

**Forgotten Women:
A study of women and homelessness
in Auckland, New Zealand.**

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Abstract

Homelessness is an issue that is highly gender bound in most western countries. The issue of women's homelessness has not been adequately recognised or addressed in New Zealand. There is a group of women who are not in permanent safe or secure homes in New Zealand. Their houses are damp, cold and unsafe. These houses are far from being homes. The violence and poverty these women face means they are a highly transient population. As a result of their housing situations they often have poor mental and physical health. This is the picture of homeless women in New Zealand society today.

The aims of this study were to investigate why some women in New Zealand are without permanent, safe and secure accommodation and what can be done to minimise the risk of female homelessness in New Zealand.

This report uses a participatory research approach. Historically homeless populations have had a dependency on service providers. Participatory methodology challenges that power relationship by putting the research participants in the driver's seat. Women were asked what caused them to become homeless and what they think could be done to decrease female homelessness in New Zealand. This information informs the findings of the dissertation in conjunction with the literature review.

This study found that homeless women often feel discriminated against because of coming from situations of domestic violence and having mental illnesses and addictions. This study also found that violence and leaving relationships in general are a major cause of homelessness amongst women. Many women lack support during this phase in their lives and become homeless as a result. The high and complex needs of these women mean that there are significant challenges to working with them. A policy and service response must acknowledge and cater to the diverse needs and backgrounds of these women.

Recommendations focussed on the need for a bond bank, access to warm, dry, energy efficient rental houses in safe neighbourhoods and coordination of addiction and mental health services. This study found that the Housing First model would be the most effective at minimising the risk of female homelessness. The focus of Housing First is to get homeless people straight into permanent housing and provide intensive support. This has been demonstrated to be highly effective. Auckland needs a women's Housing First project.

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'We're the forgotten ones.' (Lucky - focus group participant)

'Homelessness and hunger are the two most palpable indications of poverty, as well as society's clearest indications of society's inability to care even minimally for its most vulnerable members.' (Glasser, 1994)

'While the number of homeless people in New Zealand is smaller compared with overseas... homelessness does exist locally. Further, the smaller size of our homeless population should not preclude a local consciousness of homelessness and associated housing issues.' (Cooper, 2001)

1. Introduction

There is no one pathway into homelessness, but once people are homeless, issues of personal vulnerability intensify their situation so that they become stranded as members of a highly stigmatised group (Hodgetts, Radley, Chamberlain, & Hodgetts, 2007; Larson, Poortinga, & Hurdle, 2004). At present in New Zealand there are very few options available for women who do not have permanent, safe or secure housing, this is particularly the case for single women, women who have drug and alcohol issues, women with mental illness and transgender women.

The aims of this study were to investigate why some women in New Zealand are without permanent, safe and secure accommodation and what can be done to minimise the risk of female homelessness in New Zealand. A participatory research approach was taken to ensure the women's voices were heard. A literature review was undertaken and a group of women who had been without permanent safe and secure accommodation in the last twelve months were asked about the causes of their homelessness, the barriers to securing and sustaining accommodation and what can be done to decrease the risk of homelessness in vulnerable populations.

1.1. Background

1.1.1. The causation and definitions of homelessness

Homelessness can be seen as a process of marginalisation involving many complex factors (Calay, 2001; C. Chamberlain, G. Johnson & J. Theobald, 2007; Gravitass, 2005; Hodgetts et al., 2007; Stein, Andersen & Gelberg, 2007; Watson & Austerbury, 1986; Wright & Tompkins, 2006). For many women homelessness is a journey which takes them further and further towards the margins of society.

There are many stereotypes of homeless women. Historically they were seen as witches and were depicted as mad, evil and

defiant of society's norms (Baxter, 1996; Glasser, 1994; Golden, 1992). Overseas visibly homeless women are often 'bag ladies', women who carry around their worldly possessions in bags and supermarket trolleys (J. Hand, 1983; Rousseau, 1981). However, in New Zealand homeless women are often hidden from view. They are not living on the street because doing so is not safe and because they often have children to care for. Homeless women subsequently become marginalised, trapped in insecure and unsafe housing without the resources or options to improve their housing situation.

It has been argued that many people are homeless due to personal choice (Christian, 2003) and this may be so for a very small group of homeless people (Christian, 2003; Pascale, 2005). The approach taken in this study is that homeless people may have pathologies that make them more susceptible to society's structural forces (Christian, 2003; Pascale, 2005). If this view is taken it means that people are not passive victims of the system, but neither are they totally responsible for becoming marginalised and ostracised from society. This approach recognises that an individual may adapt in ultimately damaging ways to negative events in their lives.

This study has used Chamberlain and MacKenzie's definition of homelessness of tertiary, secondary and primary homelessness (C. Chamberlain & Mackenzie, 1992). Tertiary homelessness includes people living in single rooms without kitchen, bathroom or security of tenure. Secondary homelessness defines transient people. Primary homelessness categorises people living outside 'conventional accommodation' who live outside or in improvised dwelling. The fourth category of marginalised groups has also been included in this definition which categorises people excluded from the economic, social, political and cultural life of their community (Gravitas, 2005).

1.1.2. Women on their own

Single women have had a lower priority in research, policy and services than pregnant women and women with children (Austerberry & Watson, 1983; Bard, 1990; Baxter, 1996). In New Zealand this means that women with children are given priority by Housing New Zealand and by the many social services and refuges providing emergency and supportive accommodation (Baxter, 1996; Hager, 2007). Single women are often overlooked in research in preference to single men who are a much more visible group. When this is translated into policy and practice, single women are left without affordable or safe housing options (Fitzpatrick, Kemp & Klinker, 2000). The stress and possible trauma of living in unsafe, violent environments, often where alcohol and drugs are in abundance (C. Chamberlain et al., 2007; Hager, 2007) has been shown to trigger mental health and substance abuse issues (C Chamberlain, G Johnson & J Theobald, 2007). The loneliness and isolation these women endure can lead to them becoming withdrawn and consequently further hidden – in boarding houses, hostels or backpackers or in unsafe situations with men being lead into ‘survive sex’ in order to have a roof over their heads (Stein et al., 2007). This can further entrench them in the homeless world.

1.1.3. Pregnant women and women with children

Nationally, there is huge unmet demand for supported accommodation for young pregnant women and mothers. There are very few options for residential care (L. Russell & Thorpe, 2007) and waitlists for services who work with women and children are long. When a woman becomes homeless because of childbirth there is a great risk that she will go into some sort of ‘hiding’ because she fears that presenting at health or social welfare services may mean the risk of losing children to foster care (Glasser, 1994). Secondary homelessness for women is a pressing issue.

1.2. Structural overview of dissertation

This study endeavours to systematically review and analyse why some women in New Zealand lack permanent, safe and secure housing and what can be done to decrease the risk of this in vulnerable populations.

The first section comprehensively summarises the literature on women and homelessness and describes definitions of homelessness and the causation debate. It also discusses whether homelessness is a matter of personal choice or due to societal forces. The epidemiology of homeless populations is then looked at and the literature on homelessness and health is summarised. Next, housing and health is reviewed to see how people in substandard housing fit into the picture of being people without a 'home'. Following this, the last 40 years of New Zealand housing and welfare policy is summarised and examined to see how housing health policies have affected people at risk of homelessness. Then there is a discussion of the literature on homeless women, violence against homeless women, single women, women with children and pregnant women. Lastly, the effectiveness of current homeless services and policies is discussed before six different homeless treatment models are analysed.

The research methodology section introduces the methods and procedures used to gather the data for the research. It discusses the research questions that were asked and the participatory approach that lies behind the focus group interviews.

The next section summarises the findings of the focus group interviews. This includes a thematic analysis and a running narrative of the stories the women told in the groups. A

summary of what the women wanted for service provision is also included.

The implications and recommendations section summarises the key findings of this research. The convergent and emerging themes from the focus groups and literature are discussed. Ways forward for policy makers and service providers in New Zealand are recommended. The dissertation concludes with the recommendation that a particular model, Housing First, is implemented and evaluated.

2. Background: Seeing homeless women in context

'In most of the world homeless women do not exist or (more probably) are not acknowledged or written about. When there is a lack of research, there is also a wide lack of interest, which results in lack of documentation with which to justify funding of housing programmes.' (Glasser, 1994)

Women may be seen as invisible both in literature and in society. There are significant dangers in being alone for single women, hence they have typically stayed hidden from view (Glasser, 1994). Anecdotally women have been seen as less at risk of being homeless compared to men as they have been perceived to be able to stay with family or 'prostitute themselves out' in times of need. However, neither of these options is likely to provide healthy, safe and long-term solutions to issues of poverty, abuse, neglect and destitution. These issues are the everyday realities confronted by scores of largely invisible homeless women in society today.

There is a strong gender bias in the research on homelessness towards primary homeless, with rough sleeping men making up the majority of this group. Only a few studies in New Zealand have brought the issue of women and homelessness to light (L. Amore & Robinson, 2007; Baxter, 1996; Hager, 2007; Marsh, 2006) and these have been small in size. Literature on homelessness in New Zealand has focused predominantly on men (Al-Alnasrallah et al., 2005; K. Amore, 2007; Ellis & Holt, 2007; Hodgetts et al., 2007; Laurenson, 2005; Leggart-Cook, 2007; Richards, 2008; L. Smith, Robinson & AtkinRead, 2006). There are a few published books of ethnographic studies of women and homelessness from the United States, Australia and the United Kingdom (Bard, 1990; Bridgeman, 2003;

Coleman & Watson, 1987; Connolly, 2000; Glasser, 1994; Liebow, 1993; Rousseau, 1981; B. Russell, 1991). This lack of research has been seen as a barrier to securing funding and resources for women's housing services.

'Invariably the plight of women is either totally ignored or presumed to be the same as that of their male counterparts. Although the majority of research studies, both local and overseas, record whether the subject is male or female, this differential is scarcely put to any further use. Seldom do females appear in the same number as males. Seldom, if ever, are the variables analysed according to sex. Seldom do questions seek to query the particular needs of females.' (Baxter, 1996)

2.1. Definitions of homelessness

The term 'homeless' has traditionally been used to describe people living on the street such as the alcoholic tramp, 'hoboes', 'bag ladies' (Ralston, 1996; Rousseau, 1981) or 'streeties'; however, this definition is problematic as it conceals other people living without permanent, safe or secure accommodation and the complexity of the problem (Cooper, 2001). Even though street homelessness is the most visible form of homelessness, this is not the only group of homeless people and women are not often found amongst the street homeless.

This report will use the following definition of homelessness, developed by Chamberlain and Mackenzie (1992):

1. *Tertiary homelessness* includes people who are living in single rooms without kitchen, bathroom or security of tenure however often on a long-term basis.
2. *Secondary homelessness* defines people who move between houses regularly, they may 'couch surf' at friends' or relatives', use caravan parks, backpackers or hostels as their only place

of residence, stay at refuges, or frequent boarding houses, shelters or emergency accommodation.

3. *Primary homelessness* categorises people who live outside what we define 'conventional accommodation'. They may 'sleep rough', living in parks, deserted buildings, or improvised dwellings.

A fourth group has also been added and defined as:

4. *Marginalised groups* categorising people excluded from the economic, social, political and cultural life of their community. Marginalised groups may include those involved in activities which may be stigmatised within the community: drugs and alcohol users, sex workers, transgender people, people with mental illness or some other disability, abuse victims and lonely or isolated elderly people (Gravitas, 2005).

This fourth definition allows for a wider group to be included than just the visibly homeless. Even though there has been a lot of debate around the definitions of homelessness (Chamberlain & Johnson, 2001; Elliott, 1998), this definition is now being used widely in the homelessness sector in Australia and New Zealand (C. Chamberlain et al., 2007; Gravitas, 2005).

Women's homelessness is particularly difficult to define because of women's relationship to the home and their role in the family (Watson & Austerbury, 1986). It has also been argued that due to the gendered division of domestic labour, women and men experience the meaning of home very differently (Elliott, 1998). When abuse happens in the home, it can produce a profoundly different experience of homelessness for the woman¹ (Elliott, 1998) given the distinctive meanings of 'home' and 'family' to women.

¹ This has been discussed by Daly (1996) and Watson & Austerbury (1986).

The Australian National Housing Strategy (Baxter, 1996) echoed this in their definition of serious housing disadvantage as: trapped in situations of domestic violence or sexual abuse with few alternative housing options available, a tendency to become involved in unsuitable domestic relationships in order to gain shelter, denial of choice in and control over one's housing, frequent relocation which defines women opportunities to improve their economic prospects and living in seriously substandard or over-crowded housing when no affordable options are available.

Another way to see homelessness is on a continuum from 'homed' to 'homeless' and from 'housed' to 'houseless' (Cooper, 2001; Sorton, 2001). When looked at in this way, 'houselessness' is defined as being without an address while 'homelessness' defines a situation of deprivation (Sorton, 2001).

The distinction between homelessness and houselessness is useful as it allows for the circumstances and situations that lead to homelessness to be taken into account. It also takes into account that homelessness is often a *process of marginalisation*. This is especially relevant to women as women often tend to be in situations of tertiary and secondary homelessness while men are more likely to sleep rough (Watson & Austerbury, 1986).

The debate over the definition of homelessness and 'houselessness' also expands into a sociospatial discussion of what makes someone identify with either being homeless or not (Adamides, 2002; Cooper, 2001). People may still see their house as a 'home' even though it is substandard or overcrowded. People who frequently move around may not see themselves as 'homeless' if it is the culture of their group to do so, as shown in a Christchurch study (Marsh, 2006). People

without permanent, safe or secure accommodation, such as those living in situations of overcrowding or constantly shifting in search of a 'healthy home' may eventually see themselves as homeless (Marsh, 2006).

There is also a group of people who are housed (be it precariously) and are at risk of becoming homeless (Sorton, 2001). This group could be defined as being secondary or tertiary homeless (utilising Chamberlain and Mackenzie's definition).

Women are less likely to live on the streets as they often have children or still have links with family and friends (Daly, 1996). Due to issues of women's personal safety and the strong male street person subculture, women are often forced into submissive relationships with male street people in order to survive. When the relationship with a man finishes, so does their protection from other males.

2.2. Why homelessness is bad for your health: the epidemiology of homelessness

Homelessness in all of its forms has very serious health consequences. Once people are socially and economically marginalised to the point of being homeless, they are more likely to experience poor health and disease, physical or sexual violence, and a sense of fear and difficulty reintegrating into society (Hodgetts et al., 2007; Stein et al., 2007). Compared to the general public, homeless people have high rates of illness, disease and death (Adamides, 2002; Cheug & Hwang, 2004; Wright & Tompkins, 2006). Homeless people are 34 times more likely to commit suicide, 25 times more likely to die at any point in their homeless lives and are 150 times more likely to be fatally assaulted (Christian, Christopher & Abrams, 2007a). In research of homeless samples, around one-third report poor

health and just under half will have substance abuse problems (Larson et al., 2004).

There is a high prevalence of mental illness in homeless populations. Studies have shown that approximately one-third of homeless populations will have a serious mental illness. Homeless people without a mental illness are 2.4 times more likely to get housing than homeless people with a DSM IV Axis I Diagnosis (which includes conditions such as schizophrenia and bipolar disorder) (Fichter & Quadfleig, 2001).

In a study of homeless women it was shown that 50-70% of the population with mental health issues also abused substances (Padgett, Hawkins, Abrams & Davis, 2006). People outside of shelters or who are 'rough sleepers' are even more likely to experience adverse health effects, mental health issues and substance abuse issues (Adamides, 2002) and it is more likely for these problems to go untreated (Christian, Christopher & Abrams, 2007b; Larson et al., 2004; Stein et al., 2007).

Studies of residents of boarding houses and shelters show that a significant number have a mental illness (Sorton, 2001). Studies have also shown that the relative risk of staying homeless if a person has a mental illness and a substance abuse or is 'dual diagnosis' is three times higher than if a homeless person does not abuse substances (Sorton, 2001).

It was also found that the longer people stayed in boarding houses, the likelihood of them finding alternative accommodation decreased as they adapted into boarding house life and their sense of hope diminished (C. Chamberlain et al., 2007).

In a Melbourne study of 5186 people who were homeless or at risk of becoming homeless, it was found that female participants

expressed great fears around staying at boarding houses due to the violence and drug and alcohol abuse (C. Chamberlain et al., 2007). However, as in New Zealand, private boarding houses were often the only option for women seeking emergency accommodation. This study also found that due to the chaotic environments of many boarding houses, many people's mental health and substance abuse issues became worse. Of the study's 1344 female participants, 47 percent had mental health issues before becoming homeless, while 53 percent developed a problem after they became homeless. This could be due to witnessing or being victims of violence and abuse, the intimidation women experience at boarding houses and the subsequent withdrawal from social contact and the isolation and loneliness that followed (C. Chamberlain et al., 2007).

2.3. Housing and health

People who are in situations of overcrowding or in unhealthy homes that have mould, damp and cold may also fit into the category of being without safe and secure housing. It has been shown that there is a high prevalence of women and families in this group (Adamides, 2002). At present there is no definition to describe this group. However, a growing body of evidence has demonstrated how overcrowded or unhealthy homes can lead to homelessness (Adamides, 2002). It has also been argued that the definition of homelessness should include not only those without a dwelling but also people whose accommodation does not meet their physical, economic, social or emotional needs (L. Smith et al., 2006).

The term 'hidden homelessness' has been used since the 1990s (Veness, 1992; Wolch & Dear, 1993). People living in substandard conditions can be included in the 'hidden homeless' group. Watson and Austerbury found in their research (Watson & Austerbury, 1986) that women defined a

home by factors of material condition and standards. The need for space, privacy, control, safety, self expression and physical and emotional wellbeing were all important².

'Housing space adequate to the needs and desires of a family is a core component of quality of life. National and international studies show an association between the prevalence of certain infectious diseases and crowding as well as between crowding and poor educational attainment. Crowding can also contribute to psychological stress for people in the households concerned' (The Ministry of Social Development, 2007).

2.4. Ethnicity and overcrowding

In New Zealand, there is a high incidence of Pacific peoples living in overcrowded households compared to other ethnic groups. In 2006, 43 percent of Pacific peoples lived in households requiring extra bedrooms (MSD, 2007). Māori were the next most likely to be living with overcrowding, with 23 percent requiring at least one extra bedroom, followed by Asians (20 percent). Only four percent of European New Zealanders were living in houses that were overcrowded; this partly reflected their older age profile as young people have been shown to live in situations of overcrowding more often. In the Ministry of Social Development's Social Report the 'Other' ethnic group was the only ethnic group to have an increased incidence of crowding between 1986 and 2006 (from 22 percent to 23 percent). This has been explained by recent migrants, common in this ethnic group, being more likely to live in crowded households (MSD, 2007).

² Watson and Austerbury's research was conducted in the early 1980s in London so these factors are relative to cultural and social settings as discussed by Elliott (1998).

2.5. Homelessness: A matter of individual choice or societal factors?

There are two main theories why homelessness occurs – the individualistic and structural approaches. The individualistic approach sees homelessness as being due to a failing of the individual or as a personal choice. This approach focuses on people's free will to make life decisions (Christian, 2003).

'One problem that we have always had, even in the best of times, is the people who are sleeping on grates, the homeless, who are homeless, out of choice.' (President Reagan, *The Washington Post* 1984) (Pascale, 2005)

The structural approach sees homelessness as due to the social and economic structures of society. How government, policy and the market creates housing and welfare environments takes homelessness beyond the control of the individual as is it due to societal, not individual factors (Christian, 2003; Neale, 1997a).

More recently, a synthesis of the individualistic and structural approaches has been used to describe homelessness. The pathology of a homeless person may predispose that individual to be more susceptible to society's structural forces (Christian, 2003; Pascale, 2005). This means that people are not passive victims of the system, but neither are they totally responsible for becoming marginalised and ostracised from society. This approach recognises that an individual may not be able to adjust to the changing circumstances in their lives. Homelessness can be seen as a process of marginalisation involving many complex factors.

The discourse around gender inequality is also an important factor in the causation debate (Neale, 1997b). It has been argued that a woman may be more likely to face housing difficulties due to income inequality with her male counterpart, and the stigmatisation and ghetto-isation of people who do not conform to the idea of a 'home' and everlasting marriage. The impact of domestic violence, divorce and the economic issue of a woman not having the resources to make alternative living arrangements if her home is unsatisfactory (Adamides, 2002) are all factors that effect women's housing options.

2.6. A picture of homelessness in New Zealand

Since the 1970s, New Zealand has seen an increase in homelessness and a decrease in home ownership (C. Smith, Robin & Abbott, 1992). The 1960s saw a huge rural to urban shift for many Māori; urban centres grew as people migrated to urban centres to work as the farming sector decreased. There was also an increase in childless, single parent and one-person households (C. Smith et al., 1992) The fourth Labour government of 1984-1990 and the National government of the 1990s shifted the focus away from housing and other social services as they tried to curb inflation and economic stagnation through neoliberal reforms such as privatising state assets, cutting government spending and deregulating the economy (Bang, 1998). In 1987 the fourth Labour government started this reorientation away from housing although Hon. Helen Clark as Housing Minister succeeded in protecting the State house system from the more extreme suggestions of some of her Cabinet colleagues. Despite Clark's success in this regard, an increase in housing difficulties for low-income groups was seen in this period of time (C. Smith et al., 1992).

The more extreme reform took place in 1991, when the National government transformed the Housing Corporation into a State-Owned Enterprise. The corporation was run as a commercial

entity and Housing New Zealand started to charge market rent for properties. With Housing New Zealand market rents came the Accommodation Supplement, which was available to beneficiaries who could not afford rents being charged by private landlords or the new rent in state houses. However, this Accommodation Supplement contributed to an increase in what landlords could charge as they perceived all tenants could now afford to pay more. An increase in private rents drove state house rents up also as the government put them to be on par with private rentals (Bang, 1998). As a result, rental prices in New Zealand increased, leaving the most in need unable to afford the new rent prices as well as their other living costs.

In the 1990s, the lack of government housing meant people with mental health issues who had relied on the health system fell through the cracks (Padgett et al., 2006). The after shock of the stock-market crash in the late 1980s was economic downturn, which meant an increase in unemployment and subsequent issues with overcrowding, mental and physical health issues and social exclusion, all key contributors to increasing homelessness. By 1998, it was estimated that between 60,000-100,000 people were without adequate accommodation (C. Smith et al., 1992). Around this time, one of the submissions written by the Royal Commission on Social Policy and the National Housing Commission showed that housing problems were disproportionately affecting Māori and Pacific families, women-headed households, the elderly and people with physical and psychological conditions (C. Smith et al., 1992).

Psychiatric de-institutionalisation and in particular the closing of many psychiatric hospitals in the 1970s and 1980s has been seen as a causal factor in the rise in homelessness in the last two decades (Ralston, 1996) in both New Zealand and overseas. Homeless shelters and boarding houses became the

'de facto residential facilities for people with psychiatric and other disabilities' (Padgett et al., 2006; Pascale, 2005). With independent living for people with psychiatric diagnosis came the challenge for the health and welfare system to provide services to people living in the community as they made the transitions from institutions to community settings, which often meant boarding houses and flats. People were moving houses regularly as they battled with their mental health and the discrimination they faced in finding appropriate accommodation (Padgett et al., 2006), Alternatively they simply slipped through the cracks (Ralston, 1996).

Now, as populations continue to rise in urban areas and people are marginalised further through increased cost of living, privatisation and changes in the welfare and health systems, issues have emerged for many different groups. For example, literature from western nations shows that women-headed households and ethnic minorities are highly represented in groups of inadequately-housed people (C. Smith et al., 1992). For Māori, this means they represent fifty percent of primary homeless people in Auckland (Elliott, 1998; Ellis & Holt, 2007). For other groups, such as single men, women (especially pregnant women) and non-heterosexual and transgender populations, the risk of marginalisation is even greater (Wright & Tompkins, 2006).

2.7. The female specific aspects to the causation of homelessness

Historically, homeless women were seen as witches and prostitutes and were stigmatised for being residents of public lodgings. The older homeless woman is sometimes portrayed as the archetypal witch. In the United States 'witch' is a common word used to taunt older homeless women. In the 16th and 17th century, many of the witches brought to trial were poor women to whom public relief had been denied. It has been

postulated at this time that there was a tension between Christian alms giving to the poor and the burden caused by them (Baxter, 1996; Glasser, 1994; Golden, 1992).

In Austerberry and Watson's seminal study of homeless women (Austerberry & Watson, 1983), which has become a primary reference point for many authors on the topic of homelessness, the causal factors of women becoming homeless and ending up in shelters (n=102) were found to be; lack of affordable housing for single people, women's wages being two-thirds of men's wages, an educational system that does not encourage (or support) women into higher education or training and the difficulty women have finding work after doing years of unpaid domestic work. The study also found that often women have to leave the home when a relationship breaks up and that they often lacked the skills to be able to find a new home after a break up (Austerberry & Watson, 1983).

Additionally, in a study of single elderly women in Australia, it was found that due to the gendered division of labour and dependence on male partners for their housing and income, older women had often been forced into boarding houses, private rentals or unsuitable government housing or were forced to sell their house if their relationship ended. The study also highlighted that right up until the 1980s it was often difficult for a woman to secure a mortgage without a male guarantor (Coleman & Watson, 1987).

Even though the disparity between men's and women's wages for the same job may have decreased since the 1980s and banks and government agencies do not have the patriarchal financial practices that were common practice before the 1980s, what has remained is that women often have less income and assets than their male counterparts due to time out of the workforce for child rearing and the gendered division of labour.

This means that women still have less financial resources than men as a whole.

In an English study of the experiences of men and women while homeless, specifically looking at gender differences (Cramer & Carter, 2002), it was shown that women attributed their homelessness to break-ups with partners and leaving abusive and violent relationships with men. On the other hand, men were more likely to leave their partner of their own volition and have drug or alcohol abuse contribute to not being able to maintain permanent accommodation. The women studied with a history of drug and alcohol abuse often mentioned that responsibilities for children meant they had difficulties coping; however, many of the women in the study did not have their children living with them. Another issue this study highlighted was that a loss of a mother rather than a father played a part in both men's and women's explanations of why they became homeless in later life, while in young participants conflict with parents also contributed to being homeless.

2.7.1. Violence against women and homelessness

Homelessness for women is often linked to domestic violence, and for women of ethnic minorities it is often linked to poverty, marginalisation and discrimination (Calay, 2001). Although violence is distributed across all income levels, poor women are more likely to be victimised overall and have less ability to alter their environments (Bassuk, Melnick & Browne, 1998). They often engage in 'survival sex' to meet their basic needs (Stein et al., 2007) and, as a consequence, are likely to be victims of violence.

'Family violence and homelessness are not connected in the New Zealand psyche, but the relationship could not be clearer ... when a woman is forced to leave her home she is homeless. She is

homeless in the true sense of the word, not only do her (and her children) lose their familiar roof, they lose everything that gave them a sense of home – family privacy, connection to the community, a sense of place. Violence may have made it much less of a home than it should have been, but few women want to leave their home – they leave because they want the violence to stop.’ (L. Amore & Robinson, 2007)

Women are more at risk of rape, violence and abuse if they live on the street (Cheug & Hwang, 2004), and night shelters are not always safe options for women (especially for young women, women with children and gay or transgender women). Research has identified that women who have lived in commercially-run boarding houses are at risk of physical, sexual and emotional abuse both from fellow residents and from managers/owners. These women often feel very stressed at living in an unsafe environment (Hager, 2007).

2.7.2. Women on their own

There has been much more research and policy attention on pregnant women or women with children seeking emergency accommodation than on single women (Austerberry & Watson, 1983; Bard, 1990; Baxter, 1996; Hager, 2007). In New Zealand, this means that women with children are given priority by Housing New Zealand and by the many social services and refuges providing emergency or supportive accommodation (Hager, 2007). Single women are often overlooked in research in preference to single men who are a much more visible group than their female counterparts. When this is translated into policy and practice it means that single women are left without affordable or safe housing options (Fitzpatrick et al., 2000). Such a situation has been shown to trigger mental health and substance abuse issues due to stress and possible trauma of living in unsafe, violent environments, often where alcohol and

drugs are in abundance (C. Chamberlain et al., 2007). The loneliness and isolation these women endure can lead to them becoming withdrawn and, consequently, further hidden – in boarding houses, hostels or backpackers or in unsafe situations with men. This can perpetuate them becoming further entrenched in the homeless world.

2.7.2. Women seeking emergency accommodation

Most women who seek emergency accommodation, often have histories of domestic and sexual abuse as well as poverty, mental health, drug, alcohol (Burt & Cohen, 1989; Ralston, 1996) and gambling issues (van Loon & Kralik, 2005). As well, they are often marginalised and discriminated against because of these presenting issues. An awareness of these factors should help in understanding the cause (and perpetuation) of homelessness and help services shape appropriate responses (Polakow & Guillean, 2001) (Bassuk et al., 1998). In Australia, 50-70 percent of young people in the Supportive Accommodation Assistance Programme (SAAP) had been sexually assaulted, and this has been shown to be a key factor in the cause and continuation of youth homelessness (van Loon & Kralik, 2005).

Women who seek emergency accommodation often present with high and complex needs (van Loon & Kralik, 2005). They can present multiple times and be very challenging to work with both individually and in a group setting. Many homeless and extremely poor clients will accept help with basic amenities before they are willing to participate in specialised services (Bassuk et al., 1998). But with this said, data from a survey of homeless men and women in the United States (n=178) showed that homeless women were more likely to be slightly better educated (Burt & Cohen, 1989; DiBlasion & Belcher, 1995; Ralston, 1996), to have been homeless for a shorter period of time, to request child care and parenting skills training

as well as assistance with government benefits, and to be less in need of alcohol and other drug (AOD) treatment than men (DiBlasion & Belcher, 1995).

2.7.3. Pregnant women and women with children

One of the critical periods of housing need occurs for young pregnant women and mothers. New Zealand has one of the highest teenage pregnancy rates in the developed world. This is rising, even though the country has an overall declining birth rate (L. Russell & Thorpe, 2007). In 2002, 3 percent of all female teenagers between the ages of 15 and 19 years of age became pregnant (Tonkinson, 2006); this rate is three times as high for Māori women of the same age (L. Russell & Thorpe, 2007). In some samples of homeless women, as many as 35 percent were pregnant (Weitzman, 1989).

The Better Homes Fund (TBHF) in the United States found that 84 percent of the 436 homeless and poorly housed mothers surveyed had been severely assaulted (physically and/or sexually) at some points in their lives (Bassuk et al., 1998). It was also found that sheltered homeless mothers had fewer economic resources and social supports, and higher cumulative rates of violent abuse and assault over their lifespan than the low-income housed female population.

Nationally, there is huge unmet demand for supported accommodation for young pregnant women and mothers, and there are very few options for residential care (L. Russell & Thorpe, 2007). However, when a woman becomes homeless because of childbirth there is a great risk that she will go into some sort of 'hiding' because she fears that presenting at health or social welfare services may mean the risk of losing children to foster care (Glasser, 1994).

We will now turn to what is happening presently in New Zealand in Australia and briefly discuss the impact of this on homeless women.

2.8. Policies and programmes from other countries

Internationally, it has been shown that in the case of both single homeless men and women, the most effective programmes involve weaning people off the street and making affordable housing available. For street dwellers, this may start with offering them food, a shower and a place to rest. Once people become interested and ready for more permanent housing, they must be in neighbourhoods where they feel comfortable (Glasser, 1994). However, only a proportion of people who are homeless live on the street. Therefore, it has also been suggested that the ambulance needs to be at the top of the cliff, not at the bottom.

Any solution to homelessness needs a holistic and whole government approach. It requires public support and genuine empowerment of the homeless to engage in home building- home building not just in the sense of physical space, but the building block required to construct an effective self. Homelessness is often tied to poverty, but is also connected to lack of opportunity, destructive and nonsustainable relationships. Poor health, and quite often, plain bad luck. In today's volatile employment (and all too often downsizing) market and lifestyles often sustained by credit, more people realize they might also be vulnerable to homelessness. The argument here is not that people are responsible for their homelessness, or that they should be charged with resolving it. As will become clear, there are different types of homelessness ... and different types or responses required (Rubbo, 2001).

A balance between these two positions is being championed in Australia. Since 1985, all states in Australia have had The Supported Accommodation Assistance Program (SAAP). The philosophy of service provision is to encourage self-help by recognising clients as individuals, to ensure equality of access by SAAP to homeless people without discrimination, to be sensitive to problems associated with homelessness (such as domestic violence) and, by doing so, enhance the status, dignity and self esteem of service users. Even though initially only rough sleeping men were focused on in SAAP, the target groups of SAAP now include young people, women and women with children who are homeless and/or in crisis as a result of domestic violence, families (including single parent families), single men and women.

In a review of SAAP after five years of running (Commonwealth Department of Health Housing and Community & MSJ Keys Young Planners, 1991), it was stressed that if the Australian SAAP system was going to work for young single homeless women there needed to be onsite support for women at specifically female-only accommodation. It was also recommended that outpatient services for homeless women based at centralised centres be created that employ 'highly experienced and skilled staff with experience in a variety of specialist areas' (p ii). The review also highlighted that there needed to be skilled staff and the appropriate resources available for young homeless indigenous women (in their case, Aboriginal women; however, the same could be said for young Māori women in New Zealand), young homeless women of non-English speaking backgrounds, young homeless women who are the survivors of sexual assault or incest, young homeless women who abuse drugs, young homeless women who are pregnant or young mothers, young homeless lesbians and young homeless women with disabilities (physical or

psychiatric). In data collected from the SAAP in 2006, it was shown that 21 percent of SAAP were single females who were presenting alone for reasons other than domestic violence; 52 percent were under the age of 25 years and most were 15-19 years of age (Welfare, 2008).

Due to the larger population of homeless people in Australia and recognition by many in the homeless sector in New Zealand that Australia is providing effective homelessness programmes, there is good reason to heed these recommendations.

'It is obvious that the most effective way to address homelessness is to prevent it from happening in the first place. Families must be provided tools to support their children so that the children are not pushed out onto the street. Governments must invest in more social housing so that poor families are not victimised by market forces. Housing, like other basic health needs such as health care, needs more guarantees ...'(Glasser, 1994)

2.9. Discussion of current services for women who are homeless or at risk of becoming homeless in New Zealand

At present in New Zealand there are very few options available for women who do not have permanent, safe or secure housing, especially single women, women who have drug and alcohol issues, women with mental health issues and transgender women (Gravitas, 2005).

Auckland city has a high level of homeless people as well as a lack of affordable housing (Laurenson, 2005). The Auckland City Council has a Homeless Action Plan, but there are no specific points to address women who are homeless and the specific issues they face with accessing services or the violence

and abuse women face if they live in boarding houses. These are both pressing issues.

A report commissioned by the Auckland City Council (Gravitas, 2005) on current issues in Auckland City's provision of services for homeless and marginalised people,³ which involved carrying out a service provider survey, in-depth interviews and a stakeholder workshop, concluded that there was a lack of social services for those in crisis (for example, people escaping domestic violence or people with drug and alcohol or mental health issues). Secondly, it found that emergency accommodation for women, families and gay and transgender individuals needed to be improved. This was seen by the stakeholders as being needed due to the unsafe nature of emergency accommodation being dominated by middle-aged men and the risk of exposure to violence and drugs in current emergency accommodation services. Thirdly, it recommended a 24-hour service that catered for people after hours and more independent emergency flats for women. Fourthly, it recommended more supported transitional housing, so that once a person or family was housed they had assistance with

³ This report used Chamberlain and Mackenzie's definition of homelessness (1992) however included marginalised people as a fourth group. They defined them to be ' People excluded from the economic, social, political and cultural life of their community. Marginalised groups include those involved in activities which may be stigmatized within the community and often, but not always include: drugs and alcohol users, sex workers, people with mental illness or some other disability, abuse victims and lonely or isolated elderly people (Gravitas 2005 p15).

learning the skills needed to run and maintain a house. This report specifically recommended the establishment of:

'An accommodation facility, or facilities for those ready to be re-housed that is safe/secure and supported through the inclusion of necessary facilities onsite such as a doctor, day-care and training facility.' (Gravitas, 2005)

The fifth recommendation from the Auckland City Council report was a case management approach to support homeless or marginalised people. This is the only recommendation that has been actioned from the report; however, not many women fit into this category as the chronically homeless of Auckland city are mostly male rough sleepers.

There has been an improvement with Housing New Zealand establishing a homeless coordinator role. The Taylor Centre and Auckland City Council are also working together to create a role that will coordinate the Council's Homeless Action Plan with the Auckland District Health Board's mental health services homeless team.

Auckland currently lags behind Wellington in its approach to comprehensive services for homeless people. There is a women only boarding house in central Wellington, Capital Coast District Health Board and Downtown Community Ministries are currently collaborating on opening wet housing with comprehensive social work support. The Wellington City Council and Downtown Community Ministries have been running *Project Margin* which uses city council houses and apartments to house the homeless by providing appropriate support so that former homeless people remain housed and are supported in the transition from homelessness.

In a study of three New Zealand centres' approaches to homelessness, key informant interviews and a systematic analysis of council policies were used to assess the effectiveness of different services (Laurenson, 2005), *Project Margin* was seen to be immensely successful. This was because *Project Margin* had seen a rapid increase in homeless people being housed and staying housed. This was attributed to the long-term relationships and trust the homeless people of Wellington had with Downtown Community Ministries, while also having financial resources and housing stock supplied by Wellington City Council. However Boarding House regulations have more effect on homeless women, as women tend to be living in boarding houses more often than on the street (Hager, 2007). There has been nothing done in this area in New Zealand. Therefore, regulations around boarding houses would be more effective at targeting homeless women's safety (Gravitas, 2005).

2.10. Models of treatment for homeless services

This section will endeavor to summarise the key homeless service models, firstly by defining them and then discussing evidence of their effectiveness. A tabulated summary of the literature discussed in this section can be found in Appendix 1.

2.10.1. Model 1: Brokered Case Management (BCM)

BCM is a very common model in the public health system. It is used with homeless and mental health clients to case manage 50-100 clients at one time. It aims to refer clients to services they need and co-ordinate a client's care from an office base (Kenny et al., 2004). This model is what most supportive accommodation and transitional housing programmes use to coordinate clients' care.

In studies of BCM, it was found to be not as effective overall as other treatment modalities. While it was cost effective and easy

to run with untrained staff it was deemed ineffective. (Kenny et al., 2004; Morse, Calsyn & Klinkenberg, 1997; Vanderplasschen, Wolf & Broekaert, 2007).

2.10.2. Model 2: Assertive Community Treatment (ACT)

ACT is an intensive programme where case workers carry a case load of 10-15 clients and provide a mobile multi-disciplinary service 24 hours a day. Clients get frequent visits, a wide range of services and continuous care. Most services needed by clients served by ACT are provided by the team rather than by referring them to other providers (e.g. psychopharmacology and other clinical treatment, housing support, crisis intervention, vocational support). There is an emphasis placed on practical support for daily living and there are no time limits for length of service.

The research that has studied the effectiveness of ACT has shown that it is favourable against standard case management (Hampton, Koor, Bond, Mayes & Havis, 1992). It has also been shown to be superior to brokered case management (Kenny et al., 2004; Morse et al., 1997). There was no difference found between ACT and a forensic model when used with homeless people released from jail. (Solomon & Draine, 1995). However homeless women are not usually in this category.

2.10.3. Model 3: Housing First

When ACT is used with a Housing First approach, it has been shown to be more effective than a treatment first approach. Housing First was developed by Pathways to Homes in 1992 and is a consumer driven approach to providing support services to adults with mental illness who were homeless (Padget, Gulcur & Tsemberis, 2006). In Housing First participants are immediately given housing and then intensive support so that they sustain it. Housing First separates treatment from housing and is based on a model which focuses

on consumer rights to make decisions about how they live. It is seen that consumers have a human right to housing and a right to treatment but housing is not contingent on treatment compliance (Padget et al., 2006). Sobriety is not compulsory as compulsion is seen as impinging on consumer choice. Participation in a money management programme is however required. Addiction counselling is offered based on a client's readiness to change and the option of residential services is explored and encouraged. If a client has severe substance abuse issues, residential addiction treatment is urged and their apartment is either held for them or another one is found on their completion of a programme. If evicted from an apartment, staff assist them to find another one.

The New York Housing Study *Pathways to Homelessness* (Padget et al., 2006) was a longitudinal study which followed 225 participants over a 48 month period. It used an adapted ACT programme (which included a Nurse Practitioner to address health problems and a housing specialist to co-ordinate housing needs) and compared it with a treatment first programme (which required detoxification and sobriety before giving access to services such as independent housing). Programmes usually included a 12-step meeting, a day programme, shared bathroom and cooking facilities and on-site staff who administered medication. The group was randomly separated into housing first consumers between the ages of 18 and 70 years of age. The results showed that the adapted ACT programme was very effective with the client group, drinking decreased and clients stabilised in living situations compared with the treatment first programme.

2.10.4. Model 4: Intensive Case Management (ICM)

ICM approaches have been widely used with a variety of homeless subpopulations including people with substance abuse disorders, homeless families, and especially with people

with severe mental illnesses. ICM's clinical principles are; assertive and persistent outreach, reduced case loads of 10-15 per case worker and active assistance in accessing needed resources (Morse et al., 1997). It is similar to ACT but differs in that it does not require 24-hour support from a psychiatrist on the team or a shared caseload.

ICM's key features can be easily adapted to fit the differing needs of the client group and the locality of the service but include intensive community focused case management for an extended period of time, aimed at breaking the re-hospitalisation cycle and getting long-lasting stabilising effects. It also involves frequent contact rather than hours of contact. Telephone contact may supplement, but not substitute for face to face contact. The quality of the contact, not just the frequency is also emphasised, along with the philosophical orientation of the caseworker (e.g. strengths or recovery orientation) and these are seen as mitigating factors in positive outcomes. People who are at high risk for acute exacerbation of psychiatric symptoms or whose level of disability places them at high risk needing restrictive service settings, should be served by low case load case management (optimally no more than 10-15 clients per case manager or team member). The philosophy entails case managers having the ultimate responsibility for client services (with the exception of prescription of medication). They retain authority even in referral situations. However clients should be given equal or greater authority than case managers or other professionals in making treatment and life decisions.

With homeless services users it was shown that ICM was favourable above standard treatment (Cox, G.B. Walker, Freng, Short, Meijer & Gilchrist, 1998) and improved the housing status, physical and mental health of homeless adults (Braucht et al., 1996; Orwin, Sonnefeld, Garrison & Smith, 1994). When

combined with psychological rehabilitation, compared to standard case management ICM produced better housing results for severely mentally ill homeless people. (Shern et al., 1996). Also with dually diagnosed homeless people ICM was shown to decrease the utilisation of emergency and ambulance services and improve psychological functioning (Witbeck, Hornfeld, & Dalack, 2000)

2.10.5. Model 5: Strengths-Based (SB) case management

Strengths-based approaches are used more with non-homeless groups of people with severe mental illness (SMI) than with homeless groups. It emphasises clients' strengths rather than their weakness and diagnosis. Attention is paid to the client's environment, use of paraprofessional staff and focuses on following the clients' direction in goal setting and future planning (Morse et al., 1997). Not a lot of research has been done on the effectiveness of strengths-based care with homeless populations. Anderson (2001) showed that in a sample (n.150), strengths-based care improved individuals' self care measures. Apart from that piece of research, it seems that ICM and ACT (hence Housing First as it is a subset of ACT) have been the most researched and deemed the most successful models to be used with homeless populations.

2.10.6. Model 6: Critical Time Intervention (CTI)

CTI focus is on strengthening homeless people's support and self efficacy and connection to other agencies during a point of transitional housing. This has been tested with people exiting institutional care, primarily with psychiatric and multiple disabled people (Susser, Valencia, Conover, Felix & Wyatt, 1997), people re-entering the community after imprisonment (Draine & D.B., 2007) and entering transitional accommodation before entering the community on their own. People, especially people with substance use disorders, co-morbidity and medical complications, who have been a focus for this intervention are

people who are not easy to accommodate in the community service system. Thus CTI has been used successfully in the de-institutionalisation process (Susser et al., 1997). By enabling clients to develop their long term ties to other services, family and friends, they are seen to fare better in the future. Emotional and practical support at frequent intervals (approximately twice a week) are given precedence (Morse et al., 1997; Susser et al., 1997). The process of CTI is as follows:

1. The clinical team devise a plan for the transfer of care from the shelter to other formal and informal supports
2. The plan focuses on specific areas of potential risk of homelessness.
3. Each client receives a CTI worker (the worker may not necessarily be trained or have a professional degree but does need supervision from a Social Worker or Mental Health Worker).
4. The CTI worker attends meetings with the clients, takes them to appointments and facilitates the clients' planning for the future and community engagement.
5. The CTI worker will spend time with the client in the community to observe their physical surroundings and habits and then support them in the change process in how they are going to enhance engagement with treatment and community supports. This is done through building problem solving skills, motivational coaching and advocacy with community organisations.

Susser et al. (1997) found in their study (n=98) with severely mentally ill homeless people that CTI reduced homelessness. Another study (Kaspro & Rosenheck, 2007) found CTI to be successful with homeless veterans after psychiatric hospitalisation.

2.10.7. The effectiveness of the approaches

Studies⁴ evaluating the effectiveness of Intensive Case Management (ICM), Assertive Community treatment (ACT), Strengths-based (SB), Generalist Case Management (GCM), Brokered Case Management (BCM) and Clinical Case Management (CCM) and Critical Time Intervention (CTI) amongst homeless, substance abusing populations have shown that ACT is an effective programme where a large proportion of the population have mental illness. Strengths-based case management has mainly been used in mental health support, and has not been rigorously researched with its application to homeless groups. We should be careful not to apply a model just because it is widely used in the mental health field or taught in polytechnics if they do not have any evidence base. However combining it with another treatment model may be effective.

Some research also supports ICM as well as CTI and these two models are cost effective and are appropriate and realistic programmes to apply in the New Zealand context. CTI is most likely to be effective with young pregnant mothers, people waiting for admission to a residential addiction programme or people transitioning from jail back into the community.

ICM has been tested (although not as much as ACT) and has been shown to be effective at assisting homeless and substance abusing populations (Cox. G.B. Walker et al., 1998; Vanderplasschen et al., 2007). In the studies reviewed (n.5) it was shown to be an effective and cost effective method of case management with homeless people with substance abuse and other issues. It could be easily applied to a New Zealand context, easier than ACT, as it does not require 24 hour care, a shared case load, or a psychiatrist on the team. Combined with a strengths-based approach and a bicultural framework it could

⁴ See Appendix 1

work very well in New Zealand with women. However the focus on Housing First and the amount of positive research outcomes ACT and Housing First have shown makes it a strong player as well.

The available evidence of the effectiveness of these models is mixed and a decision as to which is most appropriate either in its existing form or after modification should be based on the expressed needs of the population of homeless women in New Zealand. It could be possible that several models will be required to meet diverse needs. After the analysis of the focus groups, these models will be analysed to determine which would best fit the needs of homeless women in Auckland.

3. Research Methodology

3.1. Underlying philosophy

My choice to use qualitative research was due to the desire to start to understand the structural causes of female homelessness in New Zealand through the explanations of the women themselves. I wanted to engage a group of women in the city I live in, Auckland, to answer the following questions: what caused you to become without permanent, safe and secure accommodation, how has homelessness affected your health and what could be done to secure you permanent and safe accommodation?

Though it is important to have information about the number of homeless and though quantitative data is often privileged, this was not a quantitative exercise of counting the number of homeless. The aim was to gather rich qualitative data by selective sampling techniques from a group of people who are experiencing the same issues and concerns and have shared the same identity and goals (Stewart, Shamdasani & Rook, 2007). I wanted rich data that went beyond 'surface explanations' (Stewart et al., 2007).

Qualitative research allows the reader to hear the voices of those who are:

'...silenced. othered and marginalized by the dominant social order, as the methods ask not "what is it?" but more importantly, "explain it to me – how why, what's the process, what's the significance?"'
(Hess-Biber & Levy, 2005)

I wanted to make the invisibility of this group visible. I wanted to let these women's voices be heard and make sure they were listened to. I wanted the research to be action orientated with that knowledge coming from the group who were most

knowledgeable about their situation, the homeless women themselves. I wanted to facilitate the women's social change, resistance and empowerment (Liamputton, 2007).

Embedded in the epistemology of this research was a feminist framework. A clear distinction made in feminist research is that women and their concerns are the focus of the investigation (Hess-Biber & Levy, 2005; Liamputton, 2007) The "problem" is not centralised. The methodology aimed at giving the participants a voice, an approach used in participatory action research (PAR) pioneered by Freiere in the 1970s (Freiere, 1970). PAR 'attempts to equalise the usual power relations between researcher and participants, facilitates conditions for empowerment and reciprocity, wrestles with representation and interpretation' (Maguire, 2006). This project has used a PAR approach rather than a full PAR. Under the conditions of the small size of the project and its short duration, engagement with the participants was limited.

3.2. Positionality

I am a gay woman, born in New Zealand of East European and English descent with Jewish ancestry. I have lived in Auckland and Wellington for most of my life but have travelled extensively through the United States, Australia and Asia where I have seen abject poverty and large populations of homeless people. When I was twelve years old and in San Francisco, I remember my father being tugged by a homeless woman as we made our way to a restaurant in China Town, I remember a huge sense of disbelief when my father shoved her off him, more concerned for his own (or possibly his family's) well-being than her desperation. Later that night in our comfortable hotel room, I struggled with the fact that there were so many homeless people in the same city as me who were not able to access the same resources which I, up until then, had taken for granted. So how can I represent these women's stories?

It was my attempt in this research to share some of my positional power and resources with these women so that they could have their voices heard, voices which are usually ignored.

3.3. Methods and research procedures – what, where, and how

The systematic literature review aimed to uncover what the literature said about the research questions and also extended into discussion on definitions of homelessness, causation of homelessness, and establish what is happening in New Zealand that is both helping and hindering women's housing options.

The focus groups comprised a sample of 22 women who had been homeless in the last 12 months. Participants were eligible if they identified as female (this included transgender women), were over 16 years of age and had been without permanent, safe or secure accommodation in the last twelve months. Five focus group interviews were run around Auckland. I wanted to gain information from a range of women accessing different types of services from Auckland City, North Shore, West Auckland and Manukau City. The following organisations recruited participants and hosted the focus groups.

- I. New Zealand Prostitute Collective (Auckland branch) who provide social workers and a union based collective for homeless street and brothel sex workers.
- II. The Salvation Army's Manukau Community Ministries who work with South Auckland boarding house residents and people sleeping on the street.
- III. Day Spring Trust: a residential service for women who are living with mental illness

IV. De Paul House: a refuge for women escaping domestic violence. The majority of the women at this service are from The Pacific Islands and the Middle East.

V. Methodist Mission Northern's Lifewise Programme: A day centre in Auckland's central business district which provides three meals a day and support for people living on the street.

The focus groups were 20-40 minutes long (the length was guided by the group members) and consisted of semi-structured interviews. A set of questions were asked by the interviewer across all five focus groups interviews however there was time and space left during the interviews to cover other issues that emerged. Literature has shown that using semi-structured interviews with homeless groups is successful and gathers rich data (Anderson, 2001; Taylor, 2007). In the focus group interviews, participants were asked:

1. What caused you to become without permanent, safe or secure housing?
2. How did (or does) being homeless affect your health?
3. In a questionnaire The Salvation Army has previously administered with homeless women, a lot of the respondents used the word 'safe'. What does the word safe mean to you?
4. What would help you secure and sustain permanent, safe and secure housing?
5. What do you think could be done to decrease female homelessness in New Zealand?

After the interviews, the research was transcribed and a thematic analysis was done. The transcriptions were read several times and the interview recordings listened to several more times. I checked the themes that I had established with the intern who had assisted me with the recording and had

taken back-up notes in the groups in case the recording equipment failed. The procedure of having a second person check the thematic analysis was designed to limit bias in my coding of the data (Al-Anasrallah et al., 2005). The next chapter discusses the findings of the focus groups.

4. Focus Group Results

*Now I must write for myself for this blind
woman scratching the pavement with her wand of thought
this slippered crone itching on icy streets
reaching into wire trashbaskets pulling out
what was thrown away and infinitely precious*
(Adrienne Rich 'Upper Broadway' (Golden, 1992))

4.1. Background

There were a total of 22 participants in the five focus groups conducted around Auckland. In the **Manukau City focus group**, four women attended. All were hungry when they arrived; three of the participants had also applied to The Salvation Army for food parcels that morning as they had no food or money. One of the participants had her 17-year-old and seven-month-old children in the car, so food from the focus group was also given to them.

The North Shore focus group was very diverse culturally with participants aged from 21-40. Participants were not forthcoming at first. It seemed that the number of women (eleven women turned up for the group) and the possibility that they did not know each other meant that they did not want to discuss matters that were prominent in other groups' discussions such as violence, doing criminal activities to survive and gang involvement.

Several women did not talk; this seemed to be either because of English being a second language and some possibly because of cultural barriers (especially from the Pacific Island women and the one Māori participant). One woman was taken out of the group for half an hour as she had decided not to take her children to school because it was raining and they didn't have umbrellas. The social workers went with her to drop her children to school in the agency's car.

The West Auckland focus group was attended by two women who were living together in supported housing. They were not getting along and this was obvious in the way they related in the group. Their stress had increased as they had just been given four weeks notice to vacate their house.

The first **central Auckland focus group** was attended by two women; they were both regulars at Methodist Mission's Lifewise Services and were friends. One participant brought her 5-month-old baby to the group and was a strong advocate for homeless women in Auckland, even though she didn't think things were going to improve for homeless women in New Zealand. The second participant was quieter and had to be encouraged to speak. Both women had difficulty understanding the interviewer's questions; therefore, questions were simplified and repeated several times. This issue could have been cultural or due to both women having a history of solvent abuse. However, both parties were persistent at working to bridge the gap between us.

The researcher met with three women at the Auckland branch of the New Zealand Prostitutes Collective in **central Auckland**. The women were all half-an-hour early and were eager to participate. Once the group started, it became obvious that all of the participants were sleep deprived and coming down from methamphetamine. As the researcher started to introduce herself and then explain the research procedures, there were interjects from them asking how long the interviews were going to take, and two of the participants tried to start telling their story of how they became homeless before the interview was officially started. It became obvious that the participants had short concentration spans and due to being sleep deprived, hungry and coming down were unable to concentrate. For these reasons, the participants were encouraged to eat and additional

time was spent getting to know one another before the interview started.

What was observed from this small sample of street sex workers was the chaos in their lives, and how their unstable living situations and their addiction issues caused them to present as disorganised and chaotic. Their hyper-vigilance and lack of ability to concentrate made the interview difficult but provided important evidence of what their lives (and what the lives of others in this category) were like and why they presented as disorganised and chaotic.

The dynamics of having two transgender women of different ages in the group was also interesting. The younger transgender woman tried to ask the older transgender woman if what she had said was correct, almost deferring to her as her 'elder'. She was seen as a role model to the younger transgender woman. The older transgender woman participated minimally as she stated that she had too much anger at the system to talk without getting upset.

The women all demonstrated moments where their stories came through clearly, but what quickly followed was chaotic rants and angry outbursts. What follows is the essence of what the women said through their stories and descriptions of the lives.

Names have been changed to pseudonyms, appendix 2 contains a table of the participants' ethnicities, ages, number of children and current living situation.

4.2. Focus group demographics

Five focus groups were held across the Auckland region involving 22 women. Participants ranged from 21 to 50 years of age. Twenty of the 22 participants had children although often

the children were not presently in their custody. None of the women were living on the street, seven were living in supported accommodation and one third were now living in Housing New Zealand houses but had been without permanent, safe or secure accommodation in the last 12 months. Just over one third (n=8) were Māori and six of the participants were Pacific people. Two participants were transgender women (male to female).

4.3. Causes of homelessness

In the focus groups, it was found that women were without permanent, safe and secure accommodation due to escaping abuse either from a partner or parent, addictions, overcrowding and discrimination. Many participants also attributed their housing difficulty to Housing New Zealand not providing suitable homes in safe areas, that were also warm and dry.

4.3.1. Escaping abuse at home

One of the most common themes in focus groups was that women became homeless due to escaping abuse. Maggie had moved to Auckland three weeks before with her children in an effort to get away from a violent ex-partner and to start afresh in a new city. She found a place to rent and paid the bond. However, the day after, the landlord refused to give them the house or refund the bond (they found out later he was a methamphetamine addict). With all of her money gone, they resorted to sleeping in their car and at friends' houses. They came to The Salvation Army, which helped them get a bond from Work and Income. Maggie has now moved into a private three-bedroom house along with her four children; she is also housing two other people who had nowhere to live. One of these girls was a 25-year-old Cook Island Māori woman, Mera. To escape her father, Mera moved to live with family in another city. This did not work out, so she left her job and returned to

Auckland. She was on a 13-week standdown from Work and Income and had no money.

4.3.2. Addictions as a cause of homelessness

Another issue discussed in four of the focus groups was addictions. Dallas is a 37-year-old Māori woman, and a recovering addict. She attributed her homelessness to her issues with drug and alcohol addiction and her anger problems. She had been on and off the streets since she was eighteen, and was currently living in supportive accommodation. Due to her years of drug and alcohol abuse and battling with her weight, she now had serious health issues that meant that she could not work. She had limited money due to court fines and was struggling to find accommodation due to running up debt with landlords in the past. She was unable to live with her family as she has a trespass order against her due to past incidents of violence when she was drunk. Currently, she was mowing her parents' lawns as a way to see her children and win some trust back from them. She did not know where she was going to be able to go once she had to leave the supported accommodation she was currently living in.

'That's what alcoholism and drugs do to you, makes you homeless, makes you lose your family, it stuffs up your whole life. I'm in AA now, doing counselling, its hard, it really is, you know, one of the ladies who previously lived here was a marijuana user, I really struggled with that, cos if you sit on the barber's seat, you're eventually going to get a haircut. And if you go into bars you're finally going to drink.' (Dallas)

Marama had a different story to tell:

'I just try and provide for my kids ... my situation now, at the moment I'm in a tinny shop, pumping weed out the door, just to get my kids some presents. I'm in the tinny shop a) cos I have no roof over my head; there I have a roof over my head 24 hours. b) it's got money coming in like nothing and I can just feed that to my kids. I also have addictions that I am working on that The Salvation Army is helping me with. I'm on stage one at the moment. The only reason why I am

with my parents now is that's my bail conditions, to get out of jail, which really is the key to getting out. Because you can only go inside for so long and handle it, you just want to get out of there really. But otherwise that is my last resort to getting a roof over my head is going to prison.' (Marama)

Poe said that even though her family were close and supportive of her, she could not be herself or be 'camp' around them. She comes and stays on the street because as a young transgender person that's where her community is. She saw them as her community and therefore wanted to spend time with them. However, she stated that to survive on the street and get through the night: *'You need drugs for your energy'* (Poe).

Two participants said they were wanting to go into rehab. One feared losing her house if she did so:

'It took me so long to get this house, I don't want to chuck it in and give it to someone who doesn't deserve it.' (Mandy)

4.3.3. Overcrowding leading to homelessness

Two participants talked about overcrowding being a causal factor in having to find new accommodation because the stress of staying with friends or family was not a permanent option and also because living in overcrowded situations lead to their mental health declining.

4.3.4. Discrimination leading to unstable accommodation

Discrimination came into several subcategories; First, women felt discriminated against by Housing New Zealand; secondly, for being on the Domestic Purposes Benefit; thirdly, because of being a woman on her own; and lastly, because of being transgender.

Women felt discriminated against by Housing New Zealand because they were of the wrong ethnic group. Two participants

talked about their resentment towards people from other countries being given priority to Housing New Zealand houses:

'And Housing New Zealand doesn't really help because ... they support cultures from out of New Zealand.' (Mandy)

The women were also aware that there was a priority system at Housing New Zealand that meant that they were not deemed as in need as other people:

'I'm not sure now they analyse us out ... they give us a questionnaire, we fill it in (you know) and they got certain people that qualify and most of us dumb ones don't meet the criteria because we don't even know how to answer the questions that most of them have got.' (Marama)

Women on their own and women on the Domestic Purposes Benefit felt discriminated against by landlords. The women also talked about the difficulties they had without a male partner in the rental market. One participant was told by a landlord he was looking for a 'professional working couple'. Her response was:

'Just because I am not out working eight hours a day, do they think I am going to make more wear on their carpets?' (Delisha)

One participant noticed that when she went looking for rental accommodation with her part-Japanese male partner she had been more successful, she had put this down to landlords favouring Asian tenants and couples. One transgender participant also had noticed that it was easier for her to get a private rental when she was with a male partner.

4.4. Homelessness and health

When asked how their health was affected by homelessness, the women said they were affected by foot problems, respiratory issues and stress due to caring for sick children. Their health in general was poor. As soon as women secured

accommodation, their health and the health of their children improved.

4.4.1. The effect on physical health:

The physical health concerns identified by women who lived on the street revolved around the worry of losing too much weight from methamphetamine use as well as foot health. Poe, a 21-year-transgender woman discussed losing weight as a health issue for her. Due to her drug use and her unstable living situation she worried about her light weight, this caused her pain when she was sitting on hard surfaces and she noticed the cold more. Poe described her feet and body hurting from the clothes she wore as a transgender sex worker. Another homeless woman in the central city discussed the blisters on her feet from being up for five days in a row. Interestingly women were concerned about the state of their feet as their feet were their form of transport.

The key issue for women with children was that their children were sick when they were not in safe or secure housing. This led to them constantly going to the doctor due to respiratory issues. It also meant the women had to spend more time caring for sick children, which made them unavailable and unreliable to employers.

'Well, it made my partner sick at times. We got sick quite often, when we moved houses we didn't get sick as much.' (Debbie)

'In winter, it's like really cold, and mouldy ... I rang up the 0800 number but they don't act on it as fast as they could ... My result of that, is that my son has got asthma now and none of us or my husband's family have a history of asthma. I think I've been to the doctor's more than twenty times and it's always like every week or every fortnight ...' (Dai)

Two participants stated that they had been to the doctor more than twenty times in the past 12 months due to children's health issues caused by living in cold, damp houses. There was

considerable stress caused by having to stay home to look after kids. These illnesses were often due to unhealthy homes.

4.4.2. The effect on mental and emotional health

Participants found it hard to commit to training courses and jobs due to sick children. One solo mother commented that:

'It's hard to commit to things because you don't know when your kids will have to stay home or you'll be sick.' (Dela)

The stress caused by sickness affected the women's mental and emotional health; however, other aspects of the homeless life also affected them. Participants discussed the significant emotional and psychological stress of not knowing where they were going to sleep or how they were going to feed their children. Once they were in permanent housing they noticed that they felt significantly less stressed and happier. For one participant (Maggie) it meant that her youngest child's illness came right as soon as they got a private rental.

Women also talked about feeling bad about oneself and how this affected them:

'When you are homeless you feel like you're less than other people, it's embarrassing too, it's a pride thing.' (Mandy)

'I've felt devastated in here, crying in the mornings, when I was told we could stay in a motel for the night, I was so excited about having a shower. It's heartbreaking man, to not know where your kids are sleeping that night. Driving around with all your bags, we were lucky my daughter had a car ... it's worse than coming down off drugs mentally. Like the mental abuse of not knowing where you are going to stay and trying to explain to your kids. And then waking up in the morning, hungry, and not knowing where they are. Not being able to cook a feed because you are sleeping in a car, sitting in the park in the car sharing a dollar chips between eight of us' (Maggie)

When asked whether their health issues caused them stress, the sense of feeling powerless and helpless in the housing rental environment was reiterated by the women. This feeling of powerlessness and helplessness caused the women significant stress. If something needed fixing in the house, both Housing New Zealand and private landlords were slow to respond. This meant that their properties remained substandard, unsafe and unhealthy. Examples given were of spouting being left unfixed, holes in floors and decks being left, handrails on balconies being unsafe and fences being left unfixed or properties being inadequately fitted out for children to play safely in.

The women's sense of powerlessness due to lack of confidence could actually cause mental and emotional health issues. Self esteem was identified as a theme that affected women's emotional and mental health. Being a transgender street sex worker, Poe talked about the things she had to do to get money for her drug habit as making her feel like an animal and described her group of friends on the street as 'a pack of animals'. Yet, coupled with this, was the self esteem and sense of community she got from her transgender community on the street:

'It feels like we are a pack of animals ... does that make sense? I'm just telling it from the heart because when money is involved, it's like attention, we get a lot of attention...well its not the attention, we don't want it, it just comes, but I don't need attention, money is a real ... plays the main part.'

Poe talked about feeling depressed due to being on the street.

Daphne was a 50-year-old Pakeha woman who had spent her early years in England. She did not have happy childhood memories and briefly inferred that her father had been an abusive character who put her down and bullied her and that her mother had ignored her. In adult life Daphne perpetuated these types of relationships. She was married to a gambler who

was physically abusive for 14 years. After this relationship ended Daphne found it difficult to secure permanent accommodation and also suffered from epilepsy, which she attributes to a 'pressure valve' being released after the relationship ended. She lived in boarding houses and flats but frequently moved due to fearing for her safety. The lack of locks, privacy and physical security in boarding houses and supportive accommodation exacerbated her mental health issues. Daphne described being 'paranoid' that people were moving her belongings in her room, but felt powerless to do anything due to fearing other residents. Hence, she became withdrawn and depressed. Daphne's current situation was less than ideal, she was living with one other woman who has a history of being abusive and became angry at Daphne, who was scared to leave her room and had had numerous things stolen. Daphne felt powerless to look for new accommodation and said that she really wanted somebody to help her look for a new place to live, preferably a one-bedroom flat.

4.4.3. Family and whanau health

Due to unstable living situations participants discussed it being hard to get their kids to school. One participant discussed wanting to keep up with classes at De Paul House but couldn't because of her children.

To deal with loneliness, the women looked for support from other women. Marama had friends who were prostitutes and who ran an informal halfway house for street kids. She also went there for support and company. One participant who was living in a four-bedroom home was alone as her father and partner were in jail. She felt so lonely that she said she would rather be in jail. To get support she went to a friend's house every day for company. For homeless transgender women, support from the transgender community was especially important.

4.5. Safety

The following constituted safety for the women: secure housing, male protection, support from other women, safe neighbourhoods, support from Housing New Zealand, violence-free homes, and drug and alcohol-free spaces.

4.5.1. Secure houses

The women reiterated their sense that having locks on doors was very important for their sense of safety. It was also mentioned that fences and gates (to keep children in and dangerous people out) was important. Fences were also identified as a means to keep dogs and street racers out.

4.5.2. Male protection

Having a man to protect from them other men was also a theme. For the participants in Manukau, this meant gang members looking after them while their partners were in jail. For the central Auckland group of sex workers this meant having a man living with them.

Women who had lived on the street felt that there was no safety there for women:

'When you're homeless, there is nothing safe, you get raped ... anything, use your imagination.' (Poe)

'They can get raped anytime out here.' (Lucky)

This was quite different for women who were housed as they were more easily able to control their environments than women on the street. Women on their own followed the rule of only letting their friends come over, keeping their boundaries with men and not letting men into the house if they were alone.

'Men don't come in my house if my partner's in jail because if I let them in the door and something happens - I let them in' (Mandy)

Solo mothers were also more cautious of the type of people coming over; the group of women in Manukau described this as putting themselves before their children. When women were living alone, they became hyper-vigilant about their safety:

'Only people I invite come over. But that's like an unwritten rule between your mates and your family. They shouldn't give your number and your address out to people unless they ask you first. Someone asks me for her phone number, I say nah, I can text her and tell her you want to get hold of her but I can't give her number out. Just for her own safety.'
(Mandy)

4.5.3. Support from other women

To ensure their safety, some women lived with a group of women to provide what they called 'back up'. This enabled them to look after one another:

'We had an electrician come over, and he liked my mate here, and he said 'can I come back tonight and pump you?'... because it's a whole lot of women in one house.' (Maggie)

'She was stuck at the door with the Sky TV guy too, and he just kept trying to sell to her. I just walked in 'nah mate she can't afford anything. See ya'. He was just trying to sell to her, and holding the baby, she was all nervous and flustered And then when we turned up she was like 'Nah, fuck off.' It was like when we turned up she could stick up for herself..'
(Mandy)

4.5.4. Safe neighbourhoods

Women also talked about the type of neighbourhood they lived in being an important aspect of their safety. Several Pakeha women from Manukau and the North Shore said that it was important for them to feel safe from racist attacks:

'I find racism hard in South Auckland as a white person...' (Mandy)

Solo mothers said they needed to feel safe in their neighbourhood. This included not feeling unsafe due to street racers on their street and being safe from crime.

4.5.5. Support from Housing New Zealand

The group of solo mothers who had recently acquired Housing New Zealand houses talked about the importance of having assistance when their house was broken into. Delisha told how the police never showed up to take fingerprints from her house after it was broken into and said Housing New Zealand took six months to change the lock on the door that was smashed in the burglary. This meant that for six months her family lived in the living room of their house with boxes and furniture against the door for security. Mothers with children also talked about the importance of having landlords who maintained properties. Two women stated how it was important for Housing New Zealand to keep railings secured and decks free of rot.

4.5.6. Domestic violence-free homes

Many of the women had been victims of domestic violence and so for them it was important that they lived in an environment free of abuse:

'Not being hurt, not being threatened to be hurt, feeling comfortable, just feeling you know sort of like you're in an environment where I feel ... ok about myself and my stuff around me.' (Daphne)

Women talked about the importance of not being afraid in their home. One refugee who had been a victim of violent attacks by members of her community needed to know she would feel safe to go outside her house.

4.5.7. Drug and alcohol-free spaces

For women trying to recover from drug and alcohol addictions it was important that drug associates did not come over:

'This will be the first time I'll be in a house without alcohol and drugs; it's major, I'm scared shitless, I really am. Cos all of the other times I'd bottle it up with drugs and alcohol.' (Dallas)

4.6. Solutions

The women thought that affordable housing, jobs, being taken seriously by government agencies, addiction treatment and not being discriminated against would help them secure and sustain permanent safe and secure accommodation.

4.6.1. Affordable housing

Women discussed whether their housing situations would be more stable if they were able to afford permanent safe and secure accommodation. Delisha said that many private rentals seek families who are working and discriminate against families that are receiving income support. She also discussed how having more income would mean a better standard of housing for her and her children. Two women on the sickness benefit due to mental illness were both finding it hard to get a bond together that would enable them to live independently.

'I wish I could get a job even in a tinny house to get some money.' (Maggie)

4.6.2. Jobs

Participants talked about the difficulty of getting a job with criminal convictions:

'They give you two lines to write about your convictions and I am laughing and saying 'Can I have another page please?!' Nobody will even hire me to work in a bar clearing glasses away because they don't trust me.' (Mandy)

Several participants identified that because they did not have qualifications it was difficult to get a job:

'Getting a job, that's all very well if you have passed school and got all of the papers, but for myself I didn't have a very good upbringing.' (Marama)

4.6.3. Being taken seriously

Participants said that they wanted to be taken seriously by Housing New Zealand and Work and Income when they went in asking for assistance:

'If we're in pleading for \$50 it's because we need it.'
(Mandy)

Dai felt that women were not taken seriously when they went to Housing New Zealand. In addition three other women said that they felt they were not taken seriously because they were poor. They believed that not having enough money to afford their own home and having a low income determined the quality of the house they could afford and they felt this wasn't fair. Four out of the five focus groups discussed Housing New Zealand waitlists as being a serious barrier to them gaining permanent and affordable housing.

'You don't realise your rights.' (Love)

4.6.4. Addiction treatment

Women with addiction issues stated that they would need to get their addictions under control if they were to secure and sustain permanent accommodation. One woman with a history of addictions and mental health issues identified that if she could get her addictions under control, she would be able to get back on the horticulture course she had previously attended, which would lead to a job and income to be able to afford permanent accommodation.

4.6.5. Discrimination

The transgender participants felt they were discriminated against because of their gender identity when looking for private rental accommodation. They wanted this discrimination to be eliminated.

The homeless women interviewed at NZPC seemed to have lost hope of the possibility of securing and sustaining safe accommodation.

4.7. How homelessness could be decreased in New Zealand

Focus group participants thought that homelessness in New Zealand could be decreased by housing affordability being addressed, women having more options for education which would help them in the job market, support and assistance and advocacy services.

'I feel like I have brought that baggage with me, like I haven't resolved it. I haven't been able to struggle back and get my own sense of power, my own sense of value, my own sense of space and everything. I feel the only way I think I can do that is by living on my own, you know. At the moment, I have had to take what I can, when I can. It's not really the ideal or anything like that, it's just picking up whatever I can do, whatever. If I got my own flat I would feel better about myself. I am sure I would, I would feel a lot more secure and safe and for me it would be a long term thing, I feel as though I would be able to get my shit together.' (Daphne)

4.7.1. Affordability

Affordability was the most common theme for women. Women could not afford market rents and due to Housing New Zealand waitlists being very long, they were not able to get an affordable place to rent. For women with children and women with mental illnesses this was especially difficult. Dallas, a woman in her 30s with mental health and addiction issues said: *'I want to find my own house, but the finance, the bond is hard to get'*. Dallas also talked about landlords' unreasonable expectations, and problems with getting bonds back.

Women who had been street homeless were often depending on a relationship with a man to keep them 'indoors'. Lucky, who

was currently depending on a new relationship with a man for her accommodation, wanted her own place so she was not dependent on that relationship.

4.7.2. Education

Women with children saw that the cycle of homelessness could be broken by educating children about their choices, and parents about parenting and good relationships (Dallas). Mothers with young children thought courses for mothers to help them gain skills held at times that suited mothers would be beneficial because qualifications were essential (Delisha). Other women thought that job and training combined would be useful, so that the possibility of being trained for a job you won't get was reduced.

Mothers also saw education as important as they felt that their children would look up to them and feel like they could achieve something with their lives:

'You want your children to look up to you.' (Dai)

Two women with mental illness said work and training was important for them to gain permanent employment and get the income to be able to secure permanent accommodation. Dallas, for example, talked about getting back into a horticulture and landscaping course (which also provided paid work) as a way of getting income for permanent accommodation.

4.7.3. Support and assistance

Those women currently in supported accommodation wanted to be listened to and also wanted support services to be more open to their needs.

Two groups mentioned that often women don't want to ask for help due to their pride. However, they also reported that when they did ask they were often not listened to:

'Ask women if they need help. Their pride is too big.'
(Mandy)

Women also mentioned that they thought there was ignorance in the community about how to get help if women were being abused:

'A lot of women have to suffer a lot of abuse and trauma because they don't know how to get out; they haven't got that support. They've only been brought up with that sort of thing so they don't know anything else. So that is part of the problem, ignorance in the community about how do I reach out for help. How do I get my needs met? How do I get support for myself?' (Daphne)

Women wanted information about agencies they could go to. They said that these agencies were not advertised very well. These agencies could provide support and assistance in the process of getting a house and assistance with getting to potential rental properties without a car.

'People listening to women, encouraging them. Having people speak up for you. "Hey women out there who are homeless, we're here for you, we're going to help you, what do you need"' (Dallas)

One participant felt that there needed to be culturally-specific Māori services. Daphne said that there needed to be solutions found within the community so that Māori communities help Māori and so that people come together to find solutions and cultural support:

'People within the Māori community to say not what is the problem but what is the solution?' (Daphne)

4.7.4. Advocacy services

Both participants in the West Auckland group discussed the importance of having an advocate. Daphne wanted somebody who would say for her:

'This person is alright - she should be able to go somewhere, or do something or whatever. Why not help her out? She's got a voice.' (Daphne)

Dallas discussed similar ideas:

'Listen to women; be more open to what they want to say and what their needs are. I would love to grow up and be an advocate for women because I have been there. I know what's happened and just to say to people keep sticking at it, keep going back to the organisations and say "Hey, I need this house, you're meant to be there to help me." Cos some people go there once or twice and then go "Oh, I'm not going back, they're not going to help me" and give up. And they do. I've done it, my mates have done it. It's about people listening to women, encouraging them. There needs to be strong women out there to say, "Hey, these women need help, what can we actually do as a community to help them?"' (Dallas)

4.7.5. The need for more accommodation in the form of emergency, transitional and community housing

Women who were currently in supportive accommodation with their children felt there needed to be more emergency accommodation for women. They had found women's refuges often full, so it was hard to get in when they really needed accommodation.

Dai spoke about needing more services like De Paul House to be available. As there was currently a waiting list at De Paul House, it meant that women had to continue to live in unsafe and undesirable places while they waited for a space.

Another participant discussed the idea of community housing for women where a range of women with different needs could be housed, whether they had children or not (Dallas).

4.7.6. One-stop shops

Women in Manukau city thought the one-stop shop model was a good option. Their experience of accessing The Salvation Army's Manukau Community Ministry was that it was very convenient to be able to access multiple services at one site. However, they discussed one-stop shops only helping the people who know about the service, so advertising services was considered very important.

4.7.7. Coordination between services

The participants suggested that one way to advertise services would be for services to coordinate more effectively. An example of the lack of coordination was that Dallas called 40 different services before being told about the service that is currently providing her with emergency accommodation.

4.7.8. Work and Income

Manukau and North Shore participants stressed that Work and Income needed to be more consistent in their approach to women's housing needs. Their main concerns were for Work and Income staff to stick to the same policy and for case workers to be helpful all of the time. Women also wanted clear and consistent information from Work and Income about what they were entitled to and grants they were eligible for.

There was also an issue with Work and Income case workers not being willing to give them a letter for food banks. This was a barrier to their access to Salvation Army food banks.

4.7.9. Housing New Zealand waitlists

Women suggested three ideas to decrease Housing New Zealand waitlists. Firstly, to move people on who don't need Housing New Zealand houses anymore. Dallas felt that this would make way for people who do need a house. Secondly, it

was suggested by the two West Auckland participants that other agencies needed to get involved in housing assistance again.

Housing New Zealand rent-to-buy schemes were also popular. One participant suggested bringing back the scheme that after five years, tenants could use the rent they paid as a deposit on their house.

'Since 16 I would have bought a house with the rent and bond I've paid.' (Maggie)

4.7.10. Addiction treatment

It was noted that support was also important for recovery and being able to work through previous issues. *'Getting right in myself - to get help.'* (Dallas)

However, the street homeless women pointed out that the street is an option if something goes wrong at home (for example, if you break up with partner or you spend your money on drugs or alcohol).

4.7.11. Decreased violence from men

Several women talked about the need to decrease violence from men:

'Some of it is like strong arm tactics, the male versus the female dominance. Males have the power because he is physically superior to the female and therefore his word is law. Whereas if the female tries to assert her power, she pretty much is pinned away with much physical force so that she has no individual power within herself to fight back and regain her own power inside herself. I don't think it is a fair balance and I don't think it will be fair for a long time.' (Daphne)

The sex workers interviewed also reiterated that men were sometimes the cause of homelessness and that this needed to be addressed but they did not explain how it could be (Poe).

4.7.12. Empowerment

There was a feeling in the groups of primary homeless women of total disempowerment; none of the participants could think of anything that could be done to change their own or other women's housing situations.

'I'm not going to talk about it anymore, I'm very angry and pissed off, cos that's their stuff but this is our stuff .. I think the government does a shoddy shitty job and they don't look after their people ... I lived in Sydney and I saw my whole backyard being cleared up. I came over here for myself this time, but I see what goes on, we help each other. The only thing that we do, the only thing that happens here is the girls help each other, we don't get help from nobody ... I don't think they would even bother [to help]. They put us on the backburner, they couldn't give a fuck. No more no less. ' (Pam)

However, for women in supportive accommodation there was a sense of hope and a sense that women could protect themselves, know their rights and start to empower themselves.

Of this Daphne said:

'Women need to be helped to find the power and Mana within themselves and feel empowered. They need help to respect themselves which is hard with teenage pregnancy, images from the media and how much women have been degraded in society. (Daphne)'

It is here that difference between primary and tertiary homeless women can be graphically seen. Women are not often in situations of primary homelessness. Women are more likely to be found trapped in situations of domestic violence, subject to abuse and often unable to leave because they have children to care for. This was discussed in the background section in the review of the literature and now will be discussed in the following chapter on the implications for services and policy.

5. Implications and recommendations for services and policy

5.1. Literature and findings

A recurring theme in the research was the health and security of Housing New Zealand houses. Women wanted safe and secure housing with locks, fences and gates. They also wanted to be in houses that were warm, dry and free of mould as they noticed adverse health effects from cold, damp and mouldy Housing New Zealand houses. As Housing New Zealand is the biggest landlord in New Zealand, it is important that they set higher standards.

5.1.1. Convergence of focus group findings and literature

Focus groups confirmed the finding that homelessness for women involves a process of marginalisation and tends to be a hidden problem. This research indicates that participants had on the whole not lived on the street in the past 12 months but in situations of secondary homelessness. This is consistent with the literature on women and homelessness (Baxter, 1996; Daly, 1996; Hager, 2007; B. Russell, 1991; Watson & Austerbury, 1986).

Housing affordability and income sufficiency were also found to be a congruent theme in both empirical data and the literature (Austerberry & Watson, 1983; Fitzpatrick et al., 2000; Glasser, 1994; Laurenson, 2005) and empirical work. As a result the lack of affordable housing was a significant theme in the research. Respondents discussed Housing New Zealand being difficult to access due to long waitlists and the lack of affordable rental accommodation that was safe and secure. Respondents also discussed needing higher incomes to be able to secure and sustain safe and healthy housing. A further theme which emerged from this research was the problem that many respondents had with bonds. These problems arose for two reasons. Firstly, due to low incomes many were not able to

afford bonds. Secondly, it was difficult to get bonds back from landlords in order for them to be used for the next house or flat.

A recurring theme in the focus group data was that access to Housing New Zealand houses was difficult due to 'redtape', waitlists were long and single women often found that Housing New Zealand was not responsive to their housing problems. This was often due to women with children being prioritised by Housing New Zealand. The literature also discussed that a lack of state housing could lead to homelessness for women and that state housing was essential in preventing homelessness (Coleman & Watson, 1987; Fitzpatrick et al., 2000; Glasser, 1994; Hager, 2007).

The main types of discrimination women saw as a barrier to securing and sustaining accommodation was the presence or absence of children and being without a partner. Although very few women presented without children, the women did discuss the difficulties of getting emergency accommodation without children. It seems that on the private rental market having children may be a barrier but with Housing New Zealand or housing assistance services women not having children may be a barrier. This has been an ongoing issue for women for decades. The literature review completed in this study found record of other samples of women experiencing homelessness due to this type of discrimination over the last three decades (Austerberry & Watson, 1983; Coleman & Watson, 1987; Fitzpatrick et al., 2000; Wright & Tompkins, 2006).

Addictions as part of homeless life was a theme in the focus groups as well in the literature (Burt & Cohen, 1989; C. Chamberlain et al., 2007; Cramer & Carter, 2002; Ralston, 1996; Rousseau, 1981). In the focus groups, addictions were found to be a barrier for participants gaining permanent, safe and secure housing. This was either due to their addiction or

being affected by a family member's addiction. Focus group participants were very realistic about the impact addictions had on their housing problems. This issue raises the question whether there are enough addiction treatment programmes in New Zealand to cater for these women or whether, as literature suggests, addiction issues can be precipitated by bad housing situations (C. Chamberlain et al., 2007).

5.1.2. Emergent themes from the empirical data

New themes that emerged from this study were that the women were adamant that they wanted support, assistance and advocacy to assist them to gain housing. The fact that women wanted advocacy and support can be seen to be tied in with the discrimination they often faced. The majority of women wanted family or people they knew to support them. However they also wanted assistance from agencies.

Women were not interested in emergency or supportive accommodation (unless they were already in such accommodation). A Housing First theme was reiterated by the women in that they wanted their housing needs addressed first and then wrap around support.

The houses available being cold, damp and in unsafe neighbourhoods was also a new theme. Thus the issue of healthy housing was important for these women. This is a specific issue for New Zealand. The combination of a temperate climate and damp houses intended for lower income people and the build techniques used in the last 40 years, has meant that poorly resourced people have borne the brunt of the effects of cold damp houses (Bierre, Howden-Chapman, Signal & Cunningham, 2007).

5.1.3. Importance of emergency accommodation as a transition to permanent accommodation

This study has shown that the women wanted permanent accommodation as well as emergency accommodation. Only the women currently in transitional accommodation suggested emergency accommodation as an option.

An important implication of this research is the importance of getting women housed before they become totally disempowered. A process of marginalisation was observed in the literature (C. Chamberlain et al., 2007) as well as in the focus group findings that the longer women are homeless, the less likely they are to secure and sustain permanent accommodation.

5.1.4. Dependency, empowerment and advocacy

Another important implication from this study is that services must be mindful that they are empowering women to make decisions for themselves and not encouraging service users to become dependent on their support and assistance.

Discrimination and the associated feelings of powerlessness were identified in this study. While the causes of discrimination are deeply rooted in our society and so not easily addressed directly, it is possible to address the practice and the consequences of discrimination through greater efforts at advocacy and empowerment. This will be discussed in more depth in the following section.

5.2. Outstanding research questions

The number of women over 45 who participated in this research was low. There is no New Zealand evidence available to suggest that this group of women is without significant housing problems. Overseas there have been studies specifically on older women's housing positions though these have not been

done recently (Coleman & Watson, 1987; Rousseau, 1981). Research targeted at women over the age of 45 may be needed to investigate the specific needs of older women in New Zealand. This is especially so as there is a large number of women who will soon be reaching retirement who may be vulnerable to primary homelessness (Sharam, 2008).

5.3. Recommendations

The data collected provides a framework for considering policy responses to the needs identified above. This framework links the causes of homelessness with the barriers to securing accommodation and appropriate responses to these. The table below presents the framework. This table is based on the experiences of the respondents and literature reviewed on homelessness.

Causes of homelessness	Barriers to securing and sustaining accommodation	Potential policy responses
Domestic violence and relationship break up	Inadequate provision of refuges Women without children are excluded from refuges	More emergency and supported accommodation for single women and women with children
Housing is unaffordable	Lack of affordable housing options. Housing New Zealand waiting list. Debt.	Additions to the stock of affordable housing More Housing New Zealand stock to cater for single people
Available housing options are not safe or healthy	Lack of safe and secure housing options	More social housing stock to cater for single women and solo mothers. Improve Housing New Zealand housing stock so it is warm, dry and energy efficient
Prejudice and lack of information	Discrimination based on ethnicity, relationship status, gender, age and employment status	Support and advocacy for women seeking accommodation by housing support workers
Overcrowding	Lack of family support Lack of affordable housing options	Additions to the stock of affordable housing
Addictions	Addiction problems Lack of supported accommodation and 'wet housing'	Additional emergency and supported accommodation including the provision of 'wet housing'
Insufficient income	Not being able to afford bond Not having a job Debt	Bond bank run by non governmental organisations or a government agency

The following recommendations for policy and service provision were identified:

5.3.1. Policy changes

1. Agencies providing accommodation to ensure that accommodation for single women is equitable to that of men.
2. Encourage the availability of single occupancy housing for women on their own in the private and public rental sectors.
3. Housing New Zealand housing stock to reach standards of warmth, energy efficiency and dryness.
4. Add to the Housing New Zealand stock of affordable housing.

5.3.2. Service provision

1. Bond bank run by non governmental organisations or a government agency
2. Services providing social housing to cater for single women and solo mothers.
3. Support and advocacy for women seeking accommodation by housing support workers.

5.3.3. Priority recommendation

The Housing First model emerged as a synthesis of the policy and service responses identified by this study. It is striking how this model meets the needs and recommendations that emerged from this research. Housing First is consistent with the implications identified above, supported by the voices of the women interviewed and by the literature on what would be effective in Auckland (Gravitas, 2005).

Housing First has been chosen as it would be able to meet the needs of women not in permanent, safe or secure accommodation in New Zealand. It is appropriate because this

research has shown that women want their own homes, not emergency or transitional accommodation. Research participants mentioned the need for emergency or transitional accommodation only if they were already in such a service. Housing First is also fitting because the participants wanted support and advocacy services to assist them to find housing. This support and advocacy feature is where a Housing First model is particularly beneficial.

The majority of participants wanted homes and did not suggest that more emergency or transitional accommodation was required. This leads into an interesting dilemma for service providers of whether they should focus on emergency or permanent accommodation, or both. It also opens up options of new service models such as the Housing First approach where homeless people are first housed and then provided with intensive support. Given that resources will never be sufficient to meet all housing needs immediately, some form of emergency or transitional housing is required. Emphasis however should be put on a Housing First model.

The North Shore women benefited from having a transitional time in De Paul House (approximately six months) where they could wait for an appropriate house to become available from either Housing New Zealand or on the private rental market. They had support from social work staff when talking with Work and Income and Housing New Zealand during and after their stay, and we can see that this led to positive outcomes. What was noticed however was the dependency the women had formed on the transitional house and their reluctance to advocate for themselves. If these women were placed directly into an independent house and were provided with intensive support for a six month period, their dependency on the agency would be lessened.

Women need strong advocacy skills and support to help them overcome the barriers they face gaining permanent safe and secure accommodation. Ideally advocacy should be empowering but this is often difficult to achieve in situations where those requiring the advocacy have an immediate and perhaps acute need and may be in a position of crisis. It is often easy in such circumstances to move into brokered case management where the central relationship is between the case manager and the provider of the service being sought and not between the person needing assistance and the service provider. Providing more structured and deliberate support to homeless women would be a worthwhile policy response and has been shown to be effective when the model of Housing First has been implemented (Padget et al., 2006).

Women experiencing homelessness or housing problems are quite likely to approach a community agency such as those through which this research was done. This relationship suggests that these agencies are best placed to provide the necessary advocacy and support if they are resourced to do so. The work of these agencies requires coordination between social services, both government and nongovernmental organisations. A wrap around service would mean that women vulnerable to homelessness do not slip through the cracks. Such a service could be provided within a Housing First model. This could be achieved by having case managers who specialise in housing assistance placed in existing services who can provide support and assistance for women seeking accommodation. They could help women to go and see the potential rental properties and be at appointments with landlords, coordinate mental health and addiction services and support and assist clients to sustain their accommodation. The Housing First model could also coordinate with other services when necessary. If the client needed to go to a residential

addiction programme they could help with keeping the house while the women was in treatment.

A Housing First model has many features that are likely to be effective with this population in that it takes into account the high and complex needs of homeless populations. It includes the requirement of an alcohol or other drug detoxification programme at the beginning if required, liaison with a nurse (or nurse practitioner), supports participants to go into residential addiction treatment if required, and provides money management training.

The key component Housing First would need for it to be effective in New Zealand would be housing stock, access to a bond bank and for an agency (or agencies) to adopt the model and integrate it into their service. The Salvation Army, The Methodist Mission Lifewise programme, or St Vincent De Paul (agencies which were involved in this research) could be services in Auckland to pilot a Housing First programme.

6. Conclusion

This research found that a home is somewhere which is permanent, safe and secure. A home also has to be warm, dry and free from violence. The aims of this study were to investigate why some women in New Zealand are without permanent, safe and secure accommodation and what can be done to minimise the risk of female homelessness in New Zealand. It was important for the methodological grounding of this study that the women affected by homelessness were included.

The study confirmed the complexity of the concept of homelessness and of the needs of the homeless women who participated in the study. These complex needs reflect the particular characteristics of women's homelessness. Women will often have children in their care and are often leaving violent homes, They are less likely than men to have been living on the street and more likely to be staying in overcrowded situations with friends or in refuges. A high proportion will have mental health and addiction issues. The affordability of housing is a key issue they share with all homeless people in New Zealand.

The premise of this report has been that because homeless women have been marginalised and disempowered they are more susceptible to structural inequalities. Homeless women are therefore not individually responsible for their situation. While individual women may choose to live on the street or to leave a violent home they make these choices in a structural context of lack of alternate opportunities and a culture that does not effectively protect them in the home or offer effective interventions.

This research found that there are gaps in service provision in New Zealand, especially for women on their own and single

mothers. This gap appears to be two fold. One gap was shown to be the lack of suitable emergency and supported accommodation. The other gap was found to be a lack of permanent, affordable and safe accommodation.

The women interviewed strongly advocated for support and assistance to find housing. The women wanted support and assistance because they felt disempowered. Many of the women had also experienced discrimination in the housing market. Based on the findings in the focus groups and the literature review, Housing First was identified as being a suitable model to meet the needs of homeless women. Housing First would be able to assist women to get housing instead of creating transitional and emergency accommodation which has been shown to further disempower women. It would create the long term support homeless women would need to sustain accommodation. It would be able to coordinate addiction treatment, mental health services and money management training. This is not to say that emergency and transitional accommodation may not be needed for a small group of women, but emphasis should be focused on providing support for women to find long term, sustainable housing.

A Housing First programme would ideally be piloted by one of the nongovernmental agencies who were involved in this study. The Salvation Army, Methodist Mission's Lifewise programme or St Vincent De Paul have been identified as best equipped to provide this service. A bond bank would also be needed so that women had access to bonds. Coordination would be needed so that warm, dry energy efficient public and private housing stock was available for this project.

Services need to be coordinated across the health and housing sectors. Women who are homeless and have complex needs require flexible, well resourced and expert services to meet their

immediate and long term needs. This research has included the voices of women affected by homelessness and has identified a feasible solution to the immediate problem. It is also important to address the structural issues such as the affordability of housing, domestic violence and the prevalence of substance abuse if female homelessness in New Zealand is to be prevented.

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Appendix 1: Summary of Literature on the Effectiveness of Treatment Models

Reference	Client group	n.	Study period	Study design & treatment types	Key findings
(Anderson, 2001)	Homeless adults	150		Non-experimental review of strengths-based	Strengthening individuals' self care agency would empower adequate self care measures. The things impinging on self-care that were identified as needing to be addressed were <i>self esteem, substance abuse and increasing social support.</i>
(Braucht et al., 1996)	Homeless adults	323	4&10 months	Non-experimental review of ICM	Significant improvement with substance abuse, housing status, physical and mental health, employment and quality of life
(Conrad, Hultman, Pope, & Lyons, 1998)	Homeless veterans	358	24 months	RCT. standardised care vs additional BCM	Both groups improved over time with BCM group having better outcomes in housing, medical, alcohol and employment. Effects more obvious at first year and diminished in second year.
(Cox. G.B. Walker et al., 1998)	Homeless chronic public inebriates	722	24 months	RCT with ICM compared with standard treatment	Both groups improved over time favoring ICM group on total outcome (based on nights spent in own home, nights spent drinking and total income)
(Gorde, Helfrich, & Finlayson, 2004)	Women in domestic violence programme who were in emergency shelter, transitional housing or community programmes experiencing PTSD	84 + 15	9 months	Non-experimental. Interviews with staff and clients	Participants' mental health issues must be addressed but that their anxiety and psychological distress may be magnified as they were in unstable living situations at the time of the survey. Clients who were in emergency shelter or transitional housing wanted to develop financial management, goal planning, relaxation, communication skills and self-care. Shelter staff prioritised the client's needs as employment (job referrals, job

					readiness programmes and interviewing training including interpersonal skills training) housing and self-esteem. Access to counseling was seen as important in building self-esteem and motivation to acquire the skills and be able to use the available resources.
(Hampton et al., 1992)	Homeless SMI/ homeless at risk	165	12 months	ACT vs standard CM	One ACT site improved stable housing. One ACT site (with implementation problems) vs Standard CM. non-significant
(Kasprow & Rosenheck, 2007)	Homeless veterans post psychiatric treatment	206	90 day assessments	CTI	CTI was implemented successfully at the seven sites and was shown to have positive outcomes for veterans
(Kenny et al., 2004)	Individuals with severe mental illness who were homeless or at risk for homelessness.	165	Longitudinal	Randomised study of participants with Axis I diagnoses. Recruited from inpatient units at state-funded psychiatric facilities in the United States. ACT vs BCM	ACT was more effective in reducing psychiatric symptoms and improving housing status of clients.
(Lapham, Hall, & Skipper, 1995)	Homeless alcohol abusers	469	10 months	Retrospective RCT Standardised case vs GCM + 2 control conditions	No significant difference between standardised care and GCM Programme graduates had better outcomes
(Mercier & Racine, 1993)	Homeless women	25	GCM	Retrospective study of GCM	After 12 months or more in stable housing but after 36 months most this was not maintained, factors were attributed to mental and physical health.
(Morse et al., 1997)	Mentally ill homeless	135	18 months	RCT ACT vs BCM	ACT is superior to BCM in assisting this client group
(Okin et al., 2000)	Revolving doors clients at risk of homelessness	53	12 months	Pre-post test design Studying CTM	Reduction of ED visits, reduction in homelessness, substance abuse and increased engagement in outpatient and primary

					care.
(Orwin et al., 1994)	Homeless persons	930	9 months	RCT ICM compared with standard care	ICM more effective for improving housing, substance abuse and employment outcomes.
(Padget et al., 2006)	Homeless in NYC	173	48 months	RCT Housing First's ACT vs Treatment First	The requirement for sobriety in the treatment first group fell short in bringing about abstinence amongst a group whose primary need was housing. The housing first group decreased their problematic drinking more than the treatment first group. The New York Housing study showed that individuals with severe mental illness and substance abuse problems do not have to undergo mandatory treatment before accessing independent housing successfully. Consumer driven programmes that practice housing first and harm reduction are not linked to increased substance use even when there are not restrictions on their levels of use.
(Shern et al., 1996)	SMI Homeless	168	24 months	ICM plus Psychological rehab vs Standard CM	ICM/PR produced better housing and symptom outcomes
(Solomon & Draine, 1995)	Homeless released from jail	117	1 year	ACT vs Forensic	No difference
(Susser et al., 1997)	SMI homeless	96	18 months	Critical time intervention (CTI) vs usual service	CTI reduced homelessness
(Witbeck et al., 2000)	Dual diagnosis homeless	18	12 months	RCT ICM compared with standard care	Significant decrease of utilisation of emergency and ambulance service. Improved psychosocial functioning

Appendix 2: Focus Group Demographics

<i>Area</i>	<i>Ethnicity</i>	<i>Age</i>	<i>Number of children</i>	<i>Living situation</i>
Manukau City	Māori	30	4	Stays at a tinny house.
	Cook Is Māori	25	2	Staying in overcrowded house with friends.
	Māori Pakeha	39	4	Has just secured a privately rented house, it is overcrowded, with seven people sharing three bedrooms.
	Pakeha	32	4	Living alone in Housing New Zealand (Housing New Zealand) after seven months homeless.
North Shore City	Samoaan	34	2	In supportive accommodation with her children.
	NZ Euro	25	2	In supportive accommodation with one of her children.
	Cook Island Māori	26	2	Renting Housing New Zealand house with her two children.
	Tongan	27	3	Renting Housing New Zealand house with her three children.
	Macedonian	28	2	In supportive accommodation with her children.
	Māori	40	4	In supportive accommodation with her children.
	Samoaan	31	1	Renting a private rental with her child.
	Iraqi	40	2	In supportive accommodation with her children.
	NZ Euro	30	1	Renting a Housing New Zealand house with her child.
	Tongan	21	3	Renting a Housing New Zealand house with her children.
Auckland City	Māori	23	2	Informally boarding in overcrowded apartment.
	Māori	21	0	Stays with brother and then comes into the city and lives on streets with transgender community.
	Australian	46	2	Boarding house.
	Māori		19	Staying with partner who has Housing New Zealand house but has been homeless for ten years.
	Māori	34	4	Currently staying with boyfriend who has Housing New Zealand house previously street homeless for four years.
West Auckland	NZ Euro	50	0	Supportive Accommodation, history of living in boarding houses.
	NZ Māori	37	3	Supportive Accommodation, history of being street homeless.

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HUMAN PARTICIPANTS ETHICS COMMITTEE**

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02 June 2009

MEMORANDUM TO:

Dr. Jennifer Hand / Kate Bukowski
School of Population Health

Re: Application for Ethics Approval (Our Ref. 2008 / 497)

The Committee met on 11-February-2009 and considered the application for ethics approval for your project titled "Forgotten Women: A qualitative study of women, homelessness and health in the Auckland area."

Ethics approval was given for a period of three years.

The expiry date for this approval is EXPIRES NOT AVAILABLE.

If the project changes significantly you are required to resubmit a new application to the Committee for further consideration.

In order that an up-to-date record can be maintained, it would be appreciated if you could notify the Committee once your project is completed.

Please contact the Chairperson if you have any specific queries relating to your application. The Chair and the members of the Committee would be most happy to discuss general matters relating to ethics provisions if you wish to do so.

ALL COMMUNICATIONS WITH THE UAHPEC REGARDING THIS APPLICATION SHOULD INDICATE OUR REFERENCE NUMBER.

Lana Lon
Executive Secretary
University of Auckland Human Participants Ethics Committee
c.c. Head of Department / School, School of Population Health