THE WORD FROM THE STREET:

The views of homeless men on a supportive pathway forward.

> 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” –
>
> Al-Nasrallah et al (2005).

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The 40 men who gave of their time and insights in participating in the project. Especially those who participated in the two focus groups following completion of the survey.

Also, to acknowledge the men's preparedness to act in assisting the project through piloting the survey, assisting with analysis of the focus group results and to those who have agreed to assist in presentations of the project to service organisations.

Executive Summary

Male Room Inc. is a Nelson based charity that has a 15-year history in advocating for and otherwise supporting males and their family/whanau.

This project aims to surface the views of homeless men as to their experiences of health, social and correctional services and their suggestions for more effective service provision. The project deliberately takes a 'bottom up' approach in recognition that service users have an important role in providing guidance for the development of services. Further, the participants are actively engaged in in critiquing, analysing and disseminating aspects of the project.

The literature reviewed on homeless men described a range of initiatives on assisting the men to 'move forward' but what was especially evident was the negative tone in relation to this group especially in relation to their health and social experiences. There was limited/no identification of positive factors that may be present in the lives of these men. Additionally, only one paper reviewed asked homeless men for feedback about their situation. It was evident that research from a strengths-based perspective was generally absent.

The project aimed to:

1. Develop an increased and actionable understanding of the lived reality of homeless men with emphasis on the barriers they experience in achieving positive outcomes in their lives as well as the opportunities they see for themselves.
2. Surface authentic, credible and valid information that health, social and correctional agencies can use to understand and best respond to the needs of this group.
3. Support the participants themselves having the opportunity to develop confidence in their voice, to envisage opportunities for themselves, and to contribute to service development.
4. Have participants collaborate in the project and have a degree of control over several aspects of the process.

The project design involved an initial survey followed by 2 focus groups. The survey results were the backgrounding for the discussion in the focus groups. Thirty-five men completed the survey form and 22 volunteered for the focus groups. Of the men who completed the survey, 40% identified as Pakeha and 60% as Māori or mixed Māori/Pacifika ethnicity (Nelson's Māori/Pacifika population is around 11% of the total population).

There were several areas focussed on in the literature that weren't reflected in the survey (esp. physical health issues). There were several unexpected results. For example, the participants found

most health, social and correctional services supportive. Another surprise was the 70% of participants' who were parents.

The focus group discussions were collapsed into two major themes. These being (not unexpectedly) the need for accommodation, shelter and services and the need for support. While there were a number of limitations in the project's design overall, the project was successful in surfacing the views of 35 homeless men through the survey and 16 men through the focus groups. These men proved to be insightful, affable and willing to share of their experiences and expectations.

Implications from the project pointed out the need for

- More effectively targeted and carefully considered accommodation.
- A more effective co-ordinated strategy across social, health and corrections services to best meet the needs of this group.
- The need for case workers who have a particular affinity/understanding in working with this group of men (especially from a strength-based perspective).
- Any planning to meet the needs of homeless men to include the voice of these men.
- Viewing homeless men as a 'priority group' rather than a 'hard to reach' group.

1. The background

Male Room Inc. is a Nelson based charity that has a 15-year history in advocating for and otherwise supporting males and their family/whanau. In its work Male Room Inc. has developed relationships (through MOUs and other agreements) with a range of health, social and correctional services. Each of these services recognises and communicates the complexities of working with the homeless, almost exclusively in regard to homeless men. Unfortunately, due to their erratic engagement with services and their often-transient lifestyle, these men are viewed as 'hard to reach' and, as such, are not obvious in statistics. Consequently, there is a resultant difficulty in planning and effecting appropriate service provision.

This project aims to surface the views of homeless men who find themselves on the margins of society as to their experiences of health, social and correctional services and their suggestions for more effective service provision. The project deliberately takes a 'bottom up' approach in Recognition that service users have an important, if not a vital part, in providing guidance for the development of services. Close & Peel observe this approach leads to higher quality services and, importantly, that this approach has 'intrinsic benefits for the individual service users who choose to become involved' (2012, pg.1).

More recently homelessness has come to the New Zealand public's attention through increased media attention and political action/reaction to a changing economic landscape.

The term 'homelessness' has become synonymous with the image of an older male, dishevelled, unkempt and poorly dressed. A person that the general public would rather avoid and certainly not be subject to sharing public space with. However, this image of homelessness is bedevilled with inaccuracy, stereotype and stigma. In New Zealand homelessness is defined considerably more broadly than this, affecting younger and older people as well as men and women relatively equally (Parliamentary Library Research Report, 2014). The perception that homelessness affects men more than women and children may well be due to the visibility of men on the streets and the increased support that is available to women and children. The term 'homelessness' is described as 'having no other options to acquire safe and secure housing' (Parliamentary Library Research Report, 2014, Para.2). This in itself is a very brief definition; a fuller description will be introduced later in the report.

It should be noted that Amore et al (2013) observe that although the image of the dishevelled male is entrenched in our society this does not reflect the majority of people living with what they suggest as 'severe housing need'. The authors state that they believe this term to be a more accurate reflection of the situation affecting so called 'homeless' people

While we certainly agree with the point in the previous paragraph, it has been decided for the purposes of clarity that this report will continue to use the term 'homeless'. We consider this important as this term and the assumptions underpinning it may well be the received perception of the group we will work with, that of 'homeless' men (How this group of men perceive themselves in an important aspect of the project).

While agencies that Male Room Inc. networks with express continued frustration at not being able to get alongside and otherwise support these men, homeless men themselves are thought to be largely cautious and distrustful of services. Despite this perception, Male Room Inc. has a history of successful engagement with this group. Rather than viewing these men as a 'hard to reach group' as many services do, Male Room Inc views them as a priority group and hopes to use the trust resulting from these relationships to work with a section of this group of men to obtain their views on both their experience of service provision and how services could best support them in the future.

Whatever way this group is described (marginalised, homeless or otherwise) they are a group that are considered to commonly experience complex health, relational, behavioural and economic difficulties. These complexities, along with an often-transient lifestyle, severely compromises the attempts of services in trying to positively engage with them. Conversely, this group are notable in their relative invisibility to services, isolation, silence and ultimately distrust of common societal institutions and services.

A constructionist approach has been taken to address the caution and distrust that invariably exist with marginalised groups in our society. Indeed, these men may well have internalised the negative social stereotypes held so as to, at least in part, hold them to be true of themselves. The research approach that is taken will provide a process where a degree of trust, both with the researchers and the other participants, can be achieved, thus assisting the individual participant to feel reasonably comfortable with voicing their experience and insights.

2. The Literature

The term 'homelessness' generally constructs a picture of a man (seldom a woman) resident on a small space, often within a busy street, surrounded by a mix of seemingly impermanent belongings, usually in disarray. This image is usually one of despair, hopelessness and decay. While they have many similarities, definitions of homelessness have many variations internationally. For example, the European Union has failed to agree on a common definition with some countries focussing on those people living rough, others on those living in various forms of transitional accommodation (Fazel, Geddes, & Kushel, 2014). For the purposes of this project the following New Zealand definition and descriptions will be used. Here four categories of 'homelessness' are identified, these being:

- Without shelter: Examples include living on the street and inhabiting improvised dwellings, such as shacks, cars or tents.
- Temporary accommodation: Overnight shelters or 24-hour accommodation in a non-private dwelling not intended for long-term living. These include hostels for the homeless, transitional supported accommodation for the homeless, and women's refuges. Also, in this category are people staying long-term in motor camps and boarding houses.
- Sharing accommodation: Temporary accommodation through sharing someone else's private dwelling.
- Uninhabitable housing: Dilapidated dwellings where people reside.

Parliamentary Library, 2014.

It is of note that a 2013 University of Otago study on 'homelessness', preferred to use the term 'severe housing deprivation' as they considered the term 'homelessness' was too 'burdened by stereotype'. However, it has been decided to continue to work with the term 'homeless' as this is commonly understood. In addition, the negativity associated with the term is an important aspect of this study's exploration.

2.1 The incidence of 'homelessness'.

Despite the difficulties in accurately estimating the number of homeless people in New Zealand some figures are available. Cooke (2016) states that approximately 1:100 New Zealanders were homeless at the time of the 2014 census. Also, that this number was increasing with around a tenth living 'on the streets' but with the majority living in temporary accommodation. Interestingly Cooke

went on to explain that half of the homeless were under the age of 25 years and the gender split was around 50:50. Research from the University of Otago added to these observations finding that the homeless were 'predominantly children and young adults, ethnic minorities, and either part of sole-parent families or not accompanied by family' However, males were more likely than females to be living without any accommodation.' (Parliamentary Library, 2014, para.10).

Māori are noticeable for their high incidence of homelessness. Figures from the Christchurch City Mission Night Shelter indicated the majority were male with the most common ethnic group being Pakeha (53%), Maori (38%) and Pacifica (5%) (Parliamentary library 2014).

While reports indicate that the number of homeless is increasing overall there was no increased prevalence in Tasman/Nelson for the period 2001-2006 (Parliamentary Library, 2014). However, figures may well have changed in the most recent Census. Also, the number of those 'living rough' in Tasman/Nelson is perhaps not as evident as it is in major centres of population.

2.2 Homelessness and health.

Being homeless is strongly related to a range of often serious health concerns (Hwang & Burns, 2014). These concerns include (but are certainly not limited to),

> …. poor dental and foot health, sexually transmitted diseases, liver disease, pneumonia, skin diseases along with malnutrition and under-nutrition. The focus on daily survival can also preclude seeking medical attention until problems are severe. Maintaining personal hygiene is challenging with difficulties around showering, washing clothes and storing personal belongings. Moreover, homeless people living on the street can be especially vulnerable to assault and injury.
>
> (Parliamentary Library', 2014, Para. 14).

Various authors talk of tobacco use as being particularly prevalent within the homeless population. Fazel et al (2014), cite research from several countries explaining that the homeless use tobacco at around 2·5 times that of the low-income population. This picture of ill health is exacerbated by the neglect of a range of chronic conditions. For example, diabetes and heart disease (Cooke, 2016). Neglect here meaning the continued avoidance of or the continued poor control of the condition.

While physical ill health is obviously a concern in the homeless, the picture is further complicated with the understanding that mental ill health has a considerably higher incidence in this group (Thornley & Marshall, 2016). As the Parliamentary Library (2014, para. 15) explains 'Homeless people are 'excessively burdened' with mental health problems. Mood disorders, primarily major depression,

are among the most common psychiatric disorders affecting the homeless'. Mental ill health in this context should be understood to include misuse/abuse/dependence on alcohol and other drugs where, similarly, there is a greater incidence than in the general population (Fazel, Geddes, & Kushel, 2014; Thornley & Marshall, 2016).

Further complicating this area is the presence of co-existing or co-morbid conditions where two or more conditions can exist simultaneously. For example, the presence of both mental illness and alcohol and other drug problems (Fazel, Geddes, & Kushel, 2014). These authors cite a Canadian study which found that 58% of homeless people experience co-existing conditions. Age related conditions also complicate the picture with the homeless. Fazel, Geddes, & Kushel (2014, para.18) explain that the homeless over 50 years of age have 'higher rates of age-related conditions (functional impairments, cognitive impairments, falls, and urinary incontinence) than a general population comparison that is 20 years older'.

Drawing on a range of reports Fazel, Geddes, & Kushel (2014) assess the rate of premature mortality in the homeless as being 2-5 times that of the general population. This being due to a range of factors such as suicide, infections, substance misuse and high exposure to co-existing risk factors - smoking, drug abuse/misuse and mental ill health with Māori being overrepresented in this figure (Thornley & Marshall, 2016). In both New Zealand and overseas studies alcohol abuse is suggested as being a major cause of premature mortality (Thornley & Marshall, 2016). No doubt the delays in accessing or following up on treatment are strongly linked here as well.

2.3 Homelessness and social wellbeing.

Notwithstanding the impact of health issues affecting the homeless, there are a range of what could loosely described as 'social experiences' that impact on this group.

One early and pivotal factor is reported to be the experience of childhood deprivation in the form of dysfunctional families with continued insecurity about such areas as housing, relationships and the spectre of abuse (Al-Nasrallah et al, 2005). Abuse here includes physical, emotional and sexual abuse. In a Canadian study, it was reported that 'three-quarters of homeless people reported one form of abuse, with more than half reporting a history of sexual abuse' (Fazel, Geddes, & Kushel, 2014, Para 39), and of that group 'between 27% and 52% of homeless individuals were physically or sexually assaulted in the previous year' (Fazel, Geddes, & Kushel, 2014, para.24). This, particularly with traumatic childhood experiences is confounded by poor educational experiences leaving the individual both economically and socially disadvantaged (Griffin & Kelleher, 2012; Parliamentary Library, 2014).

While there have been relatively few studies that have attempted to surface the homeless person's experience of care and/or support, what data is available suggests these experiences are largely negative with staff being unsympathetic, sometimes stigmatising and inflexible (Hwang & Burns, 2014). More broadly, the homeless are reported as experiencing 'a deep sense of disrespect because of who they are and where they live (Griffin & Kelleher, 2012, p43). This sense of unease extended to night shelters where security and rigid 'lock down' times were seen as unsupportive (Al-Nasrallah et al, 2005).

The experience of stigma appears to be of profound importance in attempting to understand the lived reality of the homeless. Typically, their presence in society is seen as disruptive and potentially dangerous (Hodgetts et al, 2008). As Lawson & Elwood (2012) suggest 'middle class-ness [can be viewed as] the antithesis of poverty'.

Finally, the risk of being a victim of violence is said to be particularly high either from other homeless people or from others (Cooke, 2016).

In a New Zealand study, it was reported that a number of services were doing an effective job in their respective areas however the benefits were tempered with what was seen as a lack of co-ordination across services (Al-Nasrallah et al, 2005). This lack of co-ordination was noticeable especially in relation to services aimed at Māori and at youth.

2.4 Homelessness and service provision

The literature accessed mainly talked of targeting a presenting issue, usually a health concern, as being the focus of intervention with the homeless person. The initiatives described targeted substance misuse treatment, smoking cessation, assessment/treatment for diabetes/hypertension (Fazel, Geddes, Kushel, 2014). In addition, screening for cognitive impairment, mobility impairments, urinary incontinence, and falls in homeless adults aged 50 years and older were advised as were the challenges of assessing for and managing comorbidities (Ibid, 2014).

The interchange between health service and homeless people also drew critique firstly with the few services that specifically target the homeless and the need for service staff to be well supported in overcoming the challenges when engaging with this group (Hwang & Burns, 2014). Effectively staff need awareness raising for managing the stigma attached to this group as well as recognising the self-stigma homeless people may hold personally (Leggatt-Cook, 2007).

> *Health-care providers who work with individuals who are homeless should keep in mind the crucial importance of establishment and maintenance of a positive interpersonal relationship between themselves and the person who is homeless. The key ingredients for such a relationship include respect for the individual, upholding the person's dignity, building mutual trust, and showing warmth and caring*
>
> Hwang & Burns, 2014, p1545.

Several literature sources explored longer term, more broad and ultimately more creative solutions in supporting the homeless. These initiatives attempted to manage the complexities involved in a person with co-morbidities while also recognising the complex mix of health and social determinants of the individual's life. This mix of determinants tended to propose that the social and health issues were so intertwined that it was fruitless (especially in relation to homelessness, mental ill health and addiction issues) to engage one without the others (Thornley & Marshall, 2016). Hwang & Burns (2014) reinforced this point, observing the paradox that "the likelihood of receiving care decreased with the complexity and severity of the homeless individual's needs, because each additional need served as an exclusion criterion" (p1546).

The need for primary health-care programmes specifically targeted for the homeless was suggested (Hwang & Burns, 2014). Additionally, Fazel et al (2014) and Al-Nasrallah et al (2005), identified the need for preventative measures in providing transitional programmes for individuals at identified high risk times in their lives, for example leaving the criminal justice system or psychiatric facilities, as being effective in reducing homelessness.

It was suggested that, especially with the homeless person with mental illness, strategies for assistance should recognise that limitations and opportunities that are present locally. This in recognition that each geographical area has its unique configuration, similar to but different from other areas (Hwang & Burns, 2014).

Surprisingly, almost in contradiction to what was said previously, Hwang & Burns (2014) concluded that, "the provision of accommodation in independent units with support is so effective for homeless individuals with serious mental illnesses that it should precede efforts to engage these individuals in specific treatments" (p1542).

Finally, but perhaps more importantly, Al-Nasrallah et al (2005) and Griffin & Kelleher (2012) emphasise that one major failing of current systems is the lack of engagement with and acceptance

of the voice of the homeless. That the input of this group into service planning is very limited if it exists at all.

2.5 Conclusion

Several themes arose from the literature review.

1. There were a range of perspectives on what may be the best path forward in relation to the health of the homeless with most focussing on effective care and treatment for individual issues, such as mental ill health, through to a more 'wrap around' service which attempted to address the factors contributing to health issues with the homeless.
2. Each geographical area has its own unique configuration of both strengths and weaknesses in relation to the provision of services. While there are commonalities between services it is important that these differences are identified and considered a vital aspect of local planning.
3. In almost all the literature accessed the perspective taken was one of negativity in relation to the homeless. Homelessness was viewed as a major risk in the affected individuals lives and, in all but one paper, efforts to manage this risk were either reviewed, critiqued or suggested. There was no identification of positive factors that may be present in the lives of the homeless person.
4. Only one paper focussed their work on asking a cohort of the homeless about their situation as well as their suggestions for improvement in services. As the authors stated,

> *To intervene effectively in their lives, it is essential both to understand the obstacles they face and to seek pathways towards social inclusion. Understanding the lives of the men will only be achieved by listening to them and by being aware of what is going on in their families and communities. The best people to impart their story are the men themselves; they are the experts in their own lives*
>
> Griffin & Kelleher, 2012, para No.

In addition to this, Griffin & Kelleher (2012) believed that progress in this area could only be achieved by agencies collaborating and working together creating partnerships across various sectors.

For the purposes of this study the literature review revealed that minimal research had been carried out that looked (from a strengths-based perspective) at homeless people's insights, knowledge and experiences in contributing to an improved understanding and appreciation of service provision as well as the challenges and opportunities that they see for the future. Given the observation in the

previous chapter that a ‘bottom up’ approach can lead to higher quality services and, importantly, that this approach has benefits for the individual service users who become involved, not consulting with the target group would appear to be a major gap in evidence for future planning for service provision.

3. Research design.

3.1 The research aims

The aims of the project are:

1. An increased and actionable understanding of the lived reality of homeless men with emphasis on the barriers they experience in achieving positive outcomes in their lives as well as the opportunities they see for themselves.
2. Authentic, credible and valid information that health, social and correctional agencies can use to understand and best respond to the needs of this group.
3. The participants themselves having the opportunity to develop confidence in their voice, to envisage opportunities for themselves, and to contribute to service development.

Being local and with a small purposive sample, caution should be exercised in attempting to generalise the findings of the project more broadly. However, the project is designed to provide a process which other regions can utilise for their benefit. This is in the understanding that each geographical area has unique characteristics that will differ from other areas. One major advantage of this research is that it is relatively small, localised and works from the 'ground up', surfacing understandings and possible solutions from the homeless men themselves.

In addition to the trust that Male Room Inc enjoys with this group, the proposed process itself believes the participants' voice is central. Essentially it is emphasised that it is the participants helping us rather than us wanting to help them, that this project is about participants assisting in the development of services. Collaboration and a high degree of participant direction and control is emphasised.

3.2 Methodologies/methods

The research process itself draws on constructionist and research perspectives involving group process. The design involves an initial survey (piloted with 6 homeless men) followed by 2 focus groups. The survey will provide useful information in relation to the aims of the project as well as demographic data about the respondents. However, it is our experience that surveys, by their very nature, often provide quite superficial responses especially in relation to complex issues of social concern, as is the case with this project.

In recognition of this and of the hegemonic processes involved in marginalised groups internalising common societal stereotypes, two focus groups are proposed. Importantly, the two focus groups are of the same participants.

The survey results will be developed into an initial report. This report will also be the base of an information sheet as backgrounding for the discussion in the focus groups. Focus groups are generally seen as a research method, a process of collecting data. In this project focus groups are viewed also as a research methodology, emphasising how data is constructed by the participants themselves. Simply put, the researchers have very little input into the groups apart from introducing the question (there is generally only one or two questions), recording the discussion, keeping the group on track and monitoring any signs of participants being distressed.

Having only a limited number of questions allows the participants to develop the discussion around their own life experiences and understandings. Keeping the group on track is rarely necessary as they tend to monitor this themselves. We will observe processes for supporting any distressed participant however, although a degree of discomfort is common in these groups, participants have always wanted to continue viewing this as a constructive and expected part of the process.

Overall, the less said by the researchers, the better. This is not particularly easy as, especially during the initial part of the group, the participants look to the researchers for advice and guidance before they move on to find their own voice and solutions.

Apart from digital recording of the discussion, the discussion is also summarised on newsprint in view of the participants. Following the completion of the discussion the participants are asked to rank these written points in order of importance to them. They are asked to do this silently, taking no notice of the opinions of others. This is to, at least in part, negate the influence of the more vocal participants in the discussion, which is always a compounding factor in group approaches. Here the participants undertake the first stage of data analysis and hence can claim a strong degree of ownership of the final results.

The recorded discussion is transcribed, compared and contrasted with the participants' summary. An inductive process is then used to identify emergent themes from the data.

In the second group the themes are reviewed with the participants and then they are asked to consider the same question as in the first group. This process, essentially of facilitated reflection, gives the participants the opportunity to deconstruct their initial understandings of their life circumstances in the second group.

3.3 Ethical considerations

Accepted processes for protecting participants and ensuring methodological rigor were followed. These included:

- Anonymity was ensured through numerical coding of survey responses.
- Informed consent obtained from all participants for participation in the focus groups.
- Participants making a commitment to respect the privacy of others in the focus groups. (Anonymity is always compromised in focus groups.)
- Protocols were put in place to rest the group if any focus group participant(s) experienced distress with a list of support services was available if required. While participants detailing their experiences can be seen as a risk of retraumatising the individual and perhaps others, Close & Peel (2012), describe how individuals may find this process a healing, positive experience.

3.4 Recruitment of participants.

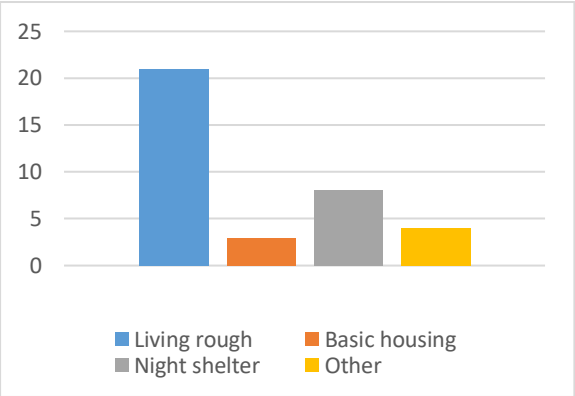
Homeless men were approached on the street and at a local transitional accommodation centre and asked if they would be prepared to complete the survey. Each was offered a $30 supermarket voucher for the time taken to complete the exercise. While this sum will most likely be seen as an inducement to participate, it was considered a reasonable recompense for the time spent in discussing and completing the survey as well as recognising their 'expertise' on the topic. Unexpectedly it became apparent that the participants had a strong local network whereby they were in touch with other homeless men, largely by mobile phone. Taking advantage of this network, the researchers enacted a snowballing technique where the men themselves introduced other homeless men to the project. This technique assists in gaining access to participants who are experiencing the same conditions being studied (Dudovski, nd.).

The survey form itself had a final detachable section asking if the participant would be prepared to participate in two focus groups following an analysis of the survey. Twenty-two men volunteered to take part in the focus groups.

4. The survey results

4.1 Your current circumstances

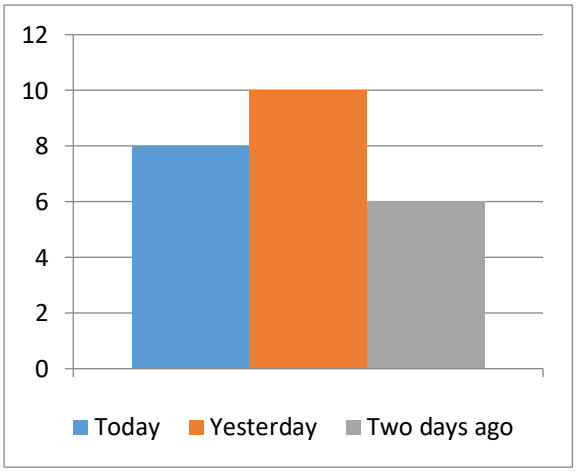
4.1.1 Where do you live?



The graph here indicates that majority of men were living rough. This high number may well be a reflection of the survey being completed in a warm Nelson summer. Many participants commented that Nelson was a good place to be homeless at this time of year.

Temporary accommodation. Before that I was in my van.

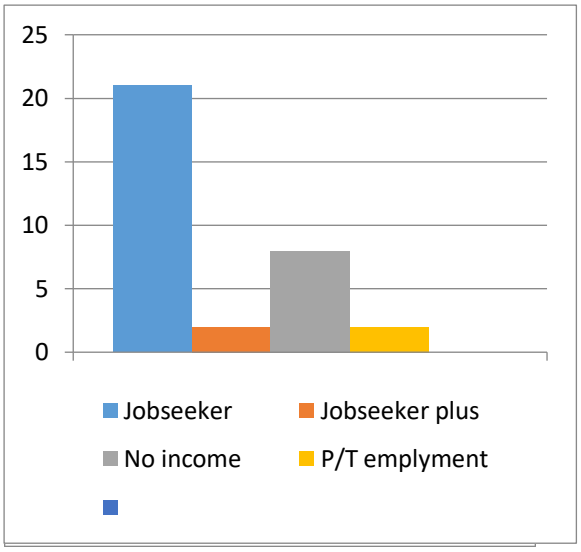
4.1.2 When did you last eat?



The graph clearly shows that inadequate nutrition is a major feature of the daily lives of these men. This was also evident in conversation around the survey.

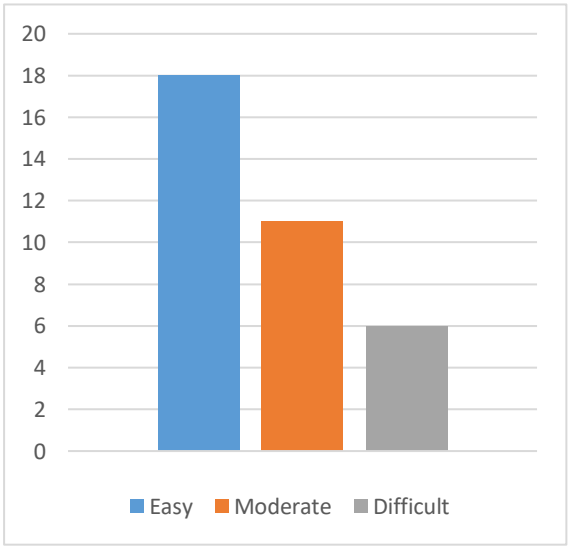
Last night. The bakery threw left overs out in the bin at the back of the shop.

4.1.3 What is your source of income?



While the majority of participants are on a benefit what was surprising was the eight men who reported that they received no income at all. This particular finding was not further explained.

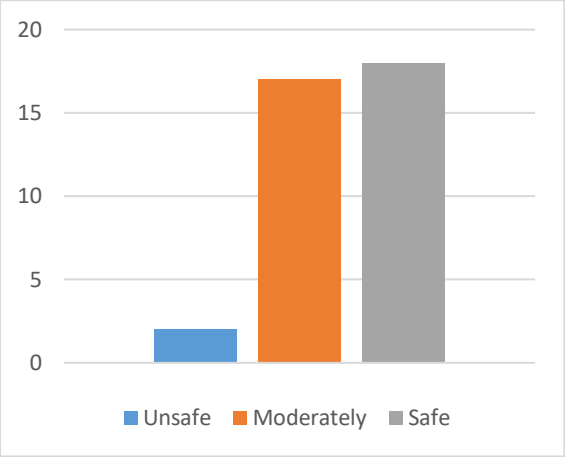
4.1.4 How do you find making and sustaining relationships with other people?



Interestingly a large number felt this was a positive feature of being homeless. In contrast others felt there was significant difficulty because of their appearance, their behavior and, if known, criminal history.

I get on well with people like myself. We tend to look out for each other in hard times.

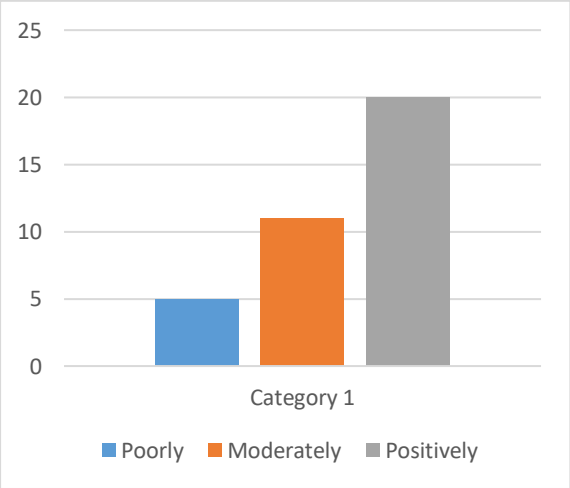
Question 4.1.5 Do you feel safe in your day to day life?



Apart from one or two participants who had been assaulted recently, nearly all participants felt safe in their surroundings. Again, Nelson was mentioned as a 'good place to be homeless', in contrast to other centres.

Yes, I feel safe, because there's a few of us living rough and we are like family.

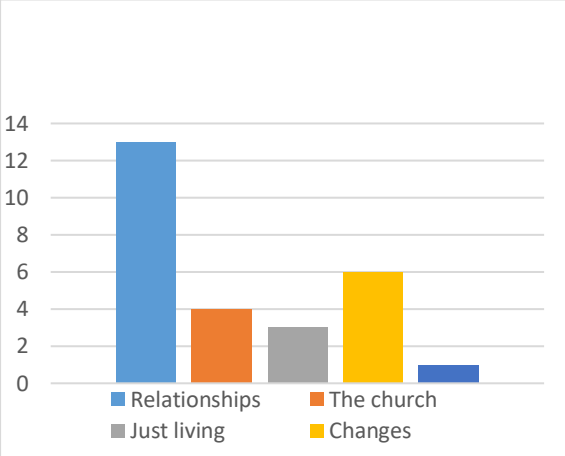
Question 4.1.6 How do you see your future?



Given the participants circumstances, this was another surprising result. The majority of participants felt reasonably or quite confident about their future.

Because I haven't done anything wrong, 'I'm confident of a positive outcome.

Question 4.1.7 What is the best thing about your life at the moment?

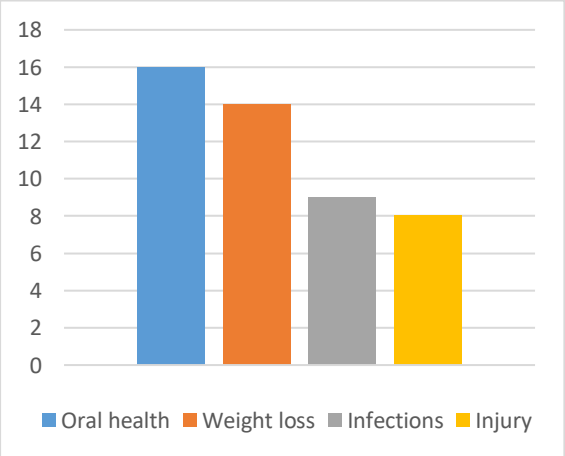


The participants were clear with their responses here, indicating a number of positive influences on their lives. The yellow bar 'çhanges' indicated positive changes the men had made in their lives. Only two participants indicated a negativity about their current situation.

The prospect of finding someone and be loved and loving. So just a dream is the best thing at the moment.

4.2 Your health status.

4.2.1 Your physical health status over the past year?



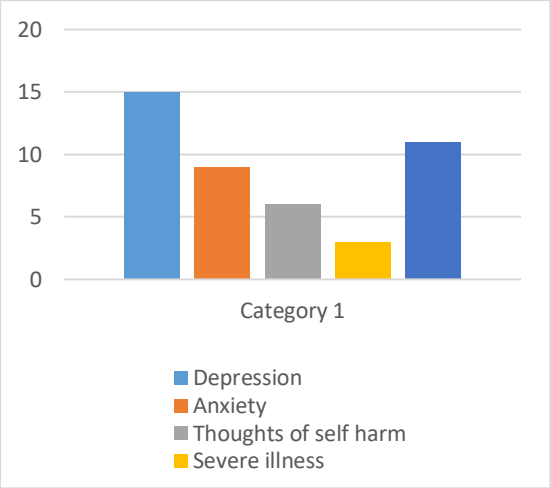
A number of conditions were listed here, drawn from the literature on common conditions with the homeless. These weren't supported by the participants.

The four areas shown in the graph featured strongly in the results with poor oral health and weight loss being commonly experienced.

I had to get my teeth removed so I could eat.

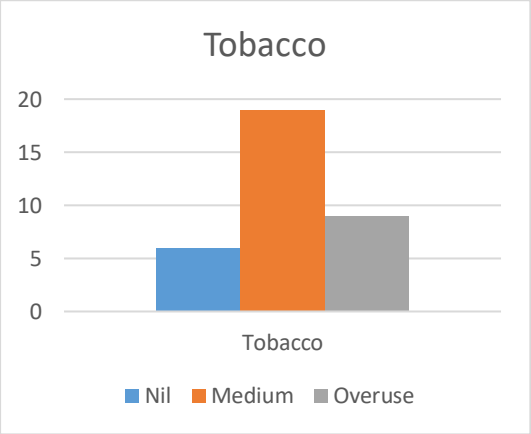
Toothache and hoping to get a top plate to fill in the gaps.

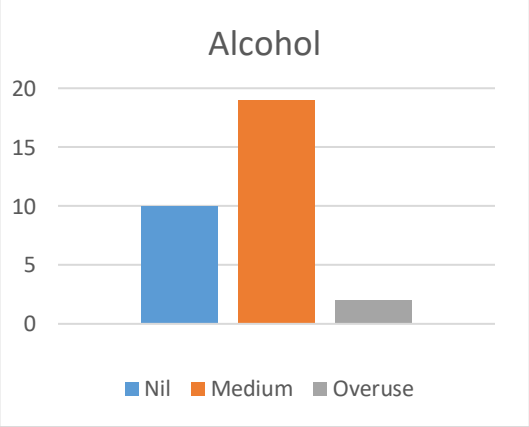
4.2.2 Your mental health status over the past year?

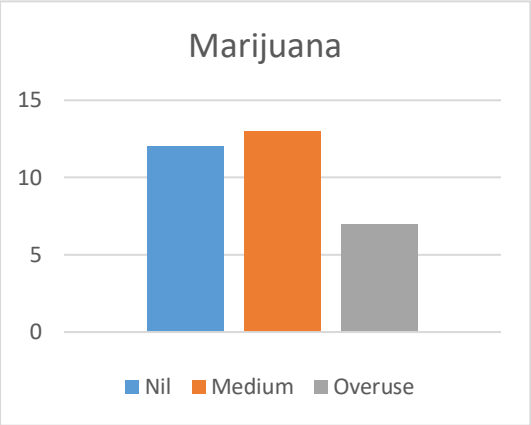


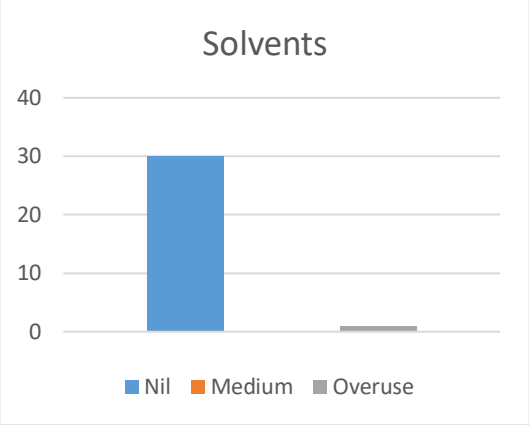
At least half of the participants voiced issues with mental health usually with a combination of mental health issues. This finding seems to be in contrast to the finding of a hopefulness for the future. Having said this, a third of the participants reported no issues with mental health at all.

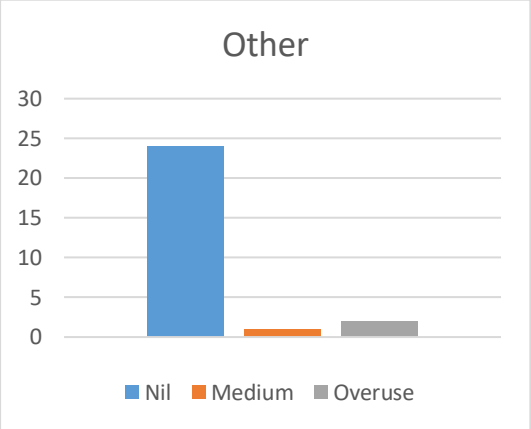
4.2.3 Your use/abuse of alcohol and other drugs?







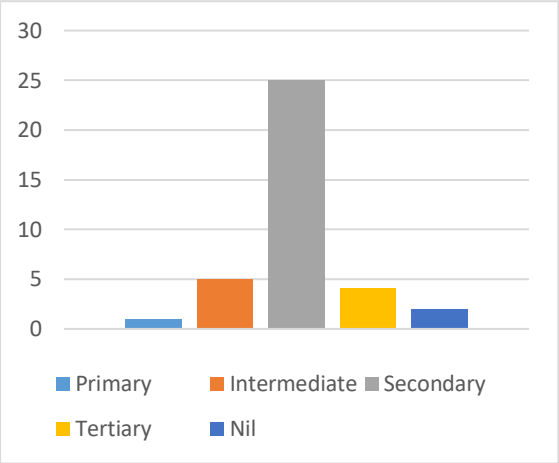




The responses here were interesting. Overall it could be said that the participants described their substance use in a manner that could be attributed to many other groups in society. Having said that, the participants answered these questions with understanding of their peer group's norms. However, this point could well be applied to other groups as well.

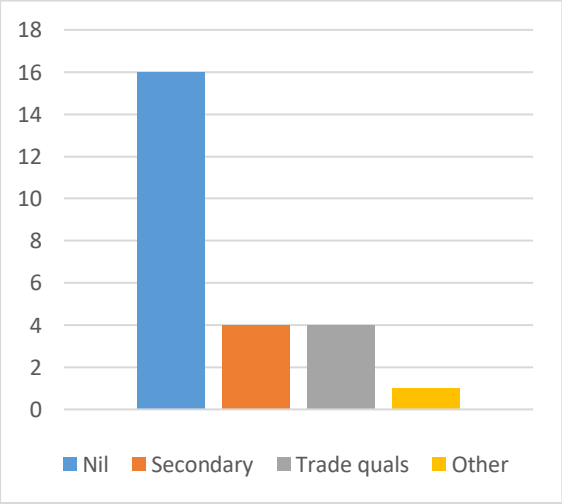
4.3 Your personal history

4.3.1 Your final level of schooling



The results on this page are quite conclusive with most participants having attended secondary school but leaving with no qualifications.

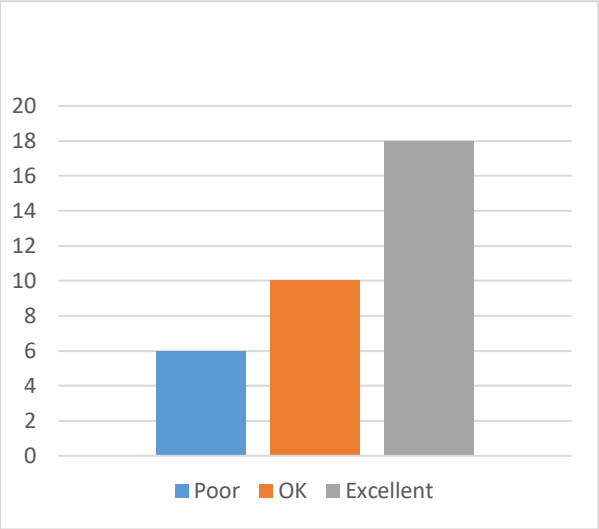
4.3.2 What qualifications did you gain?



No qualifications. [I was] a State Ward at 14.

No formal qualifications. Plasterer, concrete worker, dairy farmer, support worker, cleaner and cook

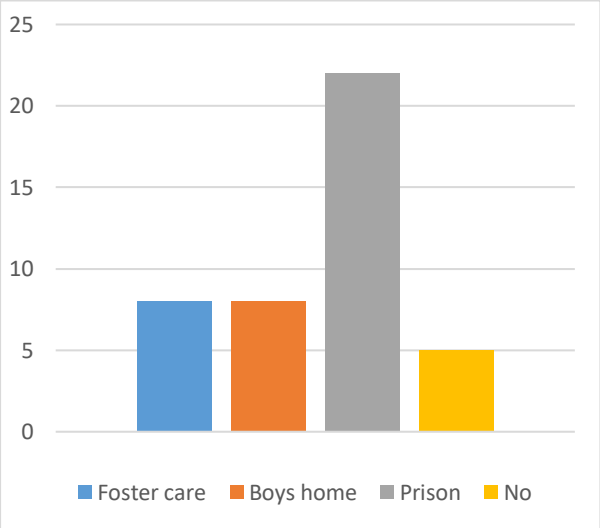
4.3.3 How would you describe your early family life?



Somewhat surprisingly, despite a variety of experiences (see the graph below on abuse experiences in childhood) most of the participants described their early family life as 'OK to excellent'. Only six men described this time as 'poor'.

My family meant a lot to me. We made what we could with what we had yet [we were] happy.

4.3.4 Have you been in an institution?

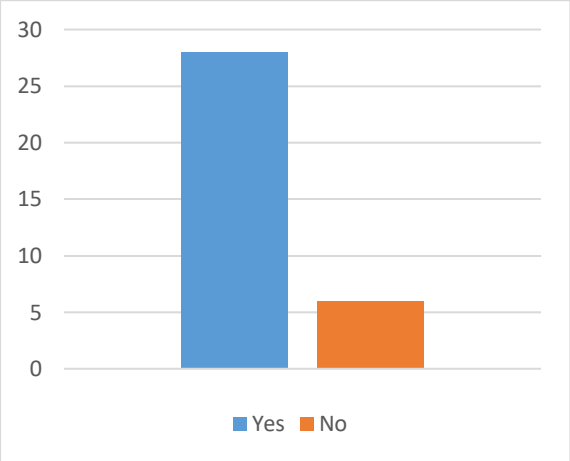


While not all participants answered this question, it is clear that only a small number had not been institutionalised at some stage of their lives. The graph should be interpreted with caution as most particpants who answered this question indicated more than one area.

4.3.5 Were you the victim of abuse as a child?

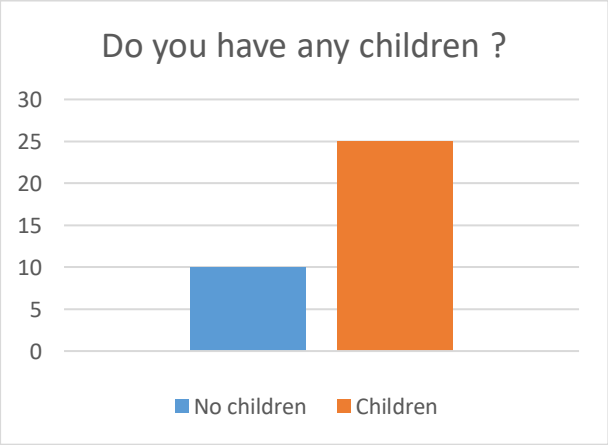
The question here asked for an indication of whether the abuse was physical, emotional, sexual or witnessing family violence. Of the twenty one participants who answered the question the majority indicated that the abuse was on multiple levels.

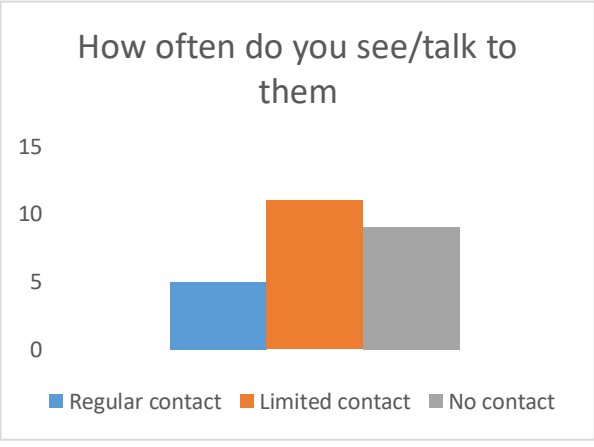
4.3.6 Do you have any convictions?



The graph clearly indicates that what could be viewed as antisocial behavior is a major factor in their history. Of those who indicated the nature of the 'crimes', driving convictions (mostly DIC - 8) predominated there were a small number of participants who indicated they had been convicted following violence against people (4) and against property (5)

4.3.7 Do you have any children?

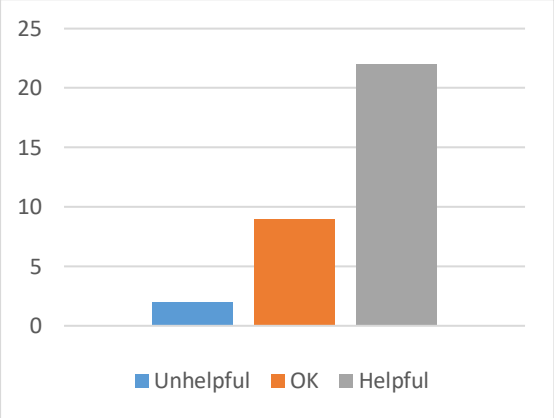




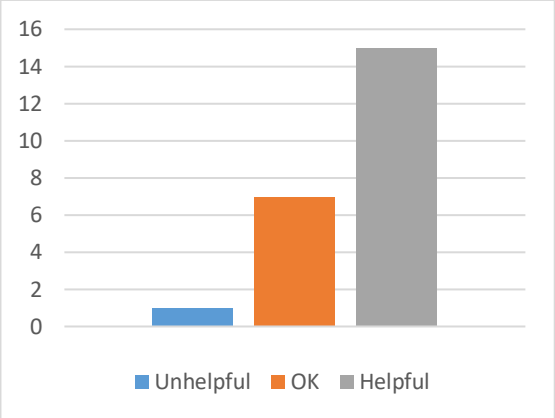
The 5 participants had regular contact with 19 children. The limited contact over the past year (and much of the contact was very limited indeed) involved 11 fathers and 26 children. Nine participants reported no contact with 21 children.

4.4 Your experience of services: Health services

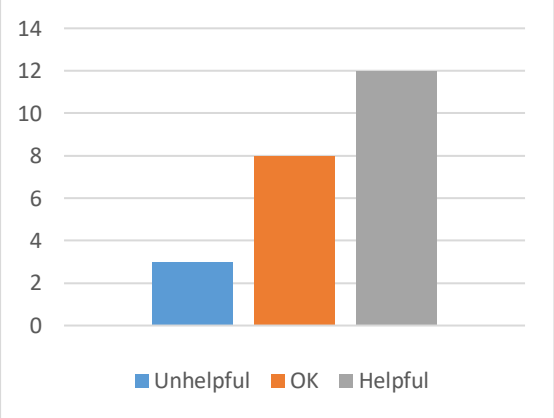
4.4.1 Emergency Departments



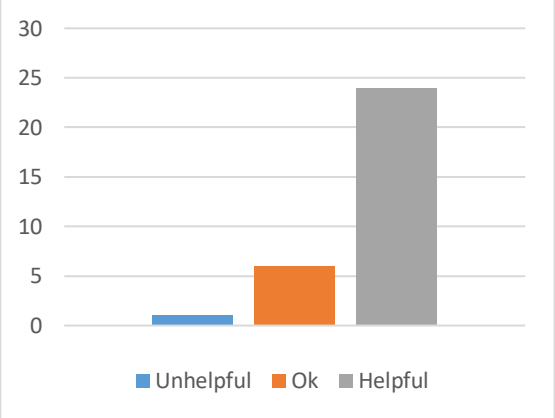
4.4.2 Hospital Social Workers



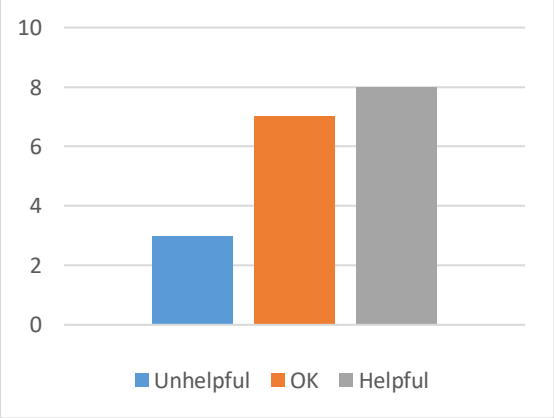
4.4.3 Alcohol and other Drug areas



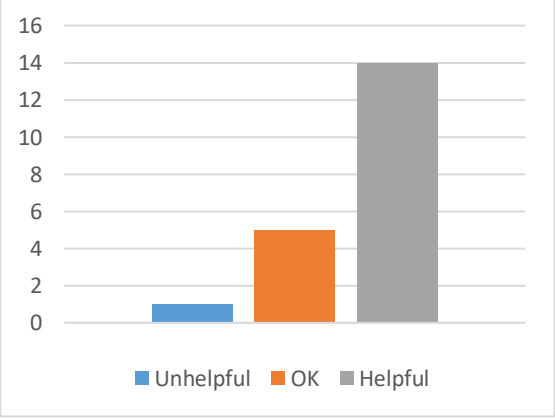
4.4.4 General Practitioners



4.4.5 Mental health services

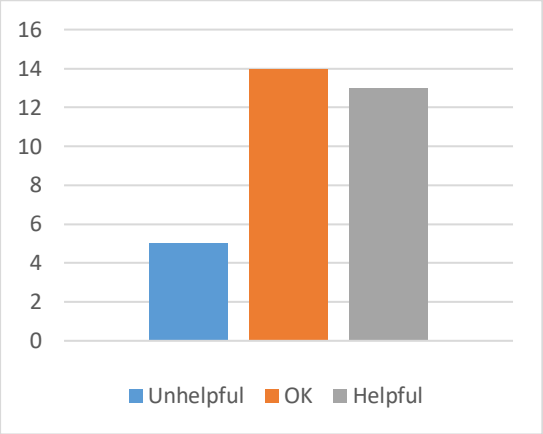


4.4.6 Counsellors

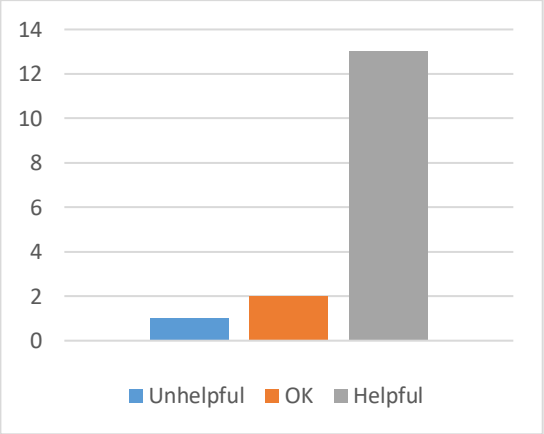


4.5 Your experience of services: Social Services

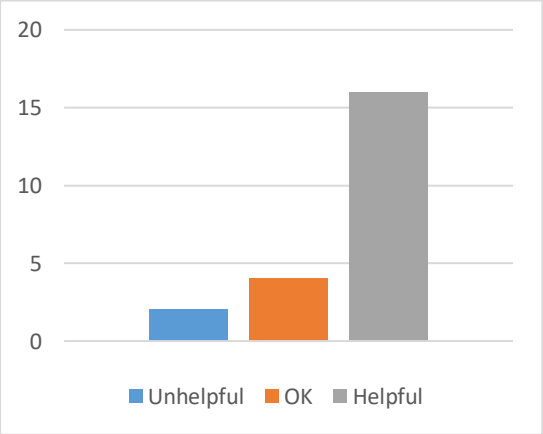
4.5.1 WINZ



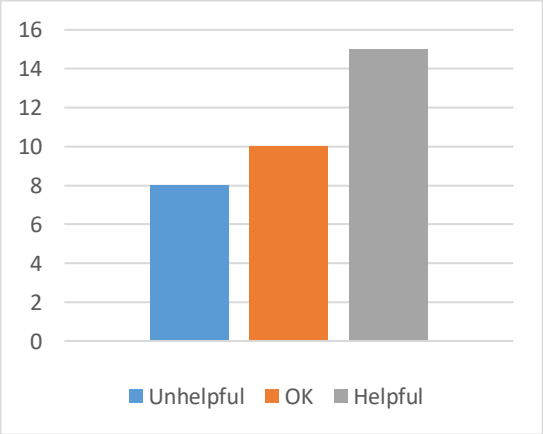
4.5.2 Marae/Māori based services



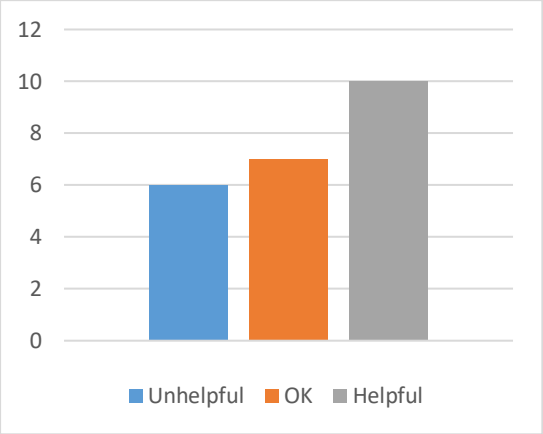
4.5.3 Night Shelter



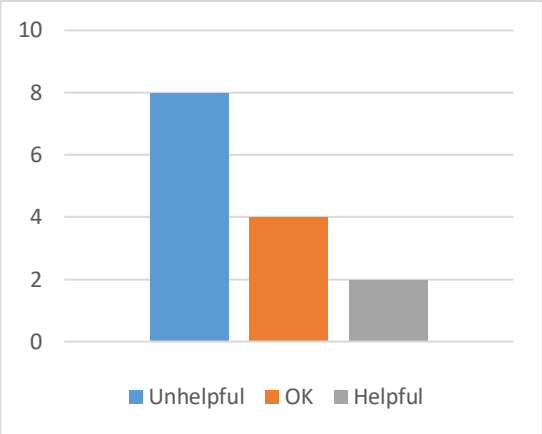
4.5.4 The police



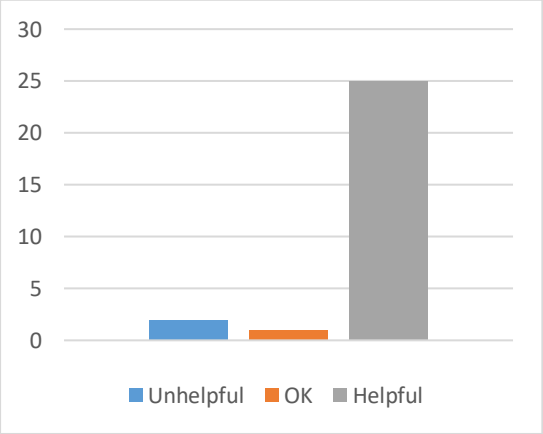
4.5.5 Corrections



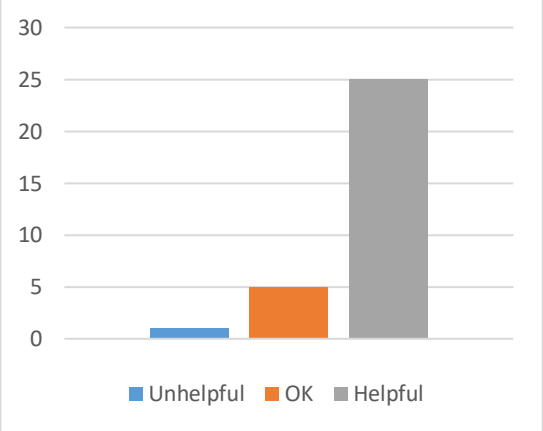
4.5.6 Housing New Zealand



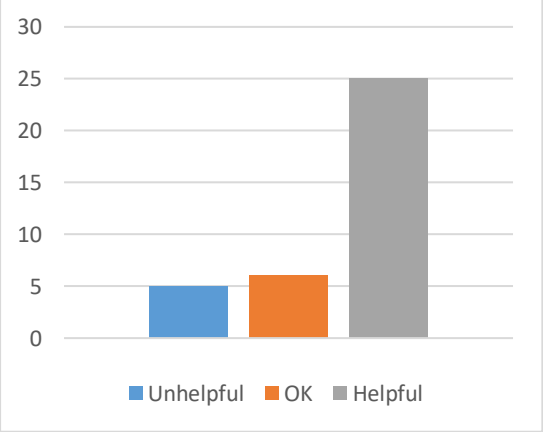
4.5.7 The Salvation Army



4.5.8 Loaves and Fishes



4.5.9 *Lawyers/Legal Aid



Overall, services were viewed as Ok or helpful. As expected those services dealing with financial and housing assistance as well as enforcing the law were seen as less helpful. Those services offering charitable support (Salvation Army, Loaves and Fishes) were seen as very helpful as were lawyers.

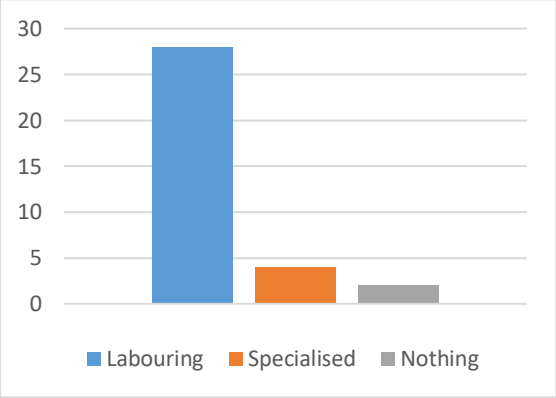
The participants were clear that the perception of helpfulness was based in their experiences with individuals. Those staff who demonstrated empathy, openness and anti-discriminatory practises were very helpful. Unfortunately, these people were rare.

4.5 Your future

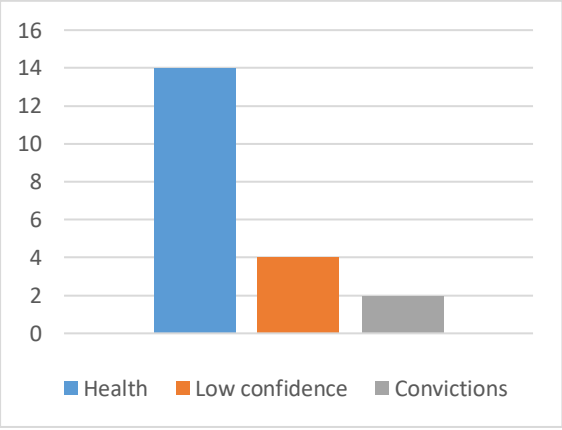
4.6.1 What sort of accommodation would you like?

All respondants ideally wished for a wam, small affordable home.

4.6.2 What sort of employment would you like?

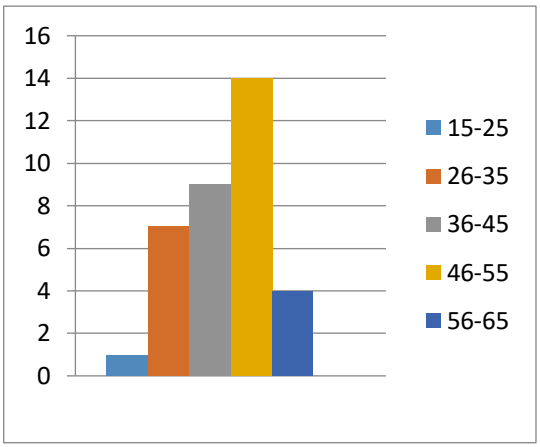


4.6.3 What is the biggest barrier for you in achieving the above?

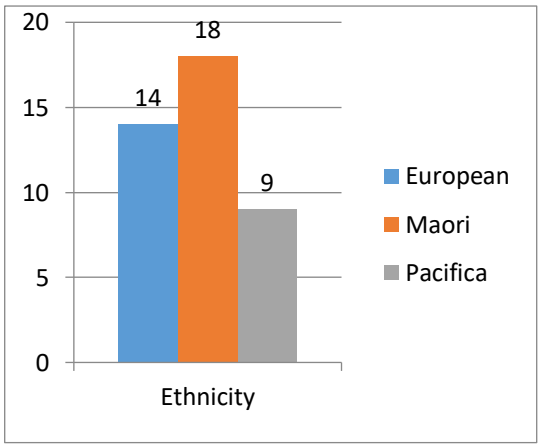


4.7 Demographics.

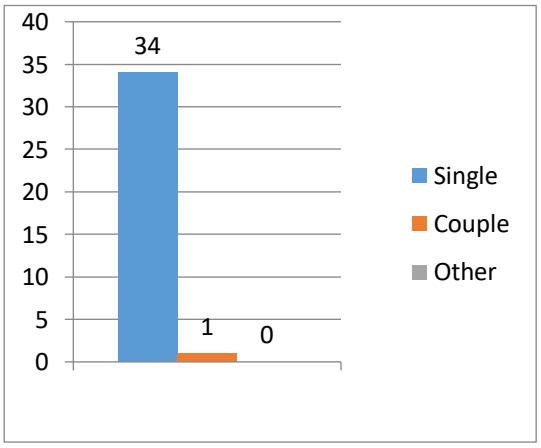
4.7.1 What is your age group?



4.7.2 What is your ethnicity?



4.7.3 What is your family status?



Research from the University of Otago added to these observations finding that the homeless were 'predominantly children and young adults, ethnic minorities, and either part of sole-parent families or not accompanied by family' However, males were more likely than females to be living without any accommodation.' (Parliamentary Library, 2014, para.10).

Māori are noticeable for their high incidence of homelessness. Figures from the Christchurch City Mission Night Shelter indicated the majority were male with the most common ethnic group being Pakeha (53%), Maori (38%) and Pacifica (5%) (Parliamentary Library, 2014).

5 The survey - conclusion

The process of moving on to collecting data from the participants, it is rather seductive to be influenced by what was surfaced through the literature review and generally held attitudes, values and beliefs about homeless men in our society. The image of an 'older male, dishevelled, unkempt and poorly dressed. A person that the general public would rather avoid and certainly not be subject to sharing public space with', was not challenged through data gathered from the survey. What was surfaced was that the participants were articulate, reasoned, insightful and hopeful about their future. In addition, they were well connected to each other and looked out for each other.

Interestingly, of the men who completed the survey, 40% identified as Pakeha and 60% as Māori or mixed Māori/Pacifika ethnicity.

The literature was clear about the complex mix of problems with physical and mental ill health. The participants did not reflect this view in their response to specific questions about physical health. The two areas that were of greatest concern were those of poor oral health and weight loss. With mental health, depression and anxiety were reported as being common, but serious mental ill health not. Issues with alcohol and other drugs were minimal and could be argued, given the responses, as reflecting what would be identified if a range of other make groups in society were surveyed.

There were a number of areas surfaced that were not anticipated nor discussed in the literature. That many participants had a history of involvement with the Police and with prison may not seem such a surprise. What was surprising was the participants' role as a father and the number of children involved as well as the nature of the relationship the men 'enjoyed (or not) with their children.

Over seventy percent of the participants were parents, parents who have fathered 66 children. Of these fathers, over 70% had limited (often very limited) or no contact with their children.

The research process involved working with homeless men to surface their views of the usefulness (or otherwise) of health, social and correctional services. This was certainly achieved but so much more was uncovered as well. However, research process dictates, quite rightly, that the process must be true to the data uncovered, data uncovered in a methodological and ethical manner. In this project, so much more data has been gifted by the participants and it would seem poor to not acknowledge these areas as we move through the report.

6 The focus groups

The Focus groups aimed to:

- Provide qualitative information that was authentic, credible and represented the considered perspectives of the participants.
- Provide an environment where participants could feel included, valued and respected both by the researchers and by others in the group.

The two focus groups were intended to involve the same participants in the expectation that, in the second group, they would enter into a more detailed and in-depth discussion after having reflected on the outcomes of the first group. However, a number of the original group did not appear for the second group and new participants appeared. It was decided that, as a core of 8 participants returned, that the essence of the reflective process would most likely be retained. Each group had 12 participants in total.

The two focus group sessions, each of 90 minutes duration, were purposely scheduled approximately 6 weeks apart. This time frame was so participants would have the opportunity to reflect on their experiences overall in preparation for the following group session. The researchers' role was to facilitate group introductions, clarify the question(s) and refocus the group discussion on the question(s) if discussion appeared to be moving off topic. Otherwise the facilitators did not take any active part in the discussion.

The question asked was, 'what needs to happen to improve your current situation?'

This process was undertaken in the belief that group discussion, combined with reflection over time, can produce insights that would not be uncovered through other research processes, especially 'one off' or 'snapshot' approaches to data collection such as in surveys or interviews. Essentially this process was informed by constructionist theory as well as the synergistic effect of focus groups. Again, these two perspectives, taken together, were expected to provide data of a quality and perspective not achievable otherwise.

The process, outline in section 3.2, resulted in the participants (individually) identifying those points summarised during the discussion they felt to be most important. Following the groups, the participants preferences were totalled, and these were collected as sub- themes These were further collapsed, resulting in the emergence of two major themes.

7 The focus group results

The two major themes, of relatively equal weighting that emerged, were those of:

a. The need for accommodation, shelter and services.
b. The need for support.

7.1 The need for accommodation

It is hardly surprising that, in a project about homeless men, the need for accommodation should be a priority from the perspective of the participants. However, what has surfaced from the survey and focus group is the nature of this need and the environment in which it exists.

Despite Nelson being seen by the participants as 'a good place to be homeless' especially during the summer, for most their living situation was frequently dismal and potentially/actually dangerous.

> *Even when you're sleeping at night [outside] you sleep with one eye open. It can be very much dangerous out there. You just have to go through the vibes and you wake up the next day and say, 'Lord thank you, I've got a life'.*

> *What I've noticed is that Nelson is getting a bit violent now and you have to sleep in a safe place.*

> *Generally, I feel pretty safe but I've always got a knife next to me, no matter where I sleep. I'm more apprehensive about those guys who go into town on a Thursday, Friday, Saturday night, get on the piss and they want to get stuck into some homeless guy, tucked up in his sleeping bag. They're the ones I'm more concerned about.*

There was one story of support and understanding from others.

> *The Police came up to me and asked who I was and what was that. I said it was a tent, but I didn't know how to put it up. So, the Police put the tent up for me outside [a club] in town. So, I slept in it that night, The Police must have got in touch with the Māori Wardens to put me in a little bit of accommodation for a couple of nights.*

Despite their living circumstances the participants considered their needs for accommodation to be quite basic.

> *We have little hidey places we can go to, but it would be good if we had a place. Not for many, maybe somewhere where accommodation could be rationed. A house or anything. A sticker or a clip that [gives you a night's accommodation] for having done some community work. A place to sleep.*
>
> *A toilet and shower. Showering and washing your clothes, yeah that's the one. That's a biggie. Mostly a water supply is needed.*
>
> *We'd definitely need a kitchen, even a BBQ area where we could do some cooking. You would need somebody there to [look after it]. Make them pay for it so they can keep it clean.*
>
> *[We need] a place where we can come and go. Showers, washing facilities, SKY [laughter]. A drop in where you can wander in and out.*
>
> *If there was a drop-in centre funded by the Government, that would restore people's confidence*
>
> *It would be good to have access to clothing we could borrow when we're being interviewed, going for a job [or suchlike].*

What surfaced during the focus group conversation were some of the reasons why the participants were homeless, particularly those who were sleeping rough. For many, sleeping rough was the result of being asked to leave their current (temporary) accommodation because of issues with alcohol and associated anti-social behavior. For others it was a reluctance to seek temporary accommodation because of a history of unsuccessful attempts to procure and sustain accommodation. For these men it could be said that it was their choice to sleep rough. Another perspective raised was that it is the only choice left after exhausting all other options.

7.2 The need for support

In the first focus group, after being asked 'what needs to happen to improve your current situation?' the participants recounted their experiences of poor service from a variety of social services.

To recap, the focus group process expects and allows for a certain degree of dissatisfaction to be expressed in the first group. This in the understanding that a marginalised group, by definition, sits in a vulnerable place. This vulnerable place generally involves a degree of isolation, a lack of understanding and empathy and a silencing of the individual. The participants, finding themselves in an environment with people who share similar experiences and who are willing to listen, initially take the opportunity to tell of their negative experiences.

> *The risk is .. it's like when they say to you, 'you can do this, you can do this, you have to go through that' You haven't got that much [knowledge of your] rights. They don't tell you about [them]. They don't tell you about it.*
>
> *They rely on you to now know your rights. They wait for you to put your head down and walk out the door. They rely on people to feel a little stupid. You walk out the door and that's what they want you to do I think.*
>
> *There's a lot of stuff we don't know about, what we're entitled to. I wouldn't be surprised if they get a bonus for this. A lot of people on their caseload are not getting what they're entitled to because they're too scared or not knowledgeable enough to ask the right questions to get what we need.*
>
> *For a lot of the guys it depends if you've got the gift of the gab, so if you go in there [the social agencies] not being able to read and write, I think they target that. If you go in there and look as though you what you're about [you're OK}. I don't seem to have as much a problem as other guys seem to have.*
>
> *If I go in just after I've had my meds I might struggle but another half hour I might be a different person. [Otherwise] they think I've got an attitude. If I sit forward, they say 'can you sit back a bit please?' They think because I talk fast that I've got an attitude problem.*

While not specifically mentioned in the quotations above, the impact of a perception of service providers' stigma and discrimination underpinned much of the discussion.

In the second focus group the participants were asked the same question as previously but, as expected, they now looked at more constructive ways of achieving a better outcome for themselves and others who find themselves in a similar situation.

The initiative that the participants rated as most important was the need for a dedicated support person

> *My Case Manager is my confident. That's been really huge for me, I can confide in her. We can pass ideas back and forward and come up with a plan. For me a big one is having someone you can trust.*
>
> *The requirement is for decency*
>
> *You just want someone who is supporting and looking after you. It takes a weight off your shoulders and you feel a little bit lighter.*
>
> *For somebody to look after us it has to be somebody that understands mental challenges. Somebody that understands that stuff*

And finally, something of a challenge to the researchers.

> *At the end of the day you guys [the researchers] are the ones with the power. So, its best that you guys come up with something [after talking with us to get our views]. Is this really going to help us or is this going to be just another bleed off. Is the message getting through?*

8 Discussion

There are a number of limitations that should be understood in relation to this project.

Being set in a local area, considerable caution should be exercised in attempting to generalise the findings of the project more broadly.

Generalisation is further compromised by the recruitment technique utilised. Snowballing certainly attracts participants from a similar situation but also does not attract those who are not aligned with the initial participants. In this project we failed to attract those homeless men who preferred to live with minimal/no contact with other homeless men and of younger homeless males.

Reliability is unable to be ensured in qualitative research. That is, if the same process was repeated, the results would not be the same. Most likely they would be similar, but not the same. For this reason, the 'robustness' of qualitative research is usually assessed on measures such as credibility and authenticity.

Overall, the project surfaced the views of 35 men through the survey and 16 men through the focus groups. These men proved to be personable, affable and willing to share of their experiences and expectations. Consistent with the literature reviewed Māori and Pacifika were over-represented in the participant mix with 40% of the participants identifying as Pakeha and 60% as Māori or mixed Māori/Pacifika ethnicity. Again, consistent with the literature, the participants almost exclusively experienced a difficult upbringing and early life as well as limited schooling. What was not so clear in the literature accessed was that most experienced being institutionalised and falling foul of the law. What was not evident in the literature was the experience of estranged parenthood for many of the participants and of course for their children. Unexpectedly, despite these trials, almost all felt hopeful about their future. Again unexpectedly, the participants experience of health, social and correctional services was, in the main, positive.

The focus groups revealed that the participants saw two clear pathways forward in improving their situation. That of supported accommodation and of support from a 'case worker' to manage the pathway through bureaucratic systems that they struggle to navigate and manage as well as manage the discrimination they encounter.

9 Implications.

It is clear that, while the participants in this project initially gave limited weight to their health issues that, as they moved through the research process, these issues became increasingly evident. Alcohol misuse with associated antisocial behavior was often mentioned as was ongoing difficulties with mental ill health. It is not difficult to see that these two issues, along with homelessness, are a compounding and septic mix for these men. The impact of stigma and discrimination became increasingly evident as well. Several options present themselves:

- The need for accommodation is obviously urgent. However, as previously mentioned, personal issues make it difficult for the homeless to both find and maintain accommodation. One approach to this problem that is being trialled overseas and in New Zealand is the concept of 'wet housing' for emergency/temporary accommodation. For example, people who have experienced chronic homelessness and long-term alcohol dependence are eligible for emergency accommodation.
- Further to the above, a co-ordinated strategy across social, health and corrections services to best meet the needs of this group. The complex mix of issues the homeless face causes problems with meeting the specific criteria for support from differing services. For example, issues with alcohol may be argued as more urgent than issues with anxiety/depression. The first stage of achieving a belief in the need for this form of approach is to provide education for services on the experiences and needs of this group.
- While emergency accommodation is needed, a more complete strategy needs to be developed. Al-Nasrallah et al (2005) support the idea of a process and suggest that differing levels of emergency accommodation, supported accommodation and sustained accommodation could be a framework to follow moving forward.
- Case workers are needed to support and help the homeless navigate through institutional processes. These people need not have a professional education/qualification but more importantly be empathic towards and aware of the real-life situation of the homeless. Again, more importantly, these people need to be committed to strength based and recovery approaches and the principles embedded within them.
- Any planning to meet the needs of homeless men needs to include the voice of those men. To not do so seriously risks further marginalising this group. The men themselves believe they are seen as a 'difficult' or 'hard to reach group'. They should be seen as a 'priority group'. This project has demonstrated the preparedness and ability of this group to add new insights into their lives.

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Consent Form

The word from the street: the views of homeless men.

I understand that the intention of the focus group as being part of a study designed to find out from homeless men their experience of health and social services provided in the Nelson area.

I have had the opportunity to discuss this study and am satisfied with the answers I have been given.

I understand that taking part in this study is voluntary and that I may withdraw from the study at any time.

I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.

I agree to protect the identity of others within the group and to keep the information that will be shared confidential to those within the group.

I know whom to contact if I have any questions about the study.

I am aware the group will be audio-taped.

I consent to take part in this study

Signature Date

Researchers:

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