Police	1	1	
Unemployment	1	1	1
Others	1	1	1
	Death of husband	Rehab A+D	Lack of documents
	Supporting drug habit of partner	work lifestyle	
	Work	bureaucratic barriers	
	D2		F
Transcriber's name	Cath, Claire		James, Cath
Sex	M	M	M

Age	30		35	50	
Ethnicity	NZE		Maori		
Alcohol	1		1		
Childhood Abuse			1		
Debt Burden	1			1	
Difficulty Budgeting	1		1	1	
Drugs			1		
Family Breakdown/Instability	1		1		
Foster Families	1		1		
Frequent Moving/Change in Housing	1		1		
Gambling	1				
Gang Involvement			1		
Institutional Care as a Child/Adolescent			1		
Lack of Schooling/Education			1		
Mental Health Issue	1		1		
Negative Beliefs about Self/Self-Image	1		1		
Prison as Adult			1	1	
Relationship Breakdowns	1				
Social Isolation	1		1		
Traumatic Parental Death				1	
Trouble Communication With Others					
Trouble With Police	1		1		
Unemployment	1			1	
Others	1 Unacceptable living situation - flatmates abusive Suicide attempts  ADHD		1 Fighting Racism  negative tools learnt in childhood		
	G		H	I	J
Transcriber's name	James		James	Claire, Cath	Cath, James
Sex	M		M	M	M
Age	39		37	45	17
Ethnicity				NZE	NZE

Alcohol	1	1	1	1
Childhood Abuse		1	1	1
Debt Burden				
Difficulty Budgeting			1	1
Drugs	1	1	1	1
Family Breakdown/Instability		1	1	1
Foster Families			1	1
Frequent Moving/Change in Housing		1	1	1
Gambling			1	
Gang Involvement	1			
Institutional Care as a Child/Adolescent	1	1	1	1
Lack of Schooling/Education				
Mental Health Issue		1		1
Negative Beliefs about Self/Self-Image				
Prison as Adult	1	1		
Relationship Breakdowns				
Social Isolation	1			
Traumatic Parental Death				
Trouble Communication With Others				
Trouble With Police	1		1	1
Unemployment	1	1	1	
Others	1 Serious housing need Violence against homeless		1 parents alcoholics	
<b>K</b>		<b>L</b>	<b>M</b>	<b>N</b>
Transcriber's name	Cath, James	Cath, Claire	Claire	James
Sex	M	M	M	M
Age	26	30	47	34
Ethnicity			NZE	

Alcohol	1	1	1	1
Childhood Abuse			1	1
Debt Burden				
Difficulty Budgeting	1	1		
Drugs	1	1	1	1
Family Breakdown/Instability	1	1		1
Foster Families		1		1
Frequent Moving/Change in Housing		1		
Gambling			1	
Gang Involvement				
Institutional Care as a Child/Adolescent		1	1	1
Lack of Schooling/Education				
Mental Health Issue	1			1
Negative Beliefs about Self/Self-Image		1	1	1
Prison as Adult	1			1
Relationship Breakdowns		1	1	
Social Isolation	1			
Traumatic Parental Death				
Trouble Communication With Others		1		
Trouble With Police		1		
Unemployment				
Others	1	1	1	
Feeling part of homeless community		Poor foresight	Dad alcoholic	
		Seasonal work		

	S	T	V	W	X
<b>Transcriber's name</b>	James, Cath	James	James	Cath, Claire	Claire, Cath
<b>Sex</b>	M	M	M	M	M
<b>Age</b>	33	48	35	41	51
<b>Ethnicity</b>	Maori		Maori		Maori
<b>Alcohol</b>			1	1	1
<b>Childhood Abuse</b>	1		1		

Debt Burden	1				
Difficulty Budgeting	1	1	1		
Drugs	1			1	
Family Breakdown/Instability	1			1	
Foster Families				1	
Frequent Moving/Change in Housing				1	
Gambling					1
Gang Involvement					
Institutional Care as a Child/Adolescent				1	
Lack of Schooling/Education					
Mental Health Issue		1		1	
Negative Beliefs about Self/Self-Image			1	1	1
Prison as Adult	1		1	1	
Relationship Breakdowns					1
Social Isolation				1	1
Traumatic Parental Death					
Trouble Communication With Others					
Trouble With Police	1			1	
Unemployment	1			1	
Others	1	1			1
	Physical disability (HI)	Mental Institution as adult		Lack support	injured in accident
	Runaway from home			Benefit not enough \$	Lack of support/advice
	Death of sister				

	Y	Z
Transcriber's name	Daisy	James
Sex	M	M
Age	37	33
Ethnicity	Maori	Maori/NZE
Alcohol		
Childhood Abuse	1	
Debt Burden	1	
Difficulty Budgeting	1	



<b>Drugs</b>	1	
<b>Family Breakdown/Instability</b>	1	1
<b>Foster Families</b>	1	
<b>Frequent Moving/Change in Housing</b>		
<b>Gambling</b>		
<b>Gang Involvement</b>		
<b>Institutional Care as a Child/Adolescent</b>	1	
<b>Lack of Schooling/Education</b>	1	1
<b>Mental Health Issue</b>		
<b>Negative Beliefs about Self/Self-Image</b>		
<b>Prison as Adult</b>	1	1
<b>Relationship Breakdowns</b>		
<b>Social Isolation</b>		
<b>Traumatic Parental Death</b>		1
<b>Trouble Communication With Others</b>		
<b>Trouble With Police</b>		
<b>Unemployment</b>		
<b>Others</b>		

## Appendix F: Stories sorted according to Pathways

1) **Family situation:** parents relationship break-up and/or family instability, domestic violence (childhood abuse) → foster care, institutional care, A+D, prison, unemployment (no skills to deal with life or problems) (*18 stories*)

- B2: family fighting → runaway, gang involvement, institutional care (Borstal) (*also in 2*)
- O: parents split up → mum breakdown, institutional care, drinking, jail, addiction
- I: parents alcoholics, child abuse, parents split up → drinking, drugs, gambling
- D: parental divorce but good childhood, misbehaviour → institutions, A+D, sporadic schooling, ran away → homeless, prison, A+D, financial issues, unemployment (sister stole his stuff so don't have any documents)
- D2: parental divorce → foster homes, 2 tertiary courses (*little bit of 2 because of injury*)
- E: mother on street → foster family, physical violence, remand home, gangs, ran away from gangs → homeless, violence, A+D, poor self-esteem, lack of life skills
- J: family breakdown → foster homes with domestic violence, anger problems leading to being placed in boys home, A+D, no support/accommodation/job
- L: family instability → welfare home, troublemaking behaviour, A+D, ran away, prison, seasonal jobs, financial issues, relationship break-ups.
- P: violent family → foster homes, arson incident, left home to work, stay with uncle → sexual abused → A+D, inability to have relationships, unemployment, gambling
- W: dysfunctional family → made ward of state, institutions, running away, social isolation, lack of education, prison sentences, trouble coping with daily life (lack of life skills), depression, unemployment
- M: family violence → ran away with his siblings, father alcoholic, taught violence, A+D while young, A+D lifestyle, powerful realisation 8 years ago regarding his life (doesn't know his own child)
- Q: kicked out of home age 13, worked on farm, moved to Wellington with girlfriend, lived together for 4 years, broke up → rough sleeping, involved with gangs, jail 4 times, nowhere to go so on street again, street is place of safety when relationships break down
- N: family violence (sexual abuse) → made ward of state, boys home, sexually abused in home (treated like prostitutes), prison, did chefs course, got a job, really enjoyed it and working out really well for 1 year but fired after finding out about criminal record
- V: Poor relationship with family, felt he wasn't wanted by anyone → drinking early, alcoholic lifestyle now, works as labourer but spends all money on drinking, stays in night shelter because \$35 per week and spends the rest on alcohol, spends all money during weekend and runs out of money by Sunday, sometimes doesn't turn up for work because of alcohol related problems and loses job but finds another one easily. Rough sleeping while unemployed.
- H: emotional abuse by stepfather, parents could not control him because he was "angry" → boys home (age 12), sexually abused in boys home, homeless from age 14, has had a period with a house with son living with him, homeless for 15 to 20 years mostly living under bridges
- A2: uncles and father smoking P and drinking, physical abuse by father and uncles, family break up → moving between father's and mothers, truancy, gang, lost partner, early alcohol experience (age 14), hard to get support
- Y: Alcoholic parents, mother steal his money → state of ward from age 3, boys home, sexual abuse with social welfare, schools couldn't handle him because of misbehaviour, Borstal, probation, lifestyle of drugs and prison, lack of money, criminal record

- B: kicked out of home at age 14, physical abuse from alcoholic father → alcohol, drugs, jail, lost partner (cheaper to live on street than in flat because has habit to support)
- C (has elements of 3 too): Put into baby home when under 2 years old, shifted around foster home and boys home → ran away from homes, very angry and violent → put into secure unit age 7/8 → by age 12 living on streets, started drinking lots, many different drugs. Supported self by crime, too young to get benefit → put into care → discharged from Social Welfare age 17, no support → moved to Adult Court, lots of crime-assaults, burglaries, problems with addictions, feels safe on streets, no trust, housed for last few months.

**2) Discrete event** → other factors → homelessness (*9 stories, [B2 also in 1], [D2 also in 1]*)

- B2: broke up with girlfriend
- X: marriage breakdown → A+D, no money
- C2: relationship breakup → no responsibilities anymore, drinking, (*a little bit of 3 because used to hang out in streets*)
- C1: death of mother → A+D, bought house with estate money, sold house, financial difficulties because of A+D, prison, methadone programme
- D2: injury → couldn't work, unemployment, relationship breakdown, gambling, low self-confidence (stays on street because sleeping rough more enjoyable than living in unsatisfactory house)
- K: stable family, move to different city → psych incident → A+D, rehab, prison, social isolation, ongoing mental illness, financial issues, unemployment, found wife on street and married her
- F: parents sudden death → rough sleeping, prison, doesn't pay rent → kicked out, night shelter is cheap, convenient and easy, happy to be on street
- S: family violence, alcoholic father → ran away, trouble with police, Borstal, prison, got a job in Akld, couldn't afford rent → kicked out, lost job → streets, debts, court fees, would like job but no support from WINZ, criminal record is biggest barrier
- Z: Traumatic parental (father) death → shaken up, didn't relate as well with mother as with father → getting into trouble, bank robbery → prison, alternating with living with mother and on the street (need time out from mother)

**3) Natural progression:** stable family but misbehaving etc. ie street kids, lack of schooling, unemployment, homelessness (*3 stories*)

- A: lack of education b/c of truancy and drugs as child → put into institution → then with family friends → homeless, in and out of flats, jail, unemployment, gambling
- R: stable childhood, trouble making behaviour, disrupted schooling → A+D, anger problems, trouble with police, ran away from home, prison, unemployment, lack of life skills
- G: Started getting into trouble about age 12 (stealing), and ended up in Borstal at age 13, in prison from age 15 (!), fell out with family and just went onto street. Believes he is easily influenced by other people, and often gets into trouble in this way (eg. doesn't go to Night shelter because gets caught up the behaviour of the people staying there), leg broken by police in Glover Park, picked on by Walkwise

**4) Other:** (specify) (*1 story*)

- T: Mental illness: ended up in several psychiatric institutions and living on streets between (schizophrenia and anxiety disorder)

## **Appendix G:**

### **INFORMATION SHEET**

#### **Homelessness In Wellington Research Project**

##### **Background to Study**

There has been limited research in NZ to date exploring the pathways into homelessness. The Wellington City Council, Downtown Community Ministry and Regional Public Health are all interested in homelessness in Wellington, including the common pathways into homelessness and degree to which their needs are being met by current services. The definition of homelessness used in this study includes rough sleepers and those people who have no fixed abode (transient homelessness).

##### **Aim**

To inform the development of a Wellington City public health strategy for homelessness.

We plan to explore the following questions:

- 1) What are the common pathways into homelessness in the Wellington Region?
- 2) What services are currently available to the homeless and do these meet the needs for effective prevention and support?

##### **Method**

The Public Health department and 5<sup>th</sup> year medical students at the Wellington School of Medicine are analysing previously collected, structured interviews from 39 homeless people in Wellington. To parallel this analysis students are interviewing a number of agencies in Wellington who provide services or care for the homeless population.

##### **How is the information going to be used?**

The 5<sup>th</sup> year medical students will present their findings in the form of a presentation and report to the Wellington School of Medicine Public Health department on May 6<sup>th</sup> 2005. If you are interested in attending this presentation please contact either one of the researchers or supervisors below.

##### **Confidentiality**

Our report and presentation will list organisations working in the area of homelessness in Wellington and describe their roles. However, it will not attribute comments to individuals. All personal identifiers will be removed before presentation and comments from individual will be treated as confidential. If you are interested in reviewing a draft of the section involving your agencies information see contacts below.

##### **Contact Details**

###### **Researchers:**

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Director, Housing and Health Research  
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Department of Public Health  
Wellington School of Medicine  
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## Homelessness in Wellington

### Definition of Homelessness:

- Lack of any adequate, secure, affordable and suitable housing, resulting in rough sleeping
- Use of dwellings for people with no fixed address.

### ***Duration?***

- *2 or more consecutive nights of rough sleeping in the last year*
- *At least 2 weeks with no fixed address in the last year*
- *With no intention or possibility of a fixed address in the near future*

## Homelessness in Wellington

### Forms of Prevention

**Primary** - to prevent people becoming homeless, includes

- (a) **high risk** approaches targeting those known to be at risk &
- (b) **general** approaches targeting the whole population

**Secondary** - early intervention to help people out of homelessness

**Tertiary** - helping people manage the consequences of homelessness

## Appendix I:

Interview guide for agencies involved in homelessness in Wellington

**Our definition:** Homelessness: lack of any adequate, secure, affordable and suitable housing which results in rough sleeping or use of dwellings for people with no fixed address.

### Questions

#### 1. Definitions and frameworks

- What is your definition of homelessness? (if you were trying to count)
- Show card 1 (our study definition of homelessness)
- What is your definition of serious housing need? (show card)
- Using a public health approach, we suggest dividing services into the following categories: 1°, 2°, 3° prevention, high risk and population approaches (show card 2). Is this approach useful?

#### 2. Role of your organisation

- What services does your organisation provide for the homeless?
- Where do the services your organisation provides fit in (note that they may provide services in several of these areas)?
- What sort of people use your service?
- What are the criteria that need to meet before homeless people can receive help from your agency?
- How do people (including homeless people, if not covered in answer) access your agency e.g. direct, referred, word of mouth, advertising (ask specifically about advertising if not already covered).
- What other agencies do you have interactions with (in regards to homeless people)?
- Do you receive funding for your agency or do clients have to pay?
- Are you taking new clients/patients at the moment?

#### 3. Perceived gaps

- Where do you think there are 'gaps' in the services that are provided for homelessness? Ask them to think about gaps in terms of 1°, 2°, 3° prevention.
- What do you think are some of the main pathways for becoming homelessness in Wgtn?
- Do most homeless people come from an identified 'high risk' population eg alcohol and drug dependent, psychiatric illness, prison
- Do you think more could be done to prevent these pathways into homelessness ie 1°?
- Do the categories of serious housing need help in understanding the process of homelessness?
- What services would help people out of homelessness and serious housing need?
- Do you think the needs of the homeless in Wgtn are being met?

#### 4. Other agencies

- Who else should we talk to get a complete picture of the organisations working on 1°, 2°, 3° prevention of homelessness?

## **Appendix J:**

### **List of agencies**

CCDHB-Alcohol and Drug Services  
Downtown Community Ministry (DCM)  
Easy Access Housing  
Evolve  
Gambling Intervention Services-phone interview  
Housing NZ Corporation  
Inner City Project  
Ministry of Social Development-WINZ  
Night Shelter  
NZ Prostitutes Collective  
Police Constable  
Prison re-integration  
Salvation Army Hope Centre  
Soup Kitchen (Tory)  
The Inn (youth)  
Wellington City Council, City Housing Manager and Community services  
Wellington Mental health Consumers Union  
National collective of Women's Refuges  
Child Youth and Family-Phone interview  
Bridge Centre (Salvation Army) A&D  
Te Aro Health Centre  
Wellington City Mission

#### **Informal discussion:**

Manager of Primary Care Planning and Funding-CCDHB  
Blossom (accommodation)

## **Appendix J1:**

### **A&D Services**

#### Definitions

- Agree with our definitions- but would include people sleeping in cars (probably covered by rough sleeping) as they have a number of clients who transiently and occasionally more permanently live in their vehicles.
- They don't have a definition for themselves as such.

#### Prevention

- Yes the primary, secondary and tertiary distinction is useful. A&D see themselves as being primarily secondary and tertiary providers.
- They also see an important primary prevention strategy would be for legislation to make it illegal for people to be homeless and the onus placed on WCC to house the homeless if indeed this occurred. This is based on a UK experience where apparently this has been successful

#### Service provision

- They are a hospital-based outpatients service for alcohol and drug abusers.
- Their clients tend to be at the more severe end of the A&D abusing spectrum and many have psychiatric co-morbidities.
- They service the Wellington, Hutt and Kapiti Coast areas.
- Have about 300 alcohol clients and 400 in the methadone programme.
- Offer individual and some group therapy.
- Currently 6.8 FTE's in A&D, and 5 in the methadone programme.
- There are 2 beds at Porirua under the control of Dr Geoff Robinson. This is for the entire CCDHB catchment. There are another couple of beds in the region (Wairarapa). They are for detoxification.
- Provide social workers, counsellors and one Psychiatrist (0.5 FTE). They are grossly under-funded (see the section below on gaps).

#### Knowledge/ Access

- Virtually all clients are referred by GPs.
- There are a couple of pertinent exceptions to this: they have accepted referrals from Te Aro Health Centre and DCM. So there are some linkages there.

#### Funding

- CCDHB
- They are the one hospital-based service operating in a milieu of a number of A&D service providers, the rest of which are NGO's.
- Believe they, and the A&D NGOs are receiving about 55-60% of the funding they should be receiving.



### Perceived gaps

- Feel that they miss the boat with the homeless, as they are not geared to an immediate response. Because of their insufficient funding they have a six-week waiting gap for people to get onto their program. Hence this is unsatisfactory with the homeless who may have acute need.
- A KEY SUGGESTION FOR IMPROVEMENT was that they need a clinic at DCM. This would physically occur at DCM. Would be staffed by an eclectic A&D team. (They acknowledge some linkages but these are informal.) The key impediment to a DCM A&D clinic is short staffing and under-funding.
- Lack of long-term residential care facilities for serious A&D abusers. These facilities have all gone. A&D note that end-stage of ETOH abuse can occur around ages 40-50 in the homeless (an acceleration of the condition).
- Under-funding in A&D generally. They cite the Government's Mental Health Commission Blueprint, which stipulates that there should be 14.5 FTE's working in Dual Diagnosis (e.g. alcohol abuse and coexisting personality disorder or other DSM diagnosis) and there are currently 0.5! Also, the mental health blueprint identifies a need for 10 dual diagnosis beds in the area and there are currently only 0. The blueprint is a government document so it is clear that the government itself ought to recognise that it is not funding the field as it should be.
- Alcohol abusers with severe dementia are discriminated against in terms of council accommodation. In general there is prejudice, discrimination and stigma with end-stage abusers.
- DHB in general doesn't perceive a need to coordinate services and there is generally poor liaison amongst organisations working in the A&D field. A service map would be useful for both workers and clients.
- Need for joint psychiatric and A&D clinics.
- Stated that about 8 of the current methadone programme users are homeless.
- Need wet houses, lower stigma and engage in harm reduction.

### Further enquiries

- Te Aro Health Centre.
- DCM.

## **Appendix J2:**

### **Downtown Community Ministry**

#### **Definitions and frameworks**

- Homelessness: use the same definition as the Wellington City Council. In her opinion, have to have more than 1 episode of rough sleeping
- Serious housing need: tertiary homelessness, families doubling up in houses (don't know how relevant this definition is to their clients)
- Prevention frameworks: useful but primary a) should be individual, not high risk

#### **Role of your organization**

- Provide 5 to 6 services:
  - Project Margin: assist into accommodation and help maintain accommodation
  - Street People Project: capped at 50 clients. Benefit agency for people with no address or bank account. Some exceptions made for people with gambling problems
  - Benefit Advocacy: help people with making sure they get the benefits they are entitled to
  - Foodbank: Poverty Indication Project. Provide 25 to 30 food parcels per week. Also run a questionnaire to find out why people need help with food (don't use questionnaire to exclude people). Very lenient with people with addictions.
  - Community Worker
- Mainly focus on tertiary prevention.
- Clients are mainly male but not so much in the foodbank and community worker areas.
- There are specific criteria for Street People Project but no explicit criteria for Project Margin. Just need to convince them that they are actually homeless. Find out through word of mouth.
- People are referred mainly through word of mouth. They also have a reputation. They do get some referrals from WINZ. Government agencies try to refer onto DCM but try not to accept because of lack of funding eg. CYF. People try to 'turf' some clients onto DCM but they don't get funding to help this people. CYF does instead but try and get out of helping them.
- Have interactions with soup kitchen, night shelter, Inner City Project (mental health), Easy Access Housing, Salvation Army Hope Centre, lesser degree with St Vincent's and Wellington City Mission. Also with housing providers eg. Blossom.
- Get funding from Wellington City Council when they started the homelessness strategy. Clients never have to pay.
- Taking new clients all the time (a few per week). Natural turnover with clients. Foodbank is according to demand.

## **Perceived Gaps**

- Very significant gaps especially in facilities and treatment services.
  - No alternative options for accommodations. Rough sleeping straight to 1-person flat. Hard to police some flats. Need more accommodation options such as wet-houses (need other models of housing)
  - Need a rehab venue (re Tim Harding at CareNZ)
  - Access to health treatment. Need a health treatment centre located in easy access areas. Also need a mental health service for addicts.
  - Gaps cover the whole range from primary to tertiary prevention
- Pathways into homelessness
  - Early childhood experiences: such as abuse (sexual, physical, mental etc), dysfunctional family, multiple foster homes
  - Literacy issues
  - Early addiction to alcohol and drugs
  - Early criminal activity: theft, prison experience
  - Mental health
- (Realise that they deal with a small proportion of homeless so may have a skewed view)
- Preventing these pathways could include decreasing poverty. Need government input because it is very complicated.
- Need more services like what we've got. Need to broaden options for people. Need to increase access. Need better interaction with the police. Need a greater understanding of the homeless.
- The needs of the homeless are not being met. Just partially met at the moment.

## **Appendix J3: Easy Access Housing**

### **Role**

- Short-term/Emergency housing for mental health consumers.
- 4 boarding houses with supportive landlords (not supported accommodation, not a respite service).
- 3 male, 1 female house, 4 tenants per house.
- Maximum term of tenancy 6 months.
- Support plan to access longer-term accommodation and other Community Service groups, eg. Budget Advice, WINZ, Mental Health services, Employment and training.
- No substances permitted on premises – although can drink in the house with the consent of all flatmates.
- Eviction is occasionally necessary due to behaviour related to substance abuse.
- Rent \$75/week, AP assignment through WINZ.

### **Criteria**

- Homelessness status
- Had/are experiencing mental illness
- Ability to live independently

### **Referral**

- From mental health services (often from Ward 17-cannot be discharged without address), community agencies, word of mouth
- Advertising – pamphlets at Comm. Agencies
- Word of mouth

### **Governed by representatives of:**

- DCM, Suzanne Albert Compassion Centre, Wellington People's Centre, SF Wellington, Inner City Project

### **Funding**

- CCDHB

### **Gaps**

- Housing for A+D – wet hostel – huge demand
- Supported accommodation
- Relocation grant from WINZ often not received by those who need it most for setting up permanent housing (St. Vincent de Paul and Sallies try to provide the basics)
- 3<sup>o</sup> prevention is the major gap, difficult because many homeless do not want the interference, and will require education of public to change idea of "getting them off the streets".

## **Appendix J4:**

### **Evolve** (Wellington Youth Service)

#### **Definition**

- Time period certainly should be much different for no fixed address compared to rough sleeping, especially in regard to young people, where having no fixed address for an extended period is very common.
- Some notion of intention is critical when considering homeless population for purpose of service provision – many young people “transients” and do not want permanent housing.

#### **Pathways**

- 20-30 street kids in Wellington, aged 12-16.
- Typical pathway:
  - Under CYFS care due to family history of abuse, A+D.
  - Run away from foster home
  - →A+D abuse, crime, behavioural problems
- Endpoint:
  - →Mental health system
  - →Prison
  - →Integration into “mainstream”
- Homelessness is a consequence – the issues that underlie it are often unaddressed in this group (esp. A+D prevention).
- Separate group of homeless – complex needs
- Not a housing issue
- Crime – usually assault, burglary
  - Most know they are protected because <16
  - Youth court can only give community service due to waiting list for juvenile detention facilities
  - Lack of deterrent of prison

#### **Risk Factors**

- Dysfunctional family
- School dropout
- Mental health problem
- A+D

#### **Prevention**

- Education
- Employment

- Sense of belonging – connectedness (to anything)
- Sense that some adult cares

### **Role**

- 3° - Harm Reduction, referral for 2°
- Primarily – a hang-out space – where they interact with Youth workers
- Showers, use of kitchen, locker storage, tea/coffee
- Nurse and GP provide free healthcare for 10-25s
- 10 Youth support workers covering 7 ethnicities
- Prescriptions <\$3
- Sexual health – free contraceptives
- Free youth counselling (soon)
- Youth benefit advocate (from People's Centre)

### **Criteria**

- Age restriction only (between 10-25).
- Evolve is the only agency that sees Wellington's homeless youth regularly.
- -Intimidated by other agencies, youth do not feel comfortable at services for homeless (eg. Soup Kitchen)
- -Not accepted by Night Shelter

Problem: Evolve only open during the day.

Emergency housing – Evolve refer to:

- Easy Access housing – Mental Health consumers
- The Inn (Salvation Army) – 16-22, short-term (transitional housing)

Problem: What can we offer to <16 homeless?

- Evolve have the refer them to CYFS – who have to place them back in foster care, run away again, cycle continues...
- Not eligible for bank account, WINZ assistance.

Problems if >16:

- Limited range of low cost housing – eg. WCC bed sits.
- Unsuitable living conditions for people who have difficulty living in close proximity to others – with refugees, gang members etc.
- Volatile mix of people living in close quarters.
- Many prefer to be on the street, especially those with mental health issues, whom the available housing arrangements are particularly difficult for.
- Depression, suicidal ideation - main mental health problem seen among street kids.

### **Access**

- Word of mouth
- Advertising – pamphlets at other agencies, flier drops, promotions at schools

### **Co-ordination**

- CYFS
- Youth Aid
- Other health organisations
- A+D – Rangataua Maoriora
- Alternative education
- WINZ
- HNZZ
- Inner City Project
- Easy Access Housing

### **Funding**

- CCDHB

### **Gaps**

- CYFS system for <16s with high needs not working.
- Lack of appropriate accommodation options for >16.
- Need for supported emergency and transitional accommodation – would have to be a “wet hostel” with flexible rules – will not work if curfew, like Night Shelter.
- Lack of A+D services for youth – only one in Wellington (Rangataua Maoriora) – Maori focus, not suitable for everyone.

## **Appendix J5:**

### **Gambling Intervention Services (phone)**

#### **Criteria**

Anyone who has gambling problems or someone closely related to them has gambling problem.

#### **Prevention**

More in the 1° category-at risk of becoming homeless  
But see clients at each level

#### **Gaps**

Need for Asian specific services

#### **Interaction**

Other City agencies where referral is needed



## **Appendix J6:**

### **Housing New Zealand Corporation (Head Office)**

#### **Definition**

- Must include some notion of choice – some homeless do not want assistance.
- Public perception of behaviour as undesirable caused “problem”.

#### **Role**

- Social housing
- Statutory responsibility – 1<sup>o</sup>/2<sup>o</sup> prevention/Serious housing need
- Work with organisations through Housing Innovation Fund, community Group Housing – provide houses for people at need through agencies.
- Eg. Salvation Army emergency housing – HNZN provide house.
- Emergency accommodation – funding for agencies that want to provide the services.
- Look at whole housing spectrum – aim to shift everyone into more suitable housing – homelessness at end of that spectrum.

Lack of suitable housing - more than bedsits

- Challenge for both WCC and HNZN
- -Encourage WCC to not sell off housing stock, reconfigure housing to suit changing needs of population (Housing Innovation Fund)
- Support required to teach behaviours than maintain tenancy
- Regional Managers do a lot more than tenancy management – support, debt problems

#### **Barriers**

- Huge chunk of income going to accommodation
- How do you get a bond together?
- Paperwork, interview

#### **Access**

- Agencies act as agents - need benefit, ID, bond
- Self-presentation
- Project Margin – provides housing
- Not much housing stock in Wellington
- People do not want to move out of the city
- Demand far exceeds suitable stock

#### **Co-ordination**

- Voluntary sector increasingly concerned
- Agencies talking together
- Need clear picture of current status

- WCC could play critical role in co-ordination – community groups look to WCC to take that role.

### **Gaps**

- A+D services
- Lack of “Bridgehaven” – residential addiction treatment programme
- ?Wet hostel
- Supported accommodation - need wrap-around support services
- e.g. Hawke’s Bay – plan for hostel for homeless men, run by Salvation Army, not enough funding.
- Young, single people missing out - more subsidised hostels required.
- Creative use of existing accommodation.
- Clear pathway for agency referral and for homeless to know where to go.
- Different models apart from Salvation Army, Night Shelter.
- Stepping stones (transitional housing).

## **Appendix J7:**

### **Housing NZ (Kilbirnie Regional Office)**

#### **Definition:** 2 definitions:

- Person at risk (public place, garage, etc.), temporary accommodation,  
True homeless: living on the streets; duration hard to define  
Better to prioritise people in a spectrum- not everyone can be helped due to limited resources. Some people don't have lifestyles suited for permanent housing. These issue need to be addressed first before meeting housing requirements.
- Someone that needs to be housed within 60 days.

#### **Role:**

- Providing housing  
Social housing: linking with community groups.
- Criteria: NZ citizen, permanent residents  
Income: single less than \$383.72, family less than \$590 but variable according to circumstance eg. Loans, debts etc.  
Asset less than \$23000.
- Word of mouth mainly, community groups wide range of agencies.
- Winz, DCM, hospital, sps, SA, WCM
- Fully funded by govt  
Have to pay set rent/ no admin fees/ rent related to percentage of income (so in essence they should be able to pay)

#### **Gaps**

- Low turnover of housing and less affordable housing: results in waiting lists
- Most 'true homeless' have co-morbidities and so these issues need to be addressed first.
- Housing not suitable for some people; the housing that is available not suitable for most homeless people. Some prejudice in communities. Need for supported housing as normal communities not willing to put up with certain behavioural issues, people from prisons, mentally ill
- Eviction due to behavioural issues, not paying rent
- More A+D counselling
- Have to be 18 to sign tenancy agreement but can use tenancy tribunal (but most homeless people not eligible for this). So young children missed.  
Community housing needed for teenagers.

## **Appendix J8:**

### **Inner City Project**

#### **Definition:**

- Definition OK for study purposes
- They include anyone who states they are homeless including those that have inappropriate accommodation by other peoples' standards

#### **Role:**

- Support service for people with mental health issues
- Provide coordinated primary health and social service with focus on linking people into existing agencies etc.
- Focus areas:
  - Helping people access services
  - Promoting inter-agency collaboration
  - Identifying and addressing unmet needs

#### **Prevention Model:**

- Viewed by other agency/community as 1°/2° and increased demand lately with 3°
- Help provide access to agency to help prevent homelessness
- Often get rang by ward 27(psych) to help patient find accommodation or help re-integrate (esp with early discharges)

#### **Services/support:**

- Physical and Mental health
- Accommodation help
- Finances, debts, benefit issues
- Misuse/dependence on substances
- Employment
- Advocacy
- Recreation

#### **Sort of people using service:**

- Mental health consumer
- Homeless
- Those with inadequate living/social conditions

#### **Criteria:**

- Priority for people whose support needs are currently not being met and who have difficulty accessing agencies
- Mental health issues of some sort e.g. anxiety, psychiatric disorder, stress etc

#### **Access:**

- Word of mouth
- Referral by other agencies

- Advertise through other agencies

### **Interactions:**

- Governed by steering group i.e. DCM, Newtown Union Health Service, SF Wgtn, Soup Kitchen, Te Aro health centre, WIPA, Wgtn Mental health Consumers Union, Wgtn Peoples centre
- Govt agencies
- Consumer lead initiatives
- Blossoms

### **Funding:**

- Fully funded by C&CDHB

### **Gaps:**

- Maori specific services + Family services (Urban Marae)
- Pharmacy services for those patients banned from most pharmacies in Wgtn...under the influence/violent
- Half way homes esp prison services and mental health
- Detox services (A& D) +increase rehab residential services
- More social inclusion/need friends and safety
- Inner City accommodation i.e. Caravan park (model from Australia)
- More therapeutic community i.e. helping with cleaning/cooking
- Emergency accommodation (for families/youth)
- Mental health-scared about re-entering services

### High Risk Population

Prison, A&D, mental health, debts (esp Maori as too embarrassed to access help)

### **Prevention:**

Working more with corrections in court→increase in supported accommodation and early intervention

Do categories help in understanding pathways into homelessness?

For project OK but a lot of grey areas

Do you think needs of homeless in Wgtn are being meet?

Possibly not for the Maori population

Always taking new clients.

## **Appendix J9:**

### **Ministry of Social Development – Work and Income NZ**

- Most homeless on unemployment benefit
- Mental health/addiction issues make eligible for Sickness/Invalid benefit, for which they would get more, but choose not to go on this benefit - probably to do with stigma
- Would also need primary health care support for regular health assessments
- This would require a Wellington City PHO to run a mobile service

### **PATHS – DHB + Work and Income NZ**

For Sickness beneficiaries who want to work – fast-track through health system – staircasing to normal work

- Homeless would be eligible for this scheme if on Sickness Benefit
- Entitlement WINZ can give them is limited by legislation – have to assess around costs – homeless have no housing costs, no utility costs – not eligible for housing supplement
- The only Special Benefit they tend to access is Food Grant (voucher) – and they only come in for this as a very last resort
- They do not want to come into WINZ to access any other grants e.g. emergency medical
- POLICY DOES NOT FIT HOMELESS
- Agent (e.g. DCM) works better - difficult for both WINZ and the client when they deal directly
- Occasionally someone has to be trespassed to get them out of office (eg. if drunk) - can't be case managed – can't give them Development Assistance
- ~40% homeless use agent/advocate – can be part of problem – advocating for beneficiary rights in terms of maximum entitlement, but as Case Manager never sees client – cannot assess other needs – limits ability to access other services.

Case Manager – aim for balance – income/other needs – Development Assistance – referral to appropriate services – strong networks with local health and community support groups, bring support into office while client is there (eg. A+D service)

Under present structure it is not feasible for Case Manager to go out into community.

- If client wants to move into housing, under Case Management model:
- -HNZC/WCC brought in
- -\$1000 grants (half recoverable) can cover bond, appliances, bed

**DEBT** – through WINZ is not a problem – is only deducted at rate of income.

- Debt problems come from Court system and Rent arrears.
- WINZ can give assistance if about to be evicted – take on arrears, but WINZ cannot pay off fines.

- There is now a plan to bring all debt under one agency – to be managed through WINZ, which would be better for the client

**HNZC Assignment** – AP from Benefit to rent (developing policy with WCC).

- Clients generally like arrangement
- But client can come in to WINZ and cancel anytime
- Doesn't cover utilities – which can force someone out of housing as easily as rent

WINZ currently working with HNZC

- 12 houses for Emergency Accommodation – for up to 8 weeks, while looking for longer-term accommodation
- Available to everyone, but will benefit homeless

**RECOMMENDATIONS**

3<sup>o</sup>/2<sup>o</sup>

- Team of people:
- WINZ Case Manager – income protection
- Social worker – needs analysis
- Health officer – meds, assessments for benefit
- (HNZC officer when they are ready for housing)
- Holistic solutions for individuals – inform directions for policy – we won't know what is most needed until we start doing something.

**STAIRCASE** – from ensuring safety, covering basic needs ---- self-sufficiency

- Get client to the point where they feel they can make a choice
- Change in approach – supports to allow to live on street safely if that is choice – inc. public education.
- Requires co-ordination between govt agencies
- Social Development – bringing services together with collaborative holistic approach.
- Strengthening Community Action – involve homeless in development of strategy, involve public.
- Easier to dedicate human resources than wait for a building – mobile group of people – covering all Social Determinants of Health
- Problem with “one-stop shop” – easily becomes another institution
- MODEL – Multi-agency Prisoner Reintegration Process

1<sup>o</sup> Prevention

- Homelessness is a symptom of other problems
- A+D, Mental Health Services (these in turn will prevent debt problems)
- Must start in schools
- Churches are in the best position to educate public

## **GAPS**

### **Lack and access**

- A+D services
- Mental health services
- Primary health care (only one outreach nurse from Te Aro Clinic)
- Emergency Housing
- Permanent Housing



## **Appendix J10:**

### **Night Shelter**

#### **Role**

- 25 bed dormitory, 14 bed hostel - semipermanent – pay rent
- Night shelter provides emergency accommodation for 350 people per month, with an average of 15 clients/night.
- Number of clients has increasing since Project Margin
- They pay \$5/night.
- Most clients are single men; women are housed at the lodge on Taranaki Street with which the Night Shelter has an agreement.
- Most clients are recurrent clients – chronic problem.

#### **Criteria**

**Inclusion:** “anyone without a roof over their head” for whatever reason, no questions asked about reasons why.

**Exclusion:** intoxicated, bad behaviour, active substance abuse.

#### **Pathways**

- ~30% Gambling
- ~20% Mental health
- ~20% serious debt problems with WINZ/WCC
- Refugees
- Students

#### **Secondary/Tertiary**

Although primarily an accommodation service, help clients to work through debt issues if they have the motivation to do so:

-Advocacy for WINZ

-Assistance with application process for WCC housing, act as referee for priority placement on waiting list.

Serious Debt a huge problem in dealing with WCC, WINZ – but also the most common problem the night shelter sees.

#### **Access**

- Word of mouth, all agencies and courts, police refer to night shelter
- No advertising
- Night Shelter have close relationship with Salvation Army, WINZ, Police, courts, soup kitchen, no referrals from Presbyterian support, catholic social services.

#### **Funding**

Originally 7 trustees

Now, rent from hostel + fundraising

WCC backing + fundraising for major upgrade beginning 2006 – same service provision

WCC proposed Night Shelter’s Garage to be used as a shelter for rough sleepers

Idea was dropped-

(Night Shelter would become legally liable for this group if on their property

Unresourced/unprepared to take that responsibility)

### **Gaps**

- WCC not doing enough to prevent serious housing need→homelessness, dealing with issues before eviction
- Lack of emergency accommodation:
  - (WCC should be funding and co-ordinating more places like the Night Shelter)
- Lack of transitional housing (supported accommodation between emergency and independent housing)
- Lack of gambling/debt agency in Wellington
- Lack of detox programme
- Substance abusers are the group that no current emergency accommodation options in Wellington are available to.
- Lack of community understanding/education
- 24hr drop in centre – problem of liability
- An organisation would have to take ownership
- Funding should come from WCC

## **Appendix J11:**

### **NZ Prostitutes Collective**

#### **Definition:**

- Happy with definition and agreed with 2 weeks duration for transient sleeper
- Wasn't too sure about the 2 nights for rough sleeper
- Asked if this included those that slept in cars?

#### **Role:**

- Offers support the rights, health and well being of all people working in the sex industry.

#### **Prevention Model:**

Fit into all categories

- Quite a lot of work into 'keeping the stitches together' 1°
- Preventing people coming homeless that are on the brink of e.g. losing house

#### **Services/support:**

- Provide condoms (different range)
- Free doctor and nurse clinics (do not have to give real name)
- Testing-STI, Pregnancy, Hepatitis A and B
- Counselling
- ECP
- Identify and help with Health issues (strategies)
- NEP-needle exchange programme
- Provides info for those considering working in the industry
- SIREN magazine (info for sex workers by sex workers)
- Referral to other agencies

#### **Sort of people using service:**

- More female (but does have PUMP...for male sex workers and ONTOP for transgender)
- More Maori than general population
- 20-25 yr is peak age group
- Indoor worker majority (vs. outdoor worker)
- Parlour/Escorts/Street/Private workers

#### **Criteria:**

- If working or thinking of working (or have before) in the sex industry

#### **Access:**

- Word of mouth
- Telephone
- Advertise in papers/signs etc
- T.V

**Interactions:**

- ICP
- SHC
- FPC
- Rape Crisis
- Police
- Help as need arises

**Funding:**

- MOH and import product to make money

**Gaps:**

- Emergency Housing esp for Women (women's shelter)
- Risk of putting 4 mental health consumer women all in same house
- Also help for those 'too messy to help' i.e. can't go to night shelter
- Need Douser home with some support people there
- Women shelter with no hours/just a caretaker/meeting with agencies not compulsory/lockers/showers/food
- Sydney-have shooting up houses-safe houses

**High Risk Population**

- MH
- Violence/abusive
- Criminal (violence)
- A&D
- Some just from general population (2<sup>nd</sup> night job)

**Prevention:**

- Main pathways into homelessness
- Home support inadequate and unrealistic
- Threshold too high for most esp addicts
- Need for Douser

Do you think needs of homeless in Wellington are being meet?

Not for women who need emergency housing

Always taking new clients

## **Appendix J12:**

### **Police interview**

#### **Questions**

##### **1. Definitions and frameworks**

What is your definition of homelessness? (if you were trying to count)

No Clear Definition. Generally dishevelled looking people in the malls/ city who appear drunk or on drugs or have no fixed abode.

Likes the idea of two or more nights for rough sleeping

- Using a public health approach, we suggest dividing services into the following categories: 1°, 2°, 3° prevention, high risk and population approaches (show card 2). Is this approach useful?  
Yes but perhaps combine primary and secondary

##### **2. Role of your organisation**

- What services does your organisation provide for the homeless?
  - Referrals to other homelessness agencies in Wellington, Detox for those to intoxicated to help themselves at central police station. Get people of the street and pick up problems before charges can be laid
- What sort of people uses your service?
  - People who have broken the law in some respect
- What are the criteria that need to meet before homeless people can receive help from your agency?
  - Break the law. Be generally disturbing the public
- How do people (including homeless people, if not covered in answer) access your agency e.g. direct, referred, word of mouth, advertising (ask specifically about advertising if not already covered).
  - Too intoxicated to help themselves
  - Referral to Jason from other police officers
- What other agencies do you have interactions with (in regards to homeless people)?
  - Key ones
    1. DCM
    2. People's resource centre
    3. WCC- status reports on homelessness
    4. CCDHB
    5. Wgtn Mental Health consumers union
- Do you receive funding for your agency or do clients have to pay?
  - No funding for homeless
  - Part of being community constable is to look after homeless
- Are you taking new clients/patients at the moment?
  - Yes

### **3. Perceived gaps**

- Where do you think there are 'gaps' in the services that are provided for homelessness? Ask them to think about gaps in terms of 1°, 2°, 3° prevention
  - Incapable of looking after themselves (especially alcohol drugs and mental health)
  - Can refer to agencies from the police but don't know if people get to the agencies. Police don't have time to take them themselves. Can only put them in cells if they've broken a law.
- What do you think are some of the main pathways for becoming homelessness in Wgtn?
  - Alcohol and drugs
  - Loss of a job and no income
  - Loss of family contacts and becoming isolated
  - Mental health issues
  - Left home young, no job, no income, falls through the youth gaps
- Do you think more could be done to prevent these pathways into homelessness i.e. 1°?
  - Yes –if young should be picked up better by police/CYPS
  - Early offending lead to being kicked out of home and then becoming homeless and area that could be addressed
  - Recommended more education on homelessness for police and providing a list of key agencies they could refer them too
- What services would help people out of homelessness and serious housing need?
  - A facility that police could deliver the homeless to which is out of public view provides shelter and access to all available agencies. Where homeless can socialise and perhaps a wet area for alcohol.
- Do you think the needs of the homeless in Wgtn are being meet?
  - No, too many being repeatedly picked up by the police

Police process: homeless picked up sent to cells for detox then kicked out of door unless referred to Police

## **Appendix J13: Prison interview**

### **Interview Prison Reintegration**

#### **Questions**

##### **1. Definitions and frameworks**

- What is your definition of homelessness? (if you were trying to count)  
No Regular Abode for less than 1 month, no possessions, rough sleeping 1-2 days
- Using a public health approach, we suggest dividing services into the following categories: 1°, 2°, 3° prevention, high risk and population approaches (show card 2). Is this approach useful? Yes

##### **2. Role of your organisation**

- What services does your organisation provide for the homeless?
  - Find accommodation for homeless inmates, can be difficult for the inmate to live in the accommodation even if it is provided
- What sorts of people use your service?
  - Prisoners in local Wellington region excluding Kapiti & Wairarapa
  - Arohata worker cover all NZ
- What are the criteria that need to meet before homeless people can receive help from your agency?
  - Be in prison, be referred by someone
- How do people (including homeless people, if not covered in answer) access your agency e.g. direct, referred, word of mouth, advertising (ask specifically about advertising if not already covered).
  - Internal referral near the time of release by case worker
  - External referral eg mental health
  - Some advertising in production as service is new and advertising for inmates who have been in for sometime
- What other agencies do you have interactions with (in regards to homeless people)?
  - Key one's
    - 1. Housing NZ
    - 2. WCC
    - 3. WINZ
    - 4. Counselling services
    - 5. CCDHB
    - 6. NZ prisoner aid society
    - 7. Operation Jericho (faith based social development)
    - 8. NZ Police
    - 9. Probation
    - 10. Parole Board
    - 11. Psychological services
  - Others include non-government private organisations

- Do you receive funding for your agency or do clients have to pay?
  - Funding only for staff salary
  - Clients don't pay
- Are you taking new clients/patients at the moment?
  - Yes

### 3. Perceived gaps

- Where do you think there are 'gaps' in the services that are provided for homelessness? Ask them to think about gaps in terms of 1°, 2°, 3° prevention
  - Support people or mentors: Can get housing, benefit etc but no one around to get furniture, cutlery etc i.e. no one to tie up loose ends. No one to drive client to WINZ. No community connections leading to isolation and then re-offending (25% re-offend in first 2 months)
- What do you think are some of the main pathways for becoming homelessness in Wellington?
  - Alcohol/Drug
  - CYPS care or being kicked out of home at young age
  - Prison sentence
  - Mental health/ physical health/ spiritual health problems
  - Poor housing/ credit history
  - History of abuse (all types)
  - Single
  - High debt
  - Poor education in life skills especially financial management
- Do you think more could be done to prevent these pathways into homelessness i.e. 1°?
  - Yes –increase social support and intervene earlier
  - Increase access to services available to those on the brink
  - Not enough A&D counsellors
  - General counselling too expensive
- What services would help people out of homelessness and serious housing need?
  - Specific homeless prevention service
    - Employment/ vocational training
    - Positive role models
    - Continuity of Accommodation
    - Different types of Accommodation not just one room bed-sit (less isolation)
- Do you think the needs of the homeless in Wellington are being meet?
  - No, for those who don't want to be homeless!!

### 4. Other agencies

- Who else should we talk to get a complete picture of the organisations working on 1°, 2°, 3° prevention of homelessness?
  1. Women's refuge



## **Appendix J14:**

### **Salvation Army Hope centre**

#### **Definition:**

- Accurate enough
- Duration→has individual difference

#### **Role:**

- To work with individuals/families/whanau and wider communities → to help them gain greater level of control over their lives and ultimately a higher quality of life for all.

#### **Prevention Model:**

1°→referral to budget services

2°→have own accommodation for emergency housing and longer term

3°→support people on street. Can come and use shower and get food

#### **Services/support:**

- Community Service/Diversion (Crime)
- Supported accommodation (elderly with intellectual disabilities)
- Early childhood education
- Emergency housing, 4 flats and 1 larger 4 bedroom-house
- Family support
- Drop in centre (10-3)
- Counselling
- Advocacy

#### **Sort of people using service:**

- Range of ethnicities...including migrants
- Homeless
- Those with housing needs or financial

#### **Criteria:**

- For emergency accommodation→don't accommodate single men
- Anyone who needs support/shower etc
- Don't take non-residents...as cannot receive government benefit. SA can arrange for accommodation benefit to come straight to them.

#### **Access:**

- Word of mouth
- Referral by other agencies
- Telephone

#### **Interactions:**

- Newtown budget services
- WINZ
- The Inn (youth house for street kids)
- Blossoms
- Te Aro health link

#### **Funding:**

- For Supportive accommodation→MOH funding and WINZ

- Early childhood program→WINZ subsidy + Ministry of education
- Hope centre→SA fund
- Ministry of housing give houses at lower % than market value

**Gaps:**

- Place for rough sleepers
- Especially a lack of accommodation for single males
- **Place for clients with severe MH/Korsakoff (memory problems) and A&D**

**High Risk Population:**

- Prison, A&D, MH, debts, gambling

**Prevention:**

- MH/Drinking/gambling/adequate income and access to income
- Cost of education
- Access to services

Do categories help in understanding pathways into homelessness?

OK

Do you think needs of homeless in Wgtn are being meet?

Some but still lots of improvements to make

Always taking new clients

## **Appendix J15:**

### **Soup Kitchen/Compassion Centre**

**Definition:** reasonable...but duration not really determined.

**Role:**

- Mission: is to know and express the compassion of Jesus Christ; by supporting ppl who are just surviving in the community to live with dignity.

**Prevention Model**

- Fits in all 3 categories
- Soup Kitchen more about 2° and 3°
- Helps those in homelessness or likely to become or have been before

**Services:**

- Breakfast and Dinner 6days/wk in dining room →aim to give nutritious meal in warm environment.
- Food collection and distribution
- Visiting isolated and lonely (hospitals)
- Spiritual guidance (prayer and rest)
- Clothing room (opened in morning after breakfast)
- Referral to agencies

**Sort of people using service:**

- Some true Homelessness (our definition)→ not all
- Including those with MH issues/A&D issues/Debt & Gambling addictions/low IQ
- High % Men and also high Maori % vs. general population
- High MH consumers among Males

**Criteria:**

- Need for food and social interaction.
- Have to treat other with dignity while on premises.
- No violence, abusive language or alcohol/glue allowed on premises.
- Can trespass people if think they are threatening others safety.

**Access:**

- Referral from other agencies
- Word of Mouth
- Don't need to advertise but people seem to know they are there

**Interactions:**

- DCM
- St Vincent de Paul
- Other foodbanks (Coalition of Regional foodbanks)
- Inner City project
- Peoples Centre
- Maori Mental health

- Housing NZ

### **Funding:**

- No govt funding
- Receive donations and grants
- Trust board set up

Take all people that want service.

### **Gaps:**

- Criteria too high for people suitable for night shelter
- Need emergency housing where people with addictions can go→Supervised house
- Lack of intervention between Prison and community→especially for those in and out of prison. There is new initiative for LT prisoners entering community again but need for all. Need help (i.e. Social Worker help) with WINZ/furniture etc...one to one work.
- Need more Maori specific agencies (A&D, Counsellors) esp Maori Women counsellors (for Men who have been molested)

### **High Risk Population:**

Yes most come from this high-risk population-esp MH and A&D (co-morbidity)

### **Prevention:**

As above for Gaps i.e. Prison/community intervention

Maori specific agencies

More social worker assistance in Schools for child at high risk i.e. those with Intellectual disability or low IQ, high risk families etc→Mentor system

Do categories help in understanding pathways into homelessness?

Ok for study

Do you think needs of homeless in Wellington are being met?

To an extent but lots more could always be done...especially in already identified areas.  
Good network of agencies working together

## Appendix J16:

### The Inn (Some part of Salvation Army)

#### 1. Definitions & Frameworks

- Believes that almost everyone has somewhere that they could call home, and it is a choice they make not to be part of it.
- Rough sleeping is a symptom
- Would challenge the third point in definition
- Serious housing need: Believes that all public agencies & NGOs that provide housing should be accountable for the places they provide – there should be set standards for agency housing.

#### 2. Role of organisation

- Transitional house for young people aged between 16-23 years old.
- They stay for a six-week period, during which time they **stabilise** (with counselling, A&D input, mental health input), pick up some life-skills and work experience, and then get helped into a flat.
- Some people only end up staying for a short period (e.g. overnight, if picked up by Police, and nowhere else to go).
- It's a stable environment where they can get on their feet, get the medical attention they need etc.
- People end up here through referral from the courts, CYFS, Police, or they can turn up (drop in) e.g. after being kicked out of a flat.
- Biggest problem with the people he deals with is what he believes is a lack of motivation – "they don't want to help themselves".

**Criteria for entry** Have to sign a tenancy agreement, which has strict guidelines e.g. no A&D, separate males & females, cooking & cleaning requirements.

Have a night a week where they have to cook dinner for the whole house (with help from supervisor) → helps to gain life-skills.

**Accessing the service** Through direct contact by person to Salvation Army, or referral from Police/Courts/Hospital/CYFS (they are listed with each of these services as an agency to contact for young people in need of housing). Some degree of word-of-mouth.

**Funding** from WINZ (annual contract – perceived to be unstable – could end with any decision/policy change), from the (minimal) rent paid by tenants, Salvation Army donations. Currently looking for sponsorship from businesses (e.g. wants to get a van donated by a car dealership so they can go out for fieldtrips etc).

Capacity is 11 people maximum (currently has 5 in at the moment), but it fills up quickly (esp since people are there for six weeks at a time). Also get referrals from other centres e.g. Palmerston North.

### **3. Gaps in Services**

Absolutely there are gaps

- Funding to keep the place open is an ongoing headache
- Would also like some volunteers to help out, but no one available

**Believes there are a lot of agencies there, but often their caseloads are so high that in effect there is a gap**

E.g. Mental Health Services, A&D, Budgeting, A&D Rehab

Believes that people needing these services, who are high risk, should get rapid intervention

#### **Pathways:**

Target **families** – believes that this is where it all breaks down

- A lot of family related stuff – families break down, or give up

Most people come from high-risk settings (referral from court/CYFS)

It is difficult to find jobs for people, because of court records

During the day, the people go off on courses or work experience. If he needs to go out for an errand/meeting, he has to kick everyone out of the house until he gets back (security risk)

## **Appendix J17:**

### **Wellington City Council**

#### **Definition**

As per Homelessness Strategy 2004

#### **Response**

Project Margin – 2 yrs

Research + Service Level Agreement to provide housing + DCM also work with other housing providers (more co-operation with other providers needed)

#### **Primary/secondary**

Allocation process:

1. Low income
2. Level of housing need - top priority = rough sleeping-house immediately, high priority = no fixed abode/couch surfers
3. Target groups

#### **Issues for WCC**

WCC Tenancy Managers not resourced for social case management (unlike HNZN) – more co-ordination with HNZN

Sustainable housing for A+D – would need some level of continued support

Raising awareness required good information – politicians

Cost of care vs. cost of doing nothing to society

Really clear expectations of homeless as tenants

Project Margin housed 22 homeless, primarily through WCC housing,

Homeless of one of target groups

DEBT – memorandum of understanding with WINZ – if client presents with huge debt, starts to get into debt, condition of WCC housing – direct debit from benefit

Depends on support from case manager for accessing all entitlements – more standardisation of different case managers required

#### **Referral**

Community agencies

Clinics at DCM, soup kitchen, Inner City Project - to try to overcome problems with ACCESS related to threatening environment of council, illiteracy, etc.\_

#### **Gaps**

Limited availability of housing for demand

Suitability of housing e.g. bedsits

Emergency housing – A+D – high need group – “unlovelies”

Health

Who is responsible for different issues

Who WCC will form partnerships with

Co-ordination – what is there doing what, networks

Mental Health model – CCDHB contract – Supported landlord + community support component – Homelessness housing also need support worker

Wet Centres as in UK – WCC exploring model

## **Appendix J18:**

### **Wellington Mental Health Consumers' Union**

**Definition:** no adequate housing, no permanent housing, secure housing  
Prevention strategy useful.

#### **Role**

Day drop ins: leisure activities, computer facilities, tea, coffee, shower, washing, pool table, machine

Advocacy service: peer advocacy, WINZ, accessing servicing

- Criteria: current/previous mental health consumers/ people that identify as mental health consumers
- Prevention
- 0.25 homeless of people that use the services
- Mental H ward, word of mouth, pamphlets, SF Wellington, telephone book, comm. Mental h team, ICP kites, well link
- Funded by DHB

#### **Gaps**

- More easy-access housing.
- More short-term accommodation in supported environments.
- People who have 'burnt' out can't access services.
- Lack of info on what to do and who's there to help.
- Lot of people that are eligible for benefits don't get benefits- they need advocacy services. WINZ need to be aware of advocate services and point people in the right direction.
- Some people only have 20-30 dollars per week after paying debts and rent. Most of these people have addictions. They can't eat pay rent/debt and satisfy addictions in with the money they get. So they have no choice but to live on the streets.
- Prejudice: most people assume that homelessness is chosen/ bad choices in life lead to h. / people should be able to survive on benefits etc. homelessness poorly understood by public---public awareness need to be raised.



## **Appendix J19:**

### **Wellington People's Centre**

#### **Definition**

??Duration

Many who come to the People's Centre are 'transient' rather than homeless – chosen lifestyle

Some notion of self-declaration of homelessness necessary

#### **Pathways**

- Abuse, neglect, CYFS history
- Substance abuse
- Trend towards more homeless women – lack of emergency accommodation.
- Returning from Australia with no resources and no family

#### **Role**

- People's Centre has no formal role – main aim to empower with information – support and referral – HARM REDUCTION (3<sup>o</sup>)
- Common knowledge that it is the place to come to for free coffee/tea/phone
- Refer to;
  - DCM (benefit advocacy), Te Aro Health, Soup Kitchen, Inner City Project, Courtney's to sleep(drop in centre for mental health consumers), mental health services
- Plan for DCM, Compassion Centre and People's Centre to come under same roof
- Funding – membership fee \$10/month, grants

#### **Gaps**

- Range of accommodation options esp. supported accommodation
- A+D/dual diagnosis is group most at need – Easy Access Housing – 16 beds not enough
- Lack of response from A+D/Mental Health – access to services
- Boredom – work programme
- 24hr drop-in centre (Auckland City Mission model – showers, some donated food, lockers)
- Emergency Housing – single men miss out – drinkers, gamblers – Night Shelter provides limited service
- Accommodation for elderly homeless with serious health needs
- Wet hostel – off police system, increases debt – most enlightened way of getting out of cycle
- Networking of prisoner relocation programme
- Financial assistance if coming out of prison after less than 3 months
- Public education – non-acceptance of 3<sup>o</sup> interventions – want them off the street, helping people who don't deserve to be helped
- Where could you put a drop-in centre?

## **Co-ordination**

### Community agencies work well together in Wellington

A government organisation needs to take control of the budget for a co-ordinated homelessness strategy

Resources need to be available for ideas from NGOs

Government needs to listen to NGOs about what is needed and provide the funding to employ the people to do the work

Eg. WCC – co-ordination, DCM partner

**Funding** from WINZ, CCDHB, corrections

## **Appendix J20:**

### **Women's Refuge Interview** (National Collective of Women's Refuges)

#### Definitions

- Theirs= Women and children in need of emergency accommodation who have been exposed to domestic violence (physical, emotional, sexual, financial)
- Agree with our definitions- but would add the word "SAFE".
- Feels the "transient sleeper" definition works well with their concept of safe houses.
- Feels that the public health approach to prevention is similar to the approach to preventing domestic violence.
- Feels that they are a secondary prevention services- may be with a little tertiary.

#### Service provision

- 24 hour crisis line offering support and advocacy.
- Includes emergency access and pick up services.
- General advocacy- to courts, police, doctors, lawyers
  - Children's schooling.
  - Finding houses- can be difficult as women may have bad housing records (debts in women's name i.e. financial abuse) plus availability.
  - Moving families.
- Education services- understanding violence.
- Counselling services.
- Childcare and children's services.
- Community networking- training other agencies.
- Specialist services for Maori women- either separate safe house or worker.
- Pasifika programme- Porirua.
- Asian and immigrant refuge in Auckland.
- Drop in community centre.
- Approx only 25% work done in safe houses- the rest in general community work.
- Safe-houses in general have 4-5 bedrooms (they are ordinary houses) with one family/bedroom.
  - Living is communal.

#### Knowledge/ Access

- Leaflets in other community agencies
- Free advertising through the media (using national situations to highlight awareness)
- Annual appeal- street collection
- Advertising in community papers i.e. telephone numbers and support groups
- Taking public speaking opportunities e.g. schools
- 24 hour phone line is in the phone book (at the front and under Women's refuge)
- Referrals: self-referred, police, CYFS, primary health providers including GP's, nurses, midwives and Plunket, WINZ (few), CAB, Barnados, lawyers.
- Deal with agencies centres around preventing and helping violence and abuse.
- Are always taking new clients.

**Funding:**

- 33% from CYFS
- 33% from annual appeal
- 33% from philanthropic trusts
- Only 25% of staff are paid- 75% are voluntary labour
- Women pay board at safe-houses- worked out through WINZ
- Barriers: need more community offices/ drop ins, safe-houses and community advocates

**Perceived gaps that increase homelessness**

- Women cannot come into safe houses if abusing substances (drugs or alcohol).
- Women with mental-health issues may be refused entry- each refuge has own policy- protecting other women in the refuge.
- Youth (14-18) in abusive relationships are referred to CYFS- need to have specific housing for the needs of youth rather than reintroducing them back into the system.
- Lack of use of the Domestic Violence Act occupation order.
  - Women can make the abuser leave the shared accommodation,
  - Not implemented by judges
  - In place to prevent women from becoming homeless.
- Not enough affordable and safe housing around. Private landlords can be prejudiced making moving on from safe house difficult- women may return to previous relationship or be housed in the same area that the abuser lives.
- Housing is a barrier to getting help, especially in the older population-they don't want to become homeless and lose personal memories and belongings.

**Further enquiries**

- Community Law Centre
- Accommodation Officer at Victoria University

## **Appendix J21**

### **Child Youth and Family**

#### **(from phone):**

##### **Gaps identified:**

Lack of suitable placement for: MH teenagers, Sexual offending behaviour, gender separation houses, lock up residential placements, other houses for <16, more foster families.

Criteria: abuse/neglect or caregiver relationship breakdown.

#### **(from internet)**

- Child, Youth and Family is the government agency that has legal powers to intervene to protect and help children who are being abused or neglected or who have problem behaviour.
- Work with the Police and the Courts in dealing with young offenders under the youth justice system.
- Provide residential and care services for children in need of care and protection and for young offenders.
- Adoption information services units assess people who wish to adopt children and report to the Family Court on adoption applications.
- Facilitate the exchange of identifying information for parties to past adoptions. fund community organisations working with children, young people and their families to support the community's role in protecting and helping children.

## **Appendix J22**

### **SA Bridge Centre**

To provide a holistic approach which empowers people with alcohol, drug and other addiction problems to make positive choices for a healthy lifestyle.

#### Definition

1. People with no advocacy; people with no one to stand up for them

#### Role

1. Outpatient counselling (50% from rough sleepers/in transition)

Day program: mainly people that come in to talk to some one; some casual.

Group therapy/ 1 to 1 counselling services

Residential program: live in supported houses. 24 beds available; 1 mens house and 2 female.

## Appendix J23

### WCM

- Many choose to be homeless. others homeless due to life style factors
- Most people that access service are in rented accommodation, low SES and on benefits
- Services offered
- Mission: need help in coping with difficult personal or family circumstances, are not able to care for themselves, need emergency assistance, are not coping in mainstream education, are unemployed, are alone and seek social interaction with their peers, seek spiritual guidance

#### Mission for Youth

- Alternative Secondary School (4 expelled students)
- Youth Centre
- Counselling

#### Mission for Families

- Family Support Service
- Budget & Money Management Service
- Emergency Relief : advocacy WINZ

#### Mission for Work

- Motivational workshops
- Workskills training
- Supported employment

#### Mission for Seniors

- Service for Seniors in the Community
- Kemp Home & Hospital

#### Ezee Meals

- Referral from WINZ, CYFS, medical services, self
- Anyone can access; no criteria; "open to all people from all walks of life"
- All services free except meals
- 2.2 mil/year required 9% govt funded, other from donations, grants, street appeal
- Gaps: A+D rehab services,

## Appendix J24

### Te Aro Health Centre

- Def: anyone who has not got a place of their own + rough sleepers + moving place to place. Most homeless people seek help when they run out of money; this could be used in the def.
- GP service + nurse: outer community work
- Hard to keep people in housing due to addictions and other life style factors. Just supplying housing does not solve problem. Current housing program not working because of this. Most just get evicted due to behavioural issues.
- Word of mouth
- Most at risk young people: they don't access med care and most are missed/overlooked by services.
- CC health, soup kitchen, DCM, ICP, WCM, walk wise, housing NZ, RSA, WINZ
- PHO funding; contract with CC health for outer comm. Work, WINZ-minor, need more
- Charge \$5- some don't pay.
- Patient list growing by 10-20 per week
- More services needed for early intervention and for children and YA. Te Aro mainly sees people that access all the appropriate services. So not very aware of gaps. Word of mouth seems to be the main way that people get to know about services. This takes time. Wellington needs a central coordinating agency that people are aware of.
- Pathways: no work, mental health, addictions-which comes first?
- Wellington needs more supported and affordable accommodation. Both wet and dry houses and more rehab centres.
- Current services need better funding. Currently in Wellington it's up to the voluntary services to take care of the homeless.
- Homelessness is a process
- Hospital releases people (old people) without verified address like prison
- Arrange day work
- Gradually into work
- Provide essential skills

Life skill programmes