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Looking Past the Mess

Maori

Homelessness and Mental Health Care

A thesis

presented in fulfilment of the

requirements for the degree of Master of Social Science

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Te Whare Wananga o

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Diana Johnson

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Abstract

Homelessness is a pressing social and health concern that affects Maori disproportionately. This research explores the provision of mental health services to Maori who are homeless. The thesis has two primary aims. First, to document the experiences of Maori homeless people who live with mental health concerns and their relationships with mental health professionals. Second, to document the experiences of mental health professionals and how they interact with, provide care for, and build relationships with Maori Homeless. The skills of, and the difficulties faced by these professionals in provisions of quality of care are also considered. Three male and three female homeless participants were recruited from the Waikato and Auckland regions. All participants had received care from Non Governmental Organisations (NGOs) and/or District Health Board services (DHB). Participating mental health professionals included one female and five males. Mental health professionals included counsellors, therapists, psychologists, social workers, crisis team coordinator, and a cultural advisor. All participants took part in individual semi-structured interviews conducted in an open and conversational manner. Key themes for homeless participants included their general life histories of mental illness, mental health service use, relationship with professionals, cultural issues, and concerns that Maori homeless wanted to discuss. Key themes for mental health professionals included their approaches when working with homeless people, relationship building, barriers to working with this group and possible solutions, linking with other professionals or organisations, and issues mental health professionals wanted to discuss. Findings highlight the importance of strong therapeutic relationships between homeless clients and mental health professionals, the need for more joined up (multi-level agency) approach to service delivery, and the importance of Maori ideology in restoring wellbeing and dignity. Findings suggest that the effectiveness of mental health service delivery relies in part on information provided by stakeholders. Information provided by homeless people and mental health professionals informs both service delivery and the ways in which practitioners can best support the needs of homeless people.

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Glossary of Terms

The following names were given as a reflection of the researcher's interaction with participants.

Names given to Maori homeless participants:

Arona	Colourful
Eruera	Happy Guardian
Kaiwhakaako	Teacher
Kakama	Insightful, astute
Pania	Mythological sea maiden
Pounamu	Treasure

Names given to mental health professionals:

Ihaka	He will laugh
Kahu	Cloak
Kaamaka	Rock, Warrior
Kaiwhakaako	Teacher
Kooputa	Albatross white feathered cloak
Te Awhina	The helper

Maori

English

Hapu	A social or political unit made up of whanau
Hui	Gathering or meeting
Iwi	A social or political unit made up of several hupu
Kai	Food
Karakia	Prayer
Maketu	Curse
Manaakitanga	Hospitality or generosity (linked to mana)
Mana	(Broad meaning) Agency to act, power, prestige, status, authority, also recognises absolute uniqueness of individual, central to action

Maori	English
Mauri	Life force
Oranga	Wellbeing (includes: sense of identity, self-esteem, confidence, pride, control of destiny, voice heard, mind, body, spiritual, respect for others, co-operative action, knowledge of te reo Maori, Maori customs, economic security, whanau support).
Rangatahi	Youth and young adults aged 13-24 years.
Taha hinengaro	Mental health
Taha tinana	Physical health
Taha wairua	Spiritual health
Taha whanau	Family health
Tamariki	Children
Tangata whaiora	People seeking wellness or recovery of self.
Tangata whenua	People of the land
Tapu	(Broad concept) spiritual restriction, sacred, set apart.
Te Puni Kokiri	Ministry of Maori Development.
Te reo Maori	Maori Language
Te Tiriti o Waitangi	The Treaty of Waitangi – Founding treaty of NZ as a nation, 1840
Tikanga Maori	Maori customs, values and knowledge
Tika	Right
Tohunga	Healer, specialist
Turoro	Maori person who interacts with a mental health service
Tumatauenga	God of war
Wairua	Spirit or essence of life
Wai tapu	Lift tapu
Whakapono	Honesty
Whakariti	Respect
Whai Korero	Speeches on Marae Atea

Maori

Whakama

Whakaawatea

Whanau

Whanau Ora

English

(Broad concept linked to mana and tapu) shame

A spiritual ritual, cleansing, or process of

Familial members belonging to kinship group (has been broadened to include non-traditional situations where Maori with similar interests form a cohesive group.

Maori families supported to achieve their maximum health and wellbeing.

Chapter One

Introduction

Background

Homelessness is a public health concern for Maori in Aotearoa New Zealand today (Kearns, 1995; McIntosh, 2005; O'Brien & de Hann, 2002; Peace & Kell, 2001). Maori are over represented in the homeless population in New Zealand (Leggatt-Cook, 2007; Al-Nasrallah, et al., 2005). Research has shown that a majority of people sleeping rough are of Maori or Polynesian descent (Gravitas Research and Strategy Ltd., 2005), and a high percentage of Auckland's homeless are of Maori or Polynesian descent (Peace & Kell, 2001; ARSI, 2008). In addition to having a considerable number of mental health concerns, research has shown that homeless people are 'sicker and die quicker' (Quine, Kendig, Russell & Touchard, 2004; Lewis, Andersen & Gelberg, 2003), experience a sense of dispossession, uncertainty, and cultural displacement (Cattell, 2001; Rollins, Saris, & Johnston-Robledo, 2002), are 34 times more likely to commit suicide and 150 times more likely to be seriously assaulted (Shaw, Dorling, & Smith, 1999) than domiciled people. Poor living conditions, economic struggles, stress, stigma, and social exclusion associated with homelessness impacts upon physical, psychological, emotional and social wellbeing (Hodgetts, Radley, Chamberlain & Hodgetts, 2007). Homelessness is more than a housing issue; it is fundamentally associated with social relationships and interactions (Hodgetts, Stolte, Chamberlain, Radley, Nikora, Nabalarua & Groot, 2008).

Maori are overrepresented among homeless. They also have higher rates of mental illness than the general public. There is a lack of information about how and when Maori homeless people access mental health services. Little is known about the experiences and practices of mental health care professionals when working with this client group. The effectiveness of mental health service delivery relies in part on this information. Information provided by mental health professionals and homeless clients may provide a basis for informing service delivery, and the ways in which therapists work to support the needs of homeless people.

Overview

This chapter considers how I came to select this topic, and presents a rationale for undertaking this research. I commence by reflecting on my personal background and interest in this research. This is followed by a brief engagement with existing literature regarding explanations for homelessness. A discussion follows concerning structural and individual level explanations for homelessness. This sets the scene for the following sections by placing explanations not merely at the individual level, but within the broader socio-political context. As awareness of structural and individual level explanations for homelessness has increased, a number of countries have developed policies to address the issue (Daly, 1997). To date, there has been no such response in New Zealand. The lack of policy development has bearing on the lives of Maori homeless people living with mental health concerns, service delivery, and the efforts afforded by mental health professionals when trying to provide best care options for this client group. Within this chapter, the ways in which mental health professionals work with Maori homeless people will also be discussed, alongside recovery processes and Maori models of wellbeing. The chapter closes with a synopsis of the present study, aims, and provides a brief overview of the following chapters.

How I came to this thesis topic

I am of Maori and Pakeha descent and was adopted at a very young age by two Pakeha parents of Scottish and English descent, both of whom I love dearly. For a large part of my life I grew up in the Pakeha world. However, I must say that my mother was instrumental in making sure I went to Maori cultural group. To her credit she was also actively involved in Maori Women's Welfare League during the 1970s. My father was a good man, kind hearted and had a very good sense of humour. In his wisdom he advised me not to worry too much about things, remember to consider others, and know that you can only ever do your best in life. Growing up primarily in the Pakeha world meant that I also grew up cross culturally, and this has provided me some experience of what it is like to be culturally dislocated (at least from my Maori connection). It is in this way that I

can identify with some of my participants who have been separated from their whanau and cultural roots from a young age.

Most of my working life has been spent in organisations that aim to enhance the lives of others, devoting some of my time to voluntary work in developing nations such as NGOs, or primary health care work amongst some of the world's poor. Among those who invited me into their homes were people who lived in urban slum dwellings or makeshift houses in unstable living environments. It was those who had the least to give, and who gave what little they had to others in need, that impressed me most. These are the people who taught me about myself, about humility, and about their struggles with oppression and injustice. While my past travels and volunteer work lay outside the parameters of scientific inquiry, the people I met, the stories they told, and the things I observed have remained salient in my mind. It was their values of giving and reciprocity that raised my awareness to a simple but pertinent rule, one of acknowledging and valuing people. In essence I think healthy relationships can make communities stick. They can provide a source of support, healing, and comfort even in the most impoverished conditions. Unhealthy relationships do the opposite; they can tax us and make us sick.

The continued interest I have in those who are oppressed or live with poverty has provided me with the impetus for this type of research. In regards to my clinical training it was important for me to understand how best to work with Maori homeless people living with mental health concerns. I appreciate the experience of informing the world of clinical psychology with insights from the broader social sciences in order to gain a more comprehensive understanding of the complexities involved in the daily lives and experiences of clients. In essence it is very much like a cross cultural experience, as one's thoughts and practices are shaped by their discipline. This also allowed me time to be reflective about my own training, how epistemologies in clinical practice and the medical world are framed and support certain ways of being, and function to support more dominant story lines. I appreciate different ways of thinking as it challenges my own way of being.

One particular reason for choosing this research topic is the overrepresentation of Maori amongst homeless populations in Aotearoa/New Zealand (Al-Nasrallah, et al., 2005), and the disproportionate number of Maori living with mental health concerns (Durie, 1999; Te Puni Kokiri, 1996; Ministry of Health, 2000; Edmonds, Williams & Walsh, 2000). There was also a lack of research and training in clinical psychology programmes in New Zealand concerning how to work alongside homeless Maori people. Such programmes have incorporated aspects of bicultural training (Herbert, 2000) to provide students with some knowledge of working from within a bicultural framework. However, little information exists concerning Maori homeless peoples' lived experiences of mental illness or mental health service use. There was also a lack of knowledge concerning the types of approaches practitioners use, or the barriers they experienced when providing quality of care for this client group.

Framing homelessness

How we define homelessness determines how we respond to it. Throughout history the way in which homelessness has been socially constructed has influenced the way in which societies have come to understand, evaluate, and respond to homelessness (Cohen, Sokolovsky & Crane, 2001). For example, early English responses failed to take into account the depth and breadth of homelessness because policy makers assumed that homeless people comprised a homogenous group of undeserving vagrants (Mayhew, 1861). As a result, restraints were placed on who was legitimately entitled to receive assistance and the very nature of the assistance on offer (Radley, Hodgetts & Cullen, 2005). Historically, if homelessness was attributed to misfortune and factors external to an individual, then assistance was more likely to follow. Conversely, if attributed to laziness or an internal factor, then assistance was less likely to follow (Daly, 1997; Levinson, 2004).

Reviews in the United Kingdom (UK) have shown that homelessness has been difficult to define (Fitzpatrick, Kemp & Klinker, 2000). Not only has the definition of what constitutes homelessness changed over many years, but research has shown that there are numerous pathways in and out of homelessness,

and multiple risk factors associated with homelessness (Anderson & Christian, 2003; Chapman, 2003). Due to the complexities involved there has been no fixed way of conceptualising homelessness, and definitions of homelessness have been based largely on the type of research being conducted (Anderson & Christian, 2003).

In the context of this research, a broad approach is used. Homelessness will include all of the following categories combined as one, occurring at any point of time or continuously over the past two years. The primary category includes: sleeping rough, no fixed abode, no roof over one's head, sleeping on streets, in bus shelters, makeshift shelters, doorways, and transient. The secondary category includes: living in caravan parks, boarding houses, unstable housing, couch surfing, or having no fixed tenure or tenancy agreement. Homelessness people are often excluded from economic, social, political and cultural life. These categories have been adapted from Gravitass Research and Strategy Ltd (2005) report on homelessness in Auckland, New Zealand.

There are many reasons for a person becoming homeless, and when homeless, people are at increased risk of a range of social and health related problems (Bang, 1998). Reasons for homelessness include structural and individual level explanations. Some researchers have focussed on structural factors related to governmental policies and procedures that impact on vulnerable citizens, while other researchers have attributed cause to a number of individual factors (Pleace, 1998; Pleace & Quilgars, 2003; Christian, 2003; Main, 2003).

Researchers in the UK and Europe have typically focused on structural reasons for homelessness, placing responsibility within the broader context of political reforms and governmental policies that regulate housing, labour markets, and welfare (Anderson & Christian, 2003; Christian, 2003; Neale, 1997), emphasising housing needs, lack of appropriate health care, and lack of social support (Connelly & Crown, 1994; Chamberlain & MacKenzie, 2003; Shinn, et al., 2007; Fitzpatrick, Kemp & Klinker, 2000; Kell & Peace, 2002). Conversely, researchers in the United States have focussed their attention more typically on individual approaches to homelessness (Anderson & Christian, 2003; Crane & Warnes,

2005; Christian, 2003; Neale, 1997). The individualist approach may contribute to the assumption that homelessness is the result of individual choice. This can lead to the placing of blame for homelessness within the individual who is 'defective.' According to the structural approach homelessness is a result of factors where the person cannot be held accountable, such as unemployment and socio-political or economic change. This may also lead to a situation in which we ignore the agency of homeless people, and their need to take some responsibility for their situations (Neale, 1997; Leggatt-Cook, 2007).

Research has identified both social and structurally related factors that contribute to homelessness and sit somewhere in between structural and individual explanations. Among some of these factors are family breakdown, domestic violence (Chamberlain & Mackenzie, 2003; Connelly & Crown, 1994; Shinn, 2007), disruptive childhood experiences such as violence and abuse and foster care (Fitzpatrick, Kemp & Klinker, 2000; Breaky & Fischer, 1990), early childhood trauma, family instability or breakdown in relationships (Al-Nasrallah, et al., 2005), lack of education, unemployment, mental health problems, contact with criminal justice system, debt, history of institutional care as a child or adolescent, loss of a loved one during childhood, and social exclusion (Wright & Thompkins, 2005; Folsom, et al., 2005; Fitzpatrick, Kemp & Klinker, 2000).

While there are many pathways into homelessness, New Zealand researchers found that pathways into homelessness for children and young persons describe patterns where children and adolescents had been involved in CYFS care due to a family history of abuse and alcohol and drug addictions (Al-Nasrallah, et al., 2005). Young people participating in the study ran away from foster homes, and had been abused, resulting in behavioural problems which often lead to being in mental health systems or in prisons, thus increasing the risk of homelessness when integrated back into the mainstream (Al-Nasrallah, et al., 2005). The same authors mention that to act preventatively would be to provide a safe environment where the child knows the adult cares, has a sense of connection and belongingness, and good education and employment options.

In Peace and Kell's (2001) study of clients using District Health Board (DHB) services, they found that Tangata whaiora were most at risk of homelessness when they were transitioning from prison, if they lived with a mental illness and had a drug and alcohol addiction, had a past history of institutionalisation, lacked community and social supports, and were not receiving mental health services (Peace & Kell, 2001; Al-Nasrallah, et al., 2005). In accounting for transitions from prison:

Homeless participants described a background of having been in prison as an adult for a variety of offences. In many cases it was difficult to determine whether having been in prison was a cause of homelessness in itself, or an effect of being homeless. Often, it is a combination of the two. Most of these people described leaving prison and moving straight back to the street. This pattern presents a problem for the Corrections service, and society in general. It appears that most of these people simply left prison and fell straight back to their original position or worse (Al-Nasrallah, et al., 2005).

A national survey conducted in New Zealand using group interviews with tangata whaiora who accessed DHB services reported that pathways in and out of homelessness were influenced by a range of interconnected factors. These factors included a lack of affordable housing, loss of housing because of periods of illness or hospitalisation followed by eviction, difficulties finding and sustaining housing due to low income and comparatively high levels of debt, relationship difficulties and conflict with others, stigma and discrimination preventing access to housing, and ending contact with the whanau, friends, and housing support services which rendered them unlikely of finding housing support (Peace & Kell, 2001; Peace, Pere, Marshall & Kell, 2002b).

As a result of increased understanding of structural and individual explanations, policies have been developed in some countries. For example, due to the rise of homelessness in Britain during the 1990s, the Government implemented the Rough Sleepers Initiative (RSI) to target the London area, extending to other regions by the late 1990s (Crane & Warnes, 2005). Legislation such as the Housing and Homeless Persons Act (1977) placed increased emphasis on local authorities for providing social services and housing (Fitzpatrick, Kemp &

Klinker, 2000). While the Act made a significant difference in provisions to homeless people by restoring their rights as citizens (Fitzpatrick, Kemp & Klinker, 2000), the Act differentiated between statutory homelessness and non statutory homelessness with criteria that defined who could seek assistance and who could not, excluding mostly single people (Anderson & Christian, 2003; Crane & Warnes, 2005; Fitzpatrick, Kemp & Klinker, 2000). Increasingly, a wider range of services were made available for homeless people. In 1999, the Rough Sleepers Unit (RSU) was formed (Crane & Warnes, 2005). New approaches were aimed at street outreach, training programmes, occupational training, employment schemes, and the like, to prevent homelessness. By 2002, responsibility was placed on all housing local authorities to reduce homelessness by planning and creating partnerships with social services and the voluntary sector; more coercive approaches also emerged such as bylaws to ban street drinking, and fines for sleeping on the street (Crane & Warnes, 2005).

A similar pattern is seen in the history of social welfare in New Zealand. During the mid 1930s, the Labour government had made a commitment to providing necessary housing for New Zealanders, including the poor (Kearns, Smith & Abbott, 1993). By the 1980s, during a time of economic restraint, the government limited the provision of housing for lower socio-economic groups (Kearns, Smith & Abbott, 1993). To date, New Zealand has no national or co-ordinated response such as the RSI or RSU. As a result, and as well intentioned as they often are, responses tend to be uncoordinated and piecemeal in nature.

Neale (1997) emphasises that theoretical frameworks involving structural versus individualistic explanations for homelessness, while seemingly simplistic, are historically relevant. The author contends that a structural explanation requires interventions on a large societal scale, while an individualistic explanation involves basic provisions such as accommodation, psychiatric care, or humanitarian aid. In the absence of a single framework that can give an explanation for the range of factors contributing to homelessness, researchers increasingly call for a multi-focused approach that combines both structural and individual factors (Christian, 2003; Fitzpatrick, Kemp & Klinker, 2000).

In summary, homelessness invokes a range of explanations that appear to be linked to cultural and social norms and expectations. Existing research suggests that complex interactions occur between policies, housing, social welfare, various social factors, and individual characteristics. The literature in this field suggests that there are overlaps between homelessness, lack of appropriate and sustainable housing, low income, lack of social support, gaps in policies and services, social isolation and exclusion, mental illness, familial distress, educational underachievement, and personal characteristics (Leggatt-Cook, 2007). While policies have been developed in other countries to try to deal with the complexities of homelessness and in response to increased understandings about structural and individual explanations, New Zealand does not have a coherent response towards the issues of homelessness.

Rough estimates on Rough Sleeping

Most researchers would agree that the transient and perhaps hidden nature of homelessness makes it difficult to estimate how many people are homeless during any given period of time. In nearly all cases, only rough estimates are given, and there are suggestions that many of these figures underestimate the true prevalence of homelessness. Measuring prevalence rates of homelessness is at least problematic due to the variations in the definitions of homelessness. Prevalence rates are also underestimated due to undercounting those who move in and out of homelessness, and the methods used for counting homeless people often miss the homeless people who do not use services (Toro & Warren, 1999; Levinson, 1996).

Research in New Zealand (Peace, Kell, Pere, Marshall & Ballantyne, 2000a) showed that District Health Boards estimated that around 3,200 of their tangata whaiora had experienced housing difficulties, and that at least 833 were homeless or living in emergency or temporary accommodation, a further 2,676 were living in a heightened risk of homelessness in the future; these rates were considered underestimated because of missing responses.

From what information is available, it would appear that there is an overrepresentation of Maori in the homeless population. Methodist Mission

Northern (Leggatt-Cook, 2007) revealed that a high percentage of homeless people visiting their centres were of Maori descent. According to Kell and Peace's (2001) national study, an estimated 8000 tangata whaiora using DHB mental health services were believed to be experiencing housing difficulties. Again these are rough estimates, as it was estimated by Mental Health Commission that only 50% of people with mental health disorders are accessing DHBs. The Auckland Rough Sleepers Initiative (ARSI, 2008) estimates that within a three kilometre radius of Sky Tower the number of people sleeping rough increased by 40% from 2007 to 2008, to a count of around 91 people in 2008. The 2008 account showed Maori to be overrepresented at 43% of this group, compared to 24% NZ European, 8% Pacific Island Peoples, with the remainder 15% unknown. Between 2004 and 2008 there has been an estimated increase of homelessness by 27%. ARSI (2008) reported that on the same night of the count there were boarding house proprietors who reported that those sleeping rough, with mental health issues, and drug and alcohol dependency, were not manageable in their boarding house environments.

Once again the transient and perhaps hidden nature of those who are homeless makes it very difficult to achieve anywhere near complete or comprehensive statistics in regards to how many people are actually homeless during any given period of time. In nearly all cases, only rough estimates are given, and there is usually some mention of estimates being below the actual count of homeless people. However, this does not belie the fact that homelessness amongst Maori who live with mental health issues is of a major societal, psychological, economic, and political concern in New Zealand today.

Social exclusion and other things detrimental to health

The likelihood that people will live in poverty is higher for social groups such as ethnic minorities, disabled, unemployed, and homeless people (Wilkinson & Marmot, 2003). These people are often socially excluded through racism, discrimination, stigma, and unemployment. They can face opposition in trying to secure necessary resources for their health and wellbeing. Research has also indicated that higher rates of homelessness are found among ethnic minorities across developing nations (Shinn, 2007). Such social stratification comes at a cost

in terms of health because poverty, deprivation, and social exclusion often associated with ethnic positioning can manifest as inequalities of health (Hodgetts, Radley, Chamberlain & Hodgetts, 2007; Wilkinson & Marmot, 2003).

An international review on the health needs of homeless people living in developed countries found that homeless people have poorer physical and mental health than the general population, and limited access to health services (Wright & Tompkins, 2005). The homeless population is characterised as having multiple problems, including mental disorders, alcohol and drug dependence, and premature death. The same authors suggest that such problems need to be addressed with a focused primary health care system and a joined up approach (multi agency approach).

Inequalities in health involve multi-levelled processes of disempowerment on governmental, political, institutional, and economic levels (WHO, 2007). Throughout history, processes of disempowerment have had a direct impact on the health of Indigenous Peoples world wide. Commonalities in effects of colonisation on Indigenous People have been associated with disempowerment, alienation, cultural erosion, and loss of land (WHO, 2007; Durie, 2005), loss of voice and dignity, all of which undermine wellbeing (Durie, 2005). For example, in New Zealand, colonisation saw the redistribution of Maori resources, social practices, and power occurring as a result of legislative acts by the Crown (Anderson, Crengle, Kamaka, Chen, Palafox & Jackson-Pulver, 2006). While there have been some great advances for Maori since the cultural renaissance in the 1970s, this has not entirely amended the longer history of colonisation (Anderson et al., 2006; Ringold, 2005). Such effects led to a break down in Maori cultural values, contributed to political and socio-economic deprivation, and unequal access to social resources.

Health inequalities have increased over the past few decades between Maori and non Maori (Te Puni Koriki, 1998; MHC, 1998a; MOH, 2002c; MOH, 2004; Taitimu, 2007). Maori mental health is also a major issue in New Zealand, with psychiatric admission rates approximately 40% higher for Maori than non Maori, including crisis, acute and forensic services (Gawith & Abrams, 2006). One of the

stated aims for previous Governments has been to reduce health disparities associated with ethnicity (MOH, 2002c; MOH, 2004). Not only does this include a reduction in the inequality of health, but also socio-economic improvements for Maori (MOH, 2000). These goals are in line with Government's recognition of and responsibility to the principles of the Treaty of Waitangi, including principles of participation, protection, partnership, and equality (MOH, 2002a). Some of the first laws to detail the health sector's responsibilities toward the Treaty of Waitangi can be seen in New Zealand's Public Health and Disability Act 2000 (Ringold, 2005). The Treaty also guarantees equality between Maori and other New Zealanders. Where Maori cultural identity and resources are secure, then Maori health is best (Durie, 2004; 1999).

According to Durie (1999) marginalisation within society also leads to lifestyles of abuse, drugs, alcohol, violence, parental abandonment and isolation, leading to feelings of powerless and hopelessness which do little to enhance wellbeing. Additionally, there is some evidence to suggest that the effects of racism, perceived or actual, also contribute to poor health, and links to disparities in health for New Zealand Maori (Harris et al., 2006). This includes unfair treatment by health professionals and difficulties in gaining access to housing (MOH, 2004; Harris et al., 2006). Harris and colleagues (2006) suggest that in addressing inequalities of health, these factors would need to be taken into account. This would also be important for Maori homeless population.

Additionally, research has also shown that homeless people are likely to suffer brutal attacks (Shaw, et al., 1999). A recent study in the United States (NCH, 2008) has shown that many homeless people have been subject to violence. These attacks are often categorised as hate crimes and or motivated by racial prejudice. Such perpetrators have beaten, stabbed, shot, harassed, tormented, burned, or robbed homeless people of what little possessions they had; some have been left naked. These attacks have occurred in public places and spaces, sometimes in broad daylight, or at night when sleeping under bridges. As a result, homeless people have been hospitalised with broken bones, or contusions, suffered internal injuries, or have died (NHC, 2008). According to Wilkinson and Marmot (2003) life is shorter where there is poorer quality of life, and amongst the unemployed,

ethnic minority groups, disabled, refugees, and homeless, it is those living on the streets who are more likely to suffer the highest rates of premature death.

In summary, homeless people often endure poverty, deprivation, social exclusion, and violence. These social factors contribute to inequalities in health and are associated with how living on the street can 'get under the skin' of homeless people. Social exclusion may occur through racism, discrimination and stigmatisation, and can limit human access to the resources necessary for their own wellbeing. International research shows that a history of social stratification, political discrimination, and economic hardship can contribute to inequalities of health. With the awareness that oppression and marginalisation are products of power inequalities occurring at various levels, it would make sense that homelessness and wellbeing are addressed at the individual, agency based, and socio-political levels. While reports discussed so far paint a rather bleak picture of homelessness, it is important to note that Maori homelessness and mental illness are not just the result of personal characteristics, they are fundamentally linked to the broader socio-political, historical, and economic dimensions in which people live. However, the above reports should not be generalised to all Maori, or all Maori homeless people. Also, there has been little mention so far of the recovery process, personal agency, strengths, resilience, knowledge, and skill set that Maori homeless people share; these will be discussed later in the research. In the following section attention will be paid to homelessness and mental health concerns.

Homelessness and mental health concerns

Homeless people living with severe mental health issues represent some of the most susceptible and disadvantaged people in society (Folsom et al., 2005). Toro & Warren (1999) point out that while many of these people talk about their de-institutionalisation, the restrictive policies or legislative measures in regards to hospitalisation have not diminished. People who become unwell live with the threat of involuntary re-hospitalisation.

Homeless people with serious mental illness are thought to represent anywhere between 15 and 30% of the total homeless population (Toro & Warren, 1999; Fischer & Breakey, 1991). Research has also shown that amongst those living with mental illness there are low to moderate prevalence rates of homelessness. One of the first studies to document the use of Adult Mental Health Services by homeless people was conducted in San Diego County in the USA (Folsom, et al, 2005). The researchers found that among the 10,340 participants, the prevalence rate for homelessness among clients with serious mental illness was 15%. Other research findings suggest one third of homeless people have severe and disabling mental illnesses (Drake, Osher & Wallach 1999).

Complementing the San Diego study, Gorton (2003) estimated that approximately 50% of homeless people living in the UK experienced mental health concerns. Field studies on homeless men and women suggest that those who are homeless and live with mental health disorders, including alcohol and drug misuse, experience a wide range of disadvantage and social exclusion; they are likely to have minimal education, low financial income, poor health and high imprisonment rates impacting on their ability to maintain employment, housing, study, and relationships with others. In general these people come from backgrounds of domestic violence, relationship breakdown, incest, abuse, assaults, accidents, and the deaths of friends and family members. According to Robinson (2004) these factors have a severe negative effect on the prevalence and management of mental illness and peoples' ability to sustain some level of appropriate housing.

Amongst the multifaceted issues that homeless people face, studies in the 1980s and 1990s showed a considerable amount of overlap between drug and alcohol addictions, mental illness, and homelessness (Fischer & Breakey, 1991). The same authors reported that in the United States, the rates of drug and alcohol misuse were higher in populations of homeless people with mental health concerns than in the general population, and almost half of those who were homeless and living with mental health concerns had co-morbid drug and alcohol related addictions. One of the largest studies conducted in London by researchers Fountain and Howes (2002) addressing the association between homelessness and

drugs found that 83% of homeless people interviewed had used drugs within one month prior to being interviewed. The same authors found that homelessness is a trigger for increased drug use, and that there is a clear association between increased dependence on drugs and time spent on the street. Flick and Rohnsch (2007) propose that alcohol and drug use often aids people in surviving on the street by helping them to escape the realities of homelessness. However, drug and alcohol abuse also lead to poor health and psychological problems.

The common characteristics of individuals who live with a mental disorder and co-occurring substance abuse include psychological and psychiatric symptoms, denial of illness or drug use, antisocial and aggressive behaviours, and increased rates of suicidal behaviour (Lezak & Edgar, 1996). The same authors say that without broad treatment planning and appropriate support, people living with mental illness and drug related issues can become poor tenants or non compliant in structured residential situations, leaving them at risk for eviction, arrest, jail, or admission to mental hospitals. Homeless people with mental illness and drug and alcohol addictions have more difficulties especially when they need to access two services for assistance (O'Connell, 2003; Lezak & Edgar, 1996). Furthermore, as with other categories of homelessness, people with mental illness and drug and alcohol misuse are characterised by severe poverty, isolation from family, friends, or social networks as relationships deteriorate over time (SAMSHA, 2003). Often this is due to carer exhaustion or frustration concerning disturbing behaviours, and homeless people may also have ongoing contact with Correction agencies (SAMSHA, 2003).

In New Zealand there has been very little in the way of statistical information concerning prevalence rates of mental health issues amongst homeless people. However, New Zealand researchers often indicate that there is an increased likelihood of mental illness among the homeless population when compared to the general population (Leggatt-Cook, 2007). For homeless people, access to mental health services has been somewhat problematic, and there has been little in the way of early intervention programmes (Leggatt-Cook, 2007; Gravitas Research and Strategy Ltd., 2005). While there are approximately 240 Maori health providers contracted to DHBs in New Zealand (MOH, 2006), there is a lack of

services for Maori homeless people that can cater for the needs of these people in a culturally appropriate way (Al-Nasrallah et al., 2005).

For Maori in general, there are also a number of barriers when using and trying to access mental health services. These include the threat of committal for compulsory treatment, inadequate funding, Maori being dubious of treatment within a Western paradigm, and methods of assessment that may be culturally inappropriate (Durie, 2001; Taitimu, 2007). As an aside, the same suspicion and mistrust of Western methods is not an uncommon pattern for Indigenous Peoples world wide, and may pose a special problem for professional helpers whether they are indigenous or non indigenous (Saleebey, 2002). Further barriers include difficulties in co-ordination between DHB services, competition between services, and professionals (MOH, 2000).

Ringold's (2005) findings suggest that increased Maori access and participation in health and social services can be attributed to a number of efforts to tailor service provision toward Maori needs and preferences. Aspects in Maori health services that include values and customs, affordable health care, holistic approaches, and community based interventions, have the potential to provide useful examples for mainstream health providers (MHC, 2008; Ringold, 2005). The same author asserts that for good outcomes to occur there need to be well functioning organisations and institutions that can be responsive to the needs of Maori. Guidelines on being responsive to Maori needs are outlined in the Maori Health Action plan (MOH, 2002b). Equality means having mechanisms in place so that all population groups can be part of the decision making process, and strategies for tackling social exclusion need to involve poor people, as decisions made will impact primarily upon their lives. This takes into account Maori homeless peoples' views, and those in the homeless population living with mental health concerns.

In summary, it has been reported that some of the most disadvantaged and susceptible people in society are those who are homeless and live with mental health concerns. International research in the UK and United States have shown that there are moderate to high prevalence rates of mental health concerns among

homeless populations. This section also revealed that there is a considerable amount of overlap between homelessness, mental illness, and drug and alcohol misuse. In New Zealand there has been very little statistical information concerning how many people are homeless and live with mental health issues. New Zealand researchers have indicated that there is an increased likelihood of mental health concerns among homeless people compared to the general population. It was identified that for homeless people, access to mental health services were problematic. A number of barriers to mental health services for Maori were also discussed. These included threat of committal for compulsory treatment, Maori being sceptical of Western approaches to assessment, diagnosis, and interventions that may be culturally inappropriate, various difficulties accessing DHB services, and more.

Working relationships

Clearly a range of services and strategies are needed to meet the diverse needs of homeless people. This thesis focuses on mental health services, but these should not be seen in isolation from other programmes. The relationship that exists between client and therapist is called a working relationship or therapeutic relationship. This working relationship begins as soon as the client has contact with a service. Success of the initial and ongoing contact with any service will help shape clients' confidence and trust in the service. For Maori who are homeless, this is even more important. Developing a relationship of trust and respect while providing a space where clients are comfortable and willing to share with mental health professionals is part of this process. This includes how we meet, working out who is who, negotiating challenges that arise, sharing information and working together. Not only do such processes reflect the way Maori think and understand the world around them (Mead, 2003), research has shown that the quality of interaction between client and professional is an important factor in treatment outcomes (Prochaska & Norcross, 2007; Cameron, 1996; Rogers, 1961). Spending time discovering people's concerns and expectations, and discussing these while asking questions and negotiating intervention plans, and having positive family/whanau support is vital for healthy outcomes (Cameron, 1996). Whanau support can be relevant as whanau are at the

heart of Maori social order (Te Puni Kokiri, 1998). However, where homeless people have been dislocated from their whanau, or have severed ties with family members, they may not wish to have Maori or whanau involvement (Taitimu, 2007). Still, this does not negate the fact that social networks and healthy relationships are an important resource for wellbeing.

A recovery focus, essentially strength-based in perspective, is conducive to positive change, and is a requirement for all mental health professionals working in New Zealand (MHC, 1998a; MOH, 2000; 2002a). These underlying values that are humanistic in nature reflect the principles of the Treaty, and focus on human beings and their ability to become all that they can. People have the right to be treated with respect, dignity, equality, and inclusion. Here we also see the connection between individuals taking responsibility, and family/whanau, community, and government taking responsibility for wellbeing (MHC, 1998b). Recovery is holistic in approach and as authors' state:

Recovery orientations are compatible with Maori mental health models, in that a balance is sought between the body, person, whanau, and the environment and ecologies within which they exist. At the base of all Maori models (irrespective of whether this is explicitly stated) is the firming and grounding of Mauri across all dimensions of a person's life (Lapsley, Nikora & Black, 2002).

There are also links and overlaps between Maori models of wellbeing, recovery, humanistic and indigenous approaches, and these will be discussed throughout this thesis. In many ways indigenous psychologies are compatible with Western humanistic approaches, especially when traced through liberation theories. From the rise of civil rights movements in the 50s and 60s, there has been a greater recognition for Indigenous Peoples and their civil rights (Makaa & Fleras, 2000). Today in New Zealand, the priority of policies placed on Maori health (MOH: He Korowai Oranga, 2002a, MOH, 2000) has seen significant growth in the development of Maori health service providers. Before the early 90s such provisions barely existed.

Humanism is multifaceted in nature; it is a way of being, a philosophy of human nature, and draws from both phenomenological and existential psychologies. The development of humanistic psychology in the 1950s is seen in Maslow's motivation and hierarchy of needs and Carl Rogers' client centred approach (Clay, 2002). The same author asserts that humanistic psychology tends to look past a deficit approach of how we see people, and builds on their strengths and abilities. There has been empirical research to show that therapies that foster the greatest degree of change include client strengths, client/family and environmental resources, quality of helping relationships, supportive social networks, a rising sense of hopefulness or positive expectations, and determination (Lambert, 1992). Rogers (1961) found that truly effective and helpful relationships in the therapeutic setting that promote change and growth include enhanced communication through empathetic listening, being genuine, accepting or appreciating others and their potential in what they are to become, without controlling their actions (Rogers, 1980). When using scientific methods, one can run into a problem of seeing the other as a fixed being, determined and shaped by their past, diagnosed and categorised with the likelihood that one will confirm the limitation in hypothesis; conversely, by accepting the person in all that they are, their strengths, potential, and creative abilities then the person is more likely to act within this assumption (Rogers, 1961). This is not to say that Rogers was against scientific methods, quite to the contrary, he viewed science as an important tool with which things could be measured, but not something that should take precedence over the human being. In the clinical and medical world, such measures are needed to ensure safe and proven practices, and best outcomes where humans are concerned.

The present study

This research is of high relevance to Maori in that it aims to identify difficulties where mental health services struggle to meet the needs of Maori who are homeless. There is a lack of information about how and when Maori homeless people access mental health services. Little is known about the experiences and practices of mental health care professionals when working with this client group. The effectiveness of mental health service delivery relies in part on this

information. Information provided by mental health professionals and homeless clients may provide a basis for informing service delivery, and the way in which therapists work to support the needs of homeless people.

Maori mental health issues mentioned in this research will be referred to in the context of DSM-IV-TR as seen within the Western mental health field for the sake of clarity. At times this may be discussed in terms of Maori understandings of wellbeing. In this research, mental health issues include drug and alcohol abuse. In terms of this thesis, mental illness is a social issue and not limited to internal states of being. It is constructed and perpetuated by history and social change. Homelessness is firstly a public concern that does not only include individual characteristics related to Maori homelessness and mental health issues, it also takes into account the broader socio-political elements that contribute to the perpetuation and maintenance of homelessness and mental health inside New Zealand.

In chapter two the methodology is described for this research. The subsequent two chapters present the analysis and findings for mental health professionals and Maori homeless participants. Chapter five is the conclusion of the thesis, and amalgamates literature and research with the findings in chapter three and chapter four.

Chapter two

Methodology

This chapter outlines the theoretical orientation of, and methods used in this research to understand the perspectives of mental health professionals and Maori homeless peoples' lived experience of mental health care. I explain the narrative approach taken, research procedure, interviews and levels of analyses, research participants, and consider ethics and cultural issues associated with the research.

Taking a narrative approach informed by Maori focused research

In order to understand the perspectives of mental health professionals and Maori homeless people in context, qualitative methods are appropriate. After all 'not everything that counts can be counted.' These methods have been used for some time with similar groups. For example, Mayhew (1861) explored the narratives of vagrants in London. During the 1800s, European social psychologists conducted qualitative studies of alcoholism and pauperism (Apfelbaum, 2000). Closer to home, anthropologists such as Bronislaw Malinowski and Ruth Benedict used qualitative methods to study cultures in the Pacific during the early 1900s. It was not until the 1950s and the 1960s that qualitative research became popular again throughout the social sciences. Qualitative research is conducted in a natural setting and is applied to try to understand the complexities of a social or human problem (Smith & Davis, 2004). Researchers using qualitative research often focus on concrete cases found in the everyday life experiences of participants, and take into account people's subjective perspectives and practices which have been shaped due to differing social backgrounds (Davidson & Tolich, 2003; Flick, 2006).

In qualitative research there are numerous ways to collect and analyse data (Taylor & Bogdan, 1998; Flick, 2006). The narrative approach seemed appropriate for this study in consideration of the oratory traditions of Maori people. Narratives are stories that can be collected in naturalistic settings (Coffey

& Atkinson, 1996). Storytelling is a popular human means of making sense of the world (Murray, 2000). Stories reveal ongoing changes in personal situations, bring order to experiences, provide a means of making sense of events, and add meaning to one's life (Crane & Warnes, 2005). Certain life crises such as illness become a turning point where people reassess their life story and sense of being, that is, the old self in continuity with new self (Frank, 1993). Stories may privilege the subjective views of the storyteller, they are always framed from within the socio-political, historical context, and from within the time and place in which the narrator lives.

Foundational to narrative approaches is recognition that all communities, organisations, and people have stories that they tell (Rappaport, 1995). Mankowski and Rappaport (2000) define two types of narratives. The first type are culturally dominant stories that are repetitively told over a lifetime in socialising institutions, such as mass media, education, or health systems. The second type of story might be the various stories that communities tell about themselves. These two forms of narrative are interlinked. Powerful people maintain dominant cultural stories about marginalised groups; the people who the stories are about may internalise and believe these narratives, which are then reflected in their stories; depending on how stories are framed this may have positive or negative implications for identity (Mankowski & Rappaport, 2000). For example, throughout history dominant stories have been told that have disempowered Indigenous Peoples all over the world, resulting in cultural erosion and dispossession of land and rights (Saleebey, 2002). Colonisation is one such story that for New Zealand Maori, saw the redistribution of Maori resources, power, and socio-cultural practices through dominant stories told and legitimated by the Crown (Anderson et al, 2006). On the other hand colonial powers may have viewed this as exploration and progress.

Interestingly enough, Rappaport (1995) says that if stories are seen as analogous to community resources, then like most resources, stories are unevenly distributed. Everyone has stories, but some of the stories dehumanise, and other stories are not even recognised as valuable at all. The same author mentions that much of the work of social change toward collective empowerment may be about

providing a place that facilitates discovery, and development of their own community narratives. Currently, the narratives of dominant groups within the settler society are being challenged and Maori voices and stories articulating injustices are in the mainstream. Maori are articulating an alternative story of colonisation that is reflected in institutions such as the Waitangi Tribunal.

To understand homeless peoples' lived experiences of mental health care, it is important to understand how their stories exemplify dominant and non dominant story lines, and how certain power relations are seen in society. How the participants talk about their experiences may illustrate the internalisation of dominant stories for Maori, homeless people, and for mental health service users. It may also bring in to focus various power structures that are supported by mental health professionals (Murray, 2000), knowingly or unknowingly. Mishler (1991) gives the example of a practitioner's formulation which is often achieved through the application of diagnostic manuals, and standardised assessments. In drawing on such resources practitioners are able to give more consistent assessments and responses. However, they also engage in a process by which clients are slotted into an existing narrative of mental illness that often neglects many of the unique features of their unique life-worlds. This reproduces existing professional understandings and our current system of care. In this way, people also act to reinforce the legitimate structures of dominant discourses that exist within society (Foucault, 1972).

The narrative perspective is well suited for Maori, and also for reframing experiences. By analysing Maori participants' stories it was possible to see how they viewed their experiences of mental illness, relationships with therapists, and how they have internalised some of the dominant cultural stories. The stories that people tell are constructed and influenced by broader socio-cultural dominant stories and from their own interpersonal contexts (Murray 1999; Mankowski & Rappaport, 2000). By telling non dominant stories, often societal standards are challenged. Practitioners and therapists have spoken a dominant discourse for many years in which the ill person is viewed through the lens of the professional (Frank, 1998; Mishler, 1991). For example, Carr (2006) notes that while labels can be beneficial, diagnoses focuses on weaknesses rather than strengths, and are

usually fixed in a pathologising and depreciatory discourse. Such ethical problems arise when overemphasis is placed on pathology, ignoring strengths and resources. It may be necessary that for effective healing and therapeutic relationships to occur, that practitioners and clinicians move beyond dominant mental health narratives. One way forward is to make client stories, rather than slotting people into existing diagnostic categories, more central to our understanding of people.

In order to understand the perspectives of mental health professionals and Maori homeless people's lived experience of mental health care, it was also important to use aspects of Maori research, which are compatible with the narrative approach. Durie (2004) has been instrumental in advancing Maori research and the understanding that Maori health is best framed from within a holistic perspective, which includes tinana, hinengaro, wairua, and whanau.

Maori research has been developed from a focus on the cultural uniqueness of Maori and with a key focus on what it is to be Maori (Smith, 1999; cited by Bishop, 1999). One such approach is Whanaungatanga, the relationship between self and others established through whanau (Bishop, 1999). From within this framework, it was important to develop relationships among all those involved in the research process. Where possible, and within time limits, this was achieved through meeting and spending time with those involved, seeking the advice of professionals involved in the research before and during the research process. Smith (1999) has indicated a number of culturally specific ideas which were incorporated into the ethics approval process for this thesis. The research was approved by the Waikato University Psychology department and Health Research Council of New Zealand.

Smith (1999) has listed a number of culturally specific ideas that reflect Maori practices which have been incorporated into the research process, taking on the following meanings: 1. Aroha ki te Tangata: showing respect for participants by allowing them to say what time they wish to meet and if possible where they were most comfortable to meet. 2. Kanohi ki te Kanohi: all research interactions were carried out in a way that was face to face. 3. Titiro, whakarongo, korero: my role as a researcher was one of a learner through observation, listening, and then

speaking. 4. Manaakitanga ki te Tangata: all those involved in the research shared information and were generous with what they had to benefit the whole group. 5. Kia tupato: it was important that we did not exploit others, especially those who were vulnerable. 6. Kauga e takahia te mana o te Tangata: there was a commitment by those involved in research to not trample over the mana of people, especially those who are Maori and homeless.

In line with Maori research practices (Smith, 1999), the role of the researcher was to listen to tangata whaiora, and mental health professionals, and respect the information that they brought to the forum. All interviews were held in a way that was respectful, friendly, and open for discussion. Maori homeless participants were offered the opportunity for karakia and to whakapapa or tell the story of their origin and place in Maori cosmology. It was also important that a particular type of interviewing style be implemented. This will be discussed further in the next section.

Interviewing participants

Semi-structured interviews were used as this was more flexible and less formalised than structured interviewing. Interviews also encouraged two way conversations between participant and researcher. By using semi-structured interviews, topics could be developed around the research question before engaging with participants, and it allowed participants' narratives to be told from their subjective views (Flick, 2006). The semi-structured interview takes into account subjective theory, which means that participants come with their own knowledge about the topic. It also seemed appropriate to use semi-structured interviews as it allowed the researcher to compare participant responses when discussing key themes and to enable them to place these within the contexts of their own lifeworlds (Flick, 2006). (See Appendix C & D for themes outlined for mental health professionals and homeless participants).

Interview schedules were developed with reference to literature concerning Maori research methods (Bishop, 1999; Smith, 1999; Durie, 2004) in consultation with my Maori supervisor, main supervisor, and in discussion with mental health professionals including a Maori cultural advisor (see Appendix C & D for further information). The supervisors had also discussed the need for this research with several homeless people, and core themes emerged from these discussions.

The themes covered in the interview for Maori homeless participants included their histories of mental illness, experiences of mental health service use, relationships with mental health professionals, homeless biographies, and cultural practices and identities. Core themes covered in the interview for mental health professionals included approaches used by clinicians and therapists when working with this client group, relationship building, difficulties or barriers experienced in service delivery, solutions found, and how they networked with other professional organisations.

The researcher explained participant rights during the consent process. The researcher emphasised that participation in the research was based on personal choice and at anytime during the research process if they wished to withdraw they

were able to do so (see appendices A & B). The researcher also ensured that Maori homeless participants and mental health professionals understood that they were not obliged to answer all the questions, or to give personal information away that would cause them to feel whakama, uncomfortable, or awkward.

Potential risks or discomfort to participants were considered. For Maori homeless participants there was a possibility of risk due to discussing personal experiences in the interviews. Therefore a majority of interviews were conducted in the offices of service agencies where the support of mental health professionals was available. One interview was conducted at a place specified by a client and in consultation with her agency worker.

Mental health professional participants

Mental health professionals participating in the research were identified through the professional networks of my supervisors, based on their work with homeless people. Initially my supervisors put me in contact with practitioners, who referred me on to colleagues who might be interested in participating in the project. I also emailed or telephoned some of the mental health professionals to see if they would be interested in assisting with the research. Meetings were arranged via email or with a telephone call, to arrange a time and place that was suitable for participants who were interested in the project. My supervisor/s, mental health professionals, and I sat down together, usually over a cup of tea or lunch. I explained in detail what the study was about. Advice from mental health professionals and NGO workers was sought regarding the focus of the study. In two instances mental health professionals welcomed me with a karakia. The karakia included acknowledging ancestors, God, and both participants' lines of ancestry. A whakawaatea, lifting wai-tapu or the clearing of our paths (acknowledging things that may have occurred in our lives prior to meeting, including those things that may have occurred between our ancestors), allowed a smooth progression for what both parties were bringing to the table. There were no anticipated risks for mental health workers and NGO workers in contributing to this research. Issues concerning participant's privacy and confidentiality were raised, and limits to confidentiality were discussed (please refer to A & B).

The professionals included clinical psychologists, counsellors, Maori cultural advisor, crisis team coordinator with psychiatric background, and social workers who worked alongside Maori homeless people. There was one female and five male mental health professionals. The interviews for mental health professionals were conducted at a time and place that was convenient for them. In some instances this was in their place of work, in a garden, at a café, or they invited me into their homes. Below I provide a short introduction to the mental health professionals who participated in the research. Again, while efforts have been made to ensure that participants remain confidential, it is possible that they may be recognised by whanau, clients, friends, or colleagues. I have changed people's names and omitted some information to assist in ensuring that these people will not be recognised.

TeAwhina is of Pakeha descent and spoke to me in a welcoming and practical way. This participant's sense of humour was evident and identified as a key attribute in working with homeless clients and building rapport. As a well established mental health professional she has worked with homeless people and shares some of her thoughts on homelessness. TeAwhina talks about some of the skills needed when working with this client group, building rapport, successful interventions, some of the frustrations and barriers to mental health care service delivery for this group. She also offers suggestions on what the ideal service would look like for homeless folk.

Kooputa identifies with both his Maori and Pakeha side. He is industrious, and always has something on the go. Kooputa has worked in mental health services for a number of years. He is a therapist and works with all types of people including homeless people. As Kooputa shares about engaging tangata whaiora in treatment, he says it's important to work with whanau "having an understanding of whanau, whakapapa whanau, and kaupapa whanau - understanding the links and resources, and understanding that bouncing from whanau to whanau or area to area is not necessarily a pathologised thing." He says meeting people face to face is important, as well as being honest, and working with everyone.

Kaamaka identifies as a Pakeha/European. He comes from a mental health nursing background and works as a coordinator for a mental health crisis team. He is focussed, energetic and enthusiastic about his work. Kaamaka raises a number of inter-related issues regarding his work with homeless people. These include mental health policies and procedures, working from within a bicultural framework, the complexity of needs where the homeless are concerned, those who slip through the cracks, limited resources, and other difficulties in service delivery. He recommends the ideal solution of a 'one stop shop' for homeless folk, a place where needs can be met.

Kahu identifies as Maori and works in a dual role as a clinician within a community mental health service and as a cultural advisor. His approach is from a holistic perspective, based on tikanga, which he delivers to whanau and individuals. He emphasises the importance of whakariti (respect), whakapono (honesty), and mana (integrity) when establishing a rapport, assimilating Western models of mental health, and making them workable for whanau. He is resourceful, and shares about skill base, knowledge, building relationships while supporting his clients in their journey to wellbeing.

Ihaka identifies as Pakeha and Maori, has a background in pastoral care and counselling, and is a social worker. He has a wide range of experience working amongst shelter youth, criminal offenders, children's homes, detox, and more. He currently manages a homeless team including a drop in centre that aims to improve the lives of rough sleepers. He has a great sense of humour, is on the ball, and runs the place well. Ihaka shares his ideas on what might work for homeless people, treatment options and health services available, over representation of Maori amongst homeless people, and the lack of Maori services that can provide and care for Maori homeless people in a way that is culturally appropriate.

Maori homeless participants

Maori homeless participants were identified through service agencies that were members of the advisory group for a larger Marsden funded homelessness project, or by a mental health worker in a Hamilton agency. Service staff approached

potential participants who had a known history of mental illness and asked if they would be keen to participate in the research. Agency workers introduced me to potential participants while I worked voluntarily in their services. This allowed time for those interested to talk with me and to find out where I was from, establish what the research was about, and decide whether or not they wanted to participate in the project. For those interested, most of the interviews were conducted at service agencies where the client felt comfortable, including one interview in Hamilton that was at a place of the participant's choosing and at the discretion of their agency worker.

It was important that homeless participants were able to give consent, identify as Maori or were connected into an Iwi, and had a history of mental health concerns and mental health service use. One of the participants did not meet all these criteria. However, it was decided that he would be interviewed because he had been both homeless living with a mental health concern, had been a mental health professional, and had been linked into an Iwi through a Maori ceremony.

Meetings with homeless participants were conducted in a face-to-face manner, and it was important that I met with clients prior to interviewing them. Meeting with participants was on their terms and at a time that was convenient for them. Participant interviews took place in a private room at one of the NGOs. This allowed for service staff to be available to support participants should any difficulties arise during the research process. While semi-structured interviews were used and a time frame of 45 minutes was scheduled, I was sensitive to the cultural needs of participants to take their time in telling their own stories.

There were two occasions where I was not able to meet face-to-face with participants prior to conducting interviews; however, I either made contact at the discretion of the agency, or a mental health worker liaised with the participant, giving preliminary information on the research. The participants were willing to participate and negotiated a time and place suitable to meet with me.

Participants were five Maori Homeless people and one Pakeha who was connected in to a northern tribe through a familial ceremonial process. They were

three females and three males between the ages of 20 to 50 years of age. All participants lived with mental health concerns and had been consumers of various mental health services for between two and thirty years. Below I provide a short introduction to the participants who have contributed to this research. While efforts have been made to ensure participants are unrecognisable it is possible that some will be recognised by whanau, friends, or those who work alongside these people. I have changed people's names and omitted some information to assist in ensuring that these participants will not be recognised.

Arona was 39 years of age, and of Maori descent. She was articulate and engaging when we spoke. She spoke of her own pathways in and out of homelessness, starting with the traumatic event of her mother passing away when she was young. Her father was left to raise many children. Arona talks about a harrowing situation that turns nasty, having been removed from her whanau by Pakeha people to live a life in what she describes to be a prison. She was only 7 years old when they told her "you are of mental status." Nowadays, Arona describes herself as a 'mental health survivor.' She tells stories of the good and the bad, stories of romance and love, mischievous stories that will make you laugh. There are also dark stories that even today consume her emotions, thoughts, and wairua. These are the stories of what it has been like for her living with a mental illness, addictions, imprisonment, feeling ostracised and powerless, stories of neglect and abuse - sometimes at the hands of those who should have known better, and other times as a result of her own doing. She has both positive and negative comments regarding mental health services, some that diminished her personhood, others restoring her mana. These are not all of her stories of course, she is still alive and still in the process of becoming. Arona has strengths: resilience, courage, and tenacity.

Kakama was aged 40 years, and of Maori and Pakeha descent. He was thoughtful, observant, quiet, and pretty much kept to himself. His experience of being homeless started very early in life and occurred after he "did drugs and things." Subsequently, he was removed from his whanau by those who had authority to do so, and placed in a number of European homes. He said "It's a lonely world when you are young, when you had to walk past your house, hearing your brothers and

sisters laughing in the house, and going on to another placement home.” Kakama wanted to share about his life; he said it helped him to get his sorrows out, gave him an explanation for why he went the way he did, and it helped him to think about a new pathway for his life. He talked about sleeping in a cemetery, living under a bridge, being disconnected from his whanau, drugs and alcohol, and feelings of being alone and uncared for. He shares about what it is like to be in his shoes, living in prison, mental health institutions, and his relationships with mental health workers. If he wasn’t in prison or in a mental health institution, he was out on the street. Kakama sometimes sees things even before they occur. These are not tangible things like the sorts of things you can touch or observe. They are things about himself, those close to him, or something to do with his ancestors. He thinks perhaps these insights may have been handed down from the ancestors, similar to the gifts of a tohunga. He doesn’t always know what they mean, and sometimes he is not sure what is real and what is not. Kakama currently has an apartment, which he says is not that good, and he is making efforts to withdraw from his addictions.

Pounamu was aged 25 years. She did not recall how she ended up in and out of CYFS care. She thinks it happened around 5 years of age. What she does remember is that she went from residential home to residential home, and often when she went back home her whanau would kick her out. She said “it’s because no one could put up with me.” Her father was high up in a gang, and her mother had known nothing else. She said that the school rang CYFS when they noticed she had bruises. She also spent time in and out of juvenile detention. Pounamu said it was not until a friend introduced her to some street people on j day (drugs and alcohol day) that she met her partner to be. Street life, compared to her old life, was much more appealing. Pounamu is also someone who sees things, sometimes spirits, or what she describes as auras. She’s generous and kind and tries to help other street people out when she can.

Pania was aged 29 years and identified as Maori and Pakeha. She says that she had a strong Pakeha upbringing. Pania was a delight to talk to, trusting of others, and unassuming. She believed that her mental illness started when she was a child. She shares about childhood abuse, hearing voices as a child, losing a mother

in her adolescent years, and her struggles with bulimia. She talks about what it is like as a teenager to want to tell someone about what is going on, but fearing what they will think of her. All she wanted was to live a normal life, like all the other kids at school. Her family were supportive and assisted her to go and see a psychiatrist and to find an appropriate mental health service. Pania had recently become homeless after a fire in her flat. She was worried that the landlords were saying bad things about her to others, and that housing New Zealand would no longer allow her to rent another place to live.

Eruera is Maori and Pakeha, and aged 31 years. He takes a protective role on the street by looking out for young people, and teaching them how to survive. He's a networker, and prides himself on building relationships. Eruera spoke of certain events in his life such as his family's gang involvement, childhood abuse, how CYFS removed him when he was around three years old, and ending up in a family where violence and aggression were the run of the mill. He shares about his challenging behaviours, relationships with psychiatrists and psychologists, his many moves from home to home, and how he escaped in between. If you were to ask Eruera how he came to be homeless, he would tell you that 'I put myself there.' It is a place where he feels comfortable, a place of freedom where there are no rules. He said:

There are a lot of men out here on the streets that wouldn't tell you their secrets – they are secrets society wouldn't be able to deal with. That is why most of us men are out here, getting away from what we have done, or what has happened to us, trying to escape.

Kaiwhakaako was considered to belong to both therapist and homeless group category (he will be discussed in both the analysis of mental health professionals and clients), having worked many years as a mental health professional, an educated person who had been homeless. Kaiwhakaako is of Pakeha descent and 39 years of age. He said:

Even though I am not Maori myself, our family had a connection in that my father, a few decades ago, saved the life of one of the sons of a Kaumatua in the Northern region. As such, my family was welcomed into the Iwi in a ceremony that took place up there. I found it really interesting in that years

later we would go up there and meet people and they would remember the situation. The story had been passed down a couple of generations. So there is a connection even though it is not an actual familiarity, it's something I find really quite neat. We had several neighbours where I grew up in [Auckland] who were from the Northern region as well. They all knew my family and remembered my father. It would be inappropriate for me to claim some deep understanding, or cultural understanding, but I do feel a deep connection that still moves me when I think about it.

Kaiwhakaako describes his pathway into homelessness. Having worked as a therapist for many years, he said “I tended to focus on my job and left my own personal crisis to one side.” According to Kaiwhakaako, this is where his life broke down. He shared about his difficulties trying to access mental health care, therapists that didn't know what to do with him, and finally ending up with a therapist that he had once trained. He offers insights around street life and being homeless, treatments, cultural issues, housing issues, economics, politics and history, and working with people who live with mental health concerns. Kaiwhakaako is a good storyteller.

Analysis

There were two group analyses. One for Maori homeless participants and the other for mental health professionals (see chapter three and chapter four for analyses). The first step was to take the first participant's interview, starting with homeless participants, and identify themes in narratives told. I listened to the research interviews, and read participants' data many times to familiarise myself with their stories. I then made a note of the themes that emerged. Such themes were easily discernable due to the given topics in the semi-structured interviews. The next step was to compare and identify common themes across each of the participants' stories. There was a process of going back several times to read participants stories, and comparing these accounts across homeless participants. Themes that emerged were used to understand, define, and illustrate the basic categories and cultural categories of similar shared meanings, perceptions, and experiences amongst participants.

The stories people tell are often influenced by interactions within the socio-cultural and political context in which they may live (Flick, 2006). The analysis in this research incorporated aspects of Murray's (2000) levels of analysis including personal, interpersonal, relational and ideological or societal levels of analysis, and seemed appropriate to take into account Maori world views that include the social, physical, emotional, political, and spiritual spheres. Sharing such personal stories is also therapeutic for the narrator. On a personal level the telling of chaotic stories can be seen as achieving some degree of healing in the recovery (Frank, 1999). Story telling has a long rich tradition amongst Indigenous Peoples and is a source of cultural strength, assists in giving meaning to experience, and gaining perspective of where one has come from and where one is going (Saleebey, 2002). At an interpersonal level of analysis, a dialogue is created between the participant and the researcher, and is concerned with how the narrative becomes the joint effort between two people (Murray 2000; Doise, 1986). A societal level of analysis takes into account the broader socio-cultural aspects that influence people's thoughts and ways of being within that society, and links to social representations (Flick, 2006). Having identified various themes, and making use of literature, I applied different levels of Murray's (2000) analysis to interpret how Maori participants tell their stories and how their stories are constructed in relation with others. It was also possible to see how their stories reflect the socio-cultural domains in which they live. By reconstructing some narratives I will show how Maori cultural perspectives may differ from the dominant stories in society, such as Western models of mental illness.

For professional participants, a more pragmatic and descriptive approach combined with Murray's (2000) levels of analysis was necessary in order to understand participants' background training, skills, approaches used, and organisations they worked with in providing care for Maori homeless people. Attention is paid to the barriers that mental health professionals experience in providing quality of care for homeless people and possible solutions. Societal and relational levels of analysis (Murray, 2000) have been applied (rather sporadically) to give insight into how history and time influence the stories that

professional participants produce. How they understand and talk about mental health care is a by product of social and political processes.

CHAPTER THREE

MENTAL HEALTH PROFESSIONAL PARTICIPANTS

Mental health professionals interviewed for this research reported being committed to working with homeless people and in doing so apply a range of approaches. They have not been trained for this type of work, and have had to draw on a raft of experiences in learning how to engage Maori homeless people. My overall intention in this chapter is to document the experiences of mental health professionals and how they interact with, and provide care for this client group. Attention is given to their background training, how they build working relationships with clients, and the difficulties that they experience in the provision of care for homeless people. A more pragmatic and descriptive approach is called for in order to understand some of these questions, and this will be presented with aspects of Murray's (2000) analysis in various sections throughout this chapter. Participants residing in Auckland or Hamilton worked in a range of services including a non governmental organisation service for homeless people, DHB mental health services, crisis intervention, drug and alcohol services, and a Maori community based service.

Briefly, section one explores the training and skills necessary for working alongside homeless people with mental health concerns. Participants discuss these in terms of their work histories, cultural resources, personal characteristics and religious affiliations. Section two explores how practitioners form relationships with clients and the importance they place on the therapeutic alliance. An important factor in building rapport is meeting the basic needs of homeless people. This gives rise to humanistic approaches which are also compatible with Maori ways of being. Section three documents participants' views regarding barriers to quality care for homeless people. They are aware of both structural and individual factors impacting on service delivery and quality of care. Their accounts emphasise numerous barriers to positive mental health outcomes for Maori homeless, and the need to look more holistically at the issues that arise. Although problem focused, participants were also solution focused, providing suggestions on how services could be enhanced, and offering professional insights

into what they think might address gaps in services or barriers to quality care for homeless people. An important element of effective care appears to be the ability of mental health professionals to network with other professionals and organisations that are also attempting to address the complex needs of homeless people. As an aside but important in terms of Indigenous People it is necessary to contemplate, very briefly, the European origins of mainstream psychotherapy with its socio-political roots in Western civilisation (Prochaska & Norcross, 2007). This will be contrasted alongside indigenous approaches in more contemporary times, and presented in the chapter conclusion.

Experience and training of practitioners in working with homeless people

This section explores the accounts of mental health professionals with regards to their background skills and training in working with Maori homeless people. There was a range of preparedness when participants started working. They refer to a variety of past vocational experiences, voluntary positions, and draw from their own cultural resources and religious affiliations. Participants rarely mentioned their formal education as being a key aspect in the development of skills. Below, three professionals give examples of a graduated approach to learning how to work with this client group. This also shows that a graduated approach to developing the necessary skills, while working in the field, is a common occurrence for different therapists or practitioners across numerous settings.

Kooputa describes his training in terms of working with people in various stages of wellness, Maori youth, whanau, and street outreach. The training and development of skills is practiced while working in the field, and learning from those more experienced.

...working with people in different stages of wellness. For example, a psychiatric geriatric hospital assisted me in developing skills to work with mental health patients. Working particularly with Maori youth in a northern agency when facilitating courses for unemployed rangatahi. This also allowed

me to work with whanau. I learned most of the street outreach skills when I was employed as a youth worker for the Hamilton agency. Further training helped me understand alcohol and drug addiction ... I learned more about dealing with risk situations out in the community, especially from more experienced mental health professionals.

In referring to a number of work situations that contribute to training and the development of work based proficiencies, it is noticeable that Kooputa does not mention his formal education. What he does not say, but can be inferred from his account, is that formal education may give some knowledge about working with this client group, but little knowledge of how to go about it.

Kooputa emphasises working with Maori and Whanau. At a societal level this is important because the frame of reference has only become legitimised in the past couple of decades. Specifically, the way in which professionals understand and practice mental health care in New Zealand has come about through a range of socio-political processes. Some of these processes have included the New Zealand government's obligation to the Treaty of Waitangi principles, Maori renaissance, service user movements, various legislative acts, and subsequent strategic planning, work-force training, and evaluation systems seen throughout the health and disability sector. In terms of the Maori resurgence, some refer to this as a period between the 1960s and 1970s when urban Maori protesters took direct action to address grievances of overt racism, and land loss (Brooking, 2004). However, Brooking asserts that the Maori renaissance began when the Treaty of Waitangi was signed in 1840, and that Pakeha awareness was spurred along by the introduction of television and a growing presence of Maori in urban city centres during the 1960s. To date, the government recognises, and has responsibility to the principles of Treaty of Waitangi including participation, partnership, protection, and equality (MOH, 2002). In this way Government strategies support Maori health initiatives, and Maori voice concerning their own wellbeing, partnership in health care decision making processes, and involvement in planning and service delivery on all levels. Consequently, legitimisation of Maori practices throughout the health and disability sector (MOH, 2000; Durie, 2005), bicultural practices, and progressive development of Maori health services over the past decade or so (MOH, 2002) has entered public consciousness, is normalised, and

discussed by participants when talking about mental health care. This also provides insight into legitimised discourses in society that professionals reproduce and support (Foucault, 1972).

Ihaka lists his past volunteer work and employment options that have focused on investing in the lives of those who are in need. It would appear that his past work experience has provided him with a rich source of experience and knowledge suited to his current position in an NGO service for homeless people. He briefly mentions his education and theological background.

BA in theology majoring in pastoral care, counseling, worked with violent and sex offenders ...I have been a manager of children's homes for boys, and have worked in Youth and Family. Normal stats applied in both those situations in terms of Maori and Pakeha, worked in sheltered youth, also worked here in the service agency, at detox, and a house for HIV Aids. I have managed the food banks, and the community support team. Currently I manage a homeless team.

The needs of homeless people are complex and multifaceted and the more services one works in the more prepared one is to work alongside homeless people. Ihaka also mentions his background training in theology. To some degree this may account for, and contribute to his work alongside homeless people, with consideration to Christian values such as caring for others, and his own perspective on faith, hope, and love. Interestingly enough, Miller states:

Love is a word often used in common language, but within psychology it is found primarily within humanistic and existential traditions. The strangely transforming power of love has been widely lauded for millennia, yet it is the concept often curiously absent in traditional psychology textbooks and clinical training (Miller, 2000. p. 11).

The same author says that in the spiritual traditions there would be no question about the ability of agape to evoke change or reduce negativity, and that its largest effects might be found amongst those in severe need. Miller (2000) questions whether or not this ancient concept 'agape' has been a poorly understood process that is able to bring about change. Human compassion, loving and kind acts, link into the skill or ability to build rapport, and cannot be separated out from this

section. When it comes to the expertise of therapists, those successful in evoking change have shown that loving, empathic styles produce relatively high success rates, where as those who are without such characteristics are liable to leave their clients worse off (Miller, 2000). This is important because homeless people are often dispossessed, disempowered, and disenfranchised, and they need therapists who will treat them as human beings, show genuine concern, acceptance, and understanding in order to build a platform for the kind of relationship that leads to positive change. There are many things besides a formal education that go into the mix of training and skill development, albeit some things cannot always be measured scientifically, or put in to boxes and ticked.

Participants draw from a range of experiences when working alongside homeless people. Kaamaka's work involves crisis intervention, and while he does not focus on past education, he does talk about personal characteristics necessary to work alongside people presenting with challenging behaviours in times of crisis.

Patience, a lot of patience and a lot of perseverance, you go over the same things a number of times, and that is just the nature of the beast. To a great extent it's about being able to let things run off sometimes, like water off a duck's back, there are times when you have to act, the person doesn't want it, you get sworn at, get told to 'f off' all sorts of things and you can't afford to take that personally. Particularly with the use of the Mental Health Act, that does give clinicians an awful lot of power. I have always been a firm believer under those circumstances that it is easy to abuse that type of power. It is incumbent upon the clinicians to be aware of that, and be very clear about why we do and what we do. Have our clinical rationales for that. Certainly for the crisis team to be able to work with people who are angry and upset and have those verbal de-escalation skills.

Character education is typically not taught in universities. However, the development of patience and perseverance is practiced in the context of life (Miller, 2000), or learned by working at the coal face in hands-on situations, where conflict is often inevitable. Kaamaka also gave his view on the use of the Mental Health Compulsory Assessment and Treatment Act 1992 that places practitioners in positions of power, and opens possibilities of abusing such power. He is aware of the power differentials between practitioner and client. People who

are homeless and live with mental health concerns also live with the added threat of involuntary hospitalisation (Toro & Warren, 1999). However, professionals may at times need to use the Act where people become unsafe to themselves or others, or working through an acute stage of mental illness.

In the following section we will focus on the importance of clinicians building rapport with homeless people. Again, it is important that we briefly touch on this issue here as it has cultural significance for Maori. The following participant gleans from his own personal background experience and cultural resource when working alongside other practitioners and Maori service users.

Kahu: Part of my learning was from my own Marae. A lot of learning was from a mainstream mental health centre, understanding each clinician, or each whanau members' perspective, and summarizing in a way that the each person's message was clear. I can relate this to a taha Maori framework to a whai-korero framework. A great orator must listen to the korero. He must listen to the korero and pick up each significant point of the speakers before him, and then the great orator must summarize all those as well as uphold the tikanga or procedure or process of the hui at the time. You must also have the skills to understand the frameworks you need to understand the karakia, tauparapara, and listen to korero, summarise and close with it with a tauparapara related to the korero...Understand the framework whai korero. I learned that from my background...

Kahu draws from his own cultural resource which has been taught to him from within his tribal area and familial background. In doing so, he provides an illustration for bicultural practice. He integrates mental health procedures along with his understanding of Marae protocol. In working with Maori, a number of models have been developed that draw on aspects of this framework. In reference to the whai korero, or speaking of the orator he refers to those who carry important cultural roles (Mead, 2003). For example, in the Marae setting it is usually those who have the mana to speak who do so (Mead, 2003; Durie, 2001). Maori ways of being, thinking, and aspects of the social order are illustrated in the whai korero. Speeches in the Marae Atea occur in the domain of Tumatauenga. This process uses the domain of space to challenge, inquire, connect, and inform, it establishes what type of relationship is between self and others, and contributes

to the rehearsal of cultural identity (Durie, 2001). The course of action is considered tapu until there is a mutual agreement and coming together as one people, or whanau. This includes lifting of tapu where both parties hongiri, and tangata whenua extend manaakitanga. Maori philosophical base is holistic in approach (Smith, 1999), and aspects of the social order seen in the whai korero include, acknowledgement or mihi to the land, ancestors, the living, tangata whenua, and giving reason or purpose for the gathering.

Kahu's narrative demonstrates working with people in a way that the contributions of each speaker has been listened to, acknowledged and summarised. In essence the relationship between person and others is respectful, and recognises the worth and value of each member by acknowledging each person's input. In doing so he builds a platform for ongoing reciprocity and obligation.

In sum, professional participants described their training and development of skills in terms of their past work histories. Participants were not taught applied skills in formal educational settings to work alongside homeless people, and they draw on a raft of experiences when working with homeless people. Participants also describe having had extensive work experience in mental health services, including crisis intervention, mainstream mental health, mental health institutions, drug and alcohol work. Some had also worked with clients and their whanau, youth work, street outreach, in NGOs, and more. It is evident that for a range of professionals, development of skills and training occurs over time while working in hands-on situations.

On a societal level, training and skill development cannot be separated out from bicultural practice, and the way in which participants understand and practice mental health care is in part, a product of socio-political processes. While not all the processes can be illustrated here the Maori resurgence, legitimisation of tikanga practices, and Treaty principles have been incorporated throughout the health and disability sector means participants are exposed to and involved in creating more holistic models of health care.

In working with Maori homeless some of the participants discuss how they draw from their own background cultural resources. They illustrate a certain skill in weaving two strands of knowledge together, namely mainstream mental health knowledge and their own understanding of the Maori world. But of course, two strands alone do not necessarily make a rope. While participants are skilled in their respective areas of expertise, not all participants are able to provide a culturally appropriate service for Maori. From participants' accounts it would appear that those more at ease in doing so are Maori practitioners or therapists who have had an upbringing in the Maori world, and are highly familiar with Maori ways of being. I am not saying that non-Maori or those who have not been accustomed to things Maori from the get-go are unable to understand and practice tikanga Maori in service delivery. But this does suggest that there must be appropriate cultural resources in training and development, provisions, relational links, and time, before non-Maori practitioners are competent to implement such skills when working with Maori homeless people. However, three sets of overlapping skills are needed here, which may imply training to work alongside homeless people, mental health practice, and bicultural practice.

These findings show that there are many things that go into the milieu of skill development or proficiency in working alongside homeless people with mental health concerns. Some of these things do not necessarily fit within a scientific framework, nor are they constructs that can be easily measured. One participant talked about the importance of personal characteristics such as patience and perseverance which assists in the use of de-escalation skills. However, character education is more likely taught in the school of life, than in university settings. Another participant mentioned his theological training which linked into a discussion that Miller (2000) brings up concerning the nature of love or agape. While practitioners, or psychologists, may find this an uncomfortable word to deal with, this kind of love is, in many ways, referring to the very things Rogers (1961; 1980) talked about such as unconditional positive regard, accurate empathy, and personal congruency, has been shown to be important in bringing about positive change in a therapeutic setting. These characteristics are similar to what most of the participants discuss as necessary skills in working with homeless people, such as the notions of doing what is right, acts of kindness, being honest,

showing human concern for others, giving respect and dignity, and working in collaboration with others. Such attributes appear to reflect Maori social order with a strong emphasis on relationship and connectedness (Smith, 1999). The same author mentions that the term respect often highlights the significance of relationships in the Maori world. These characteristics are not entirely cultural specific; they are also human qualities which all participants demonstrate by offering similar accounts of building relationships with homeless people, and are visible in the following section.

How do practitioners build rapport?

In this section, participants describe how they go about building relationships with homeless people. They discuss this in terms of meeting primary human needs prior to embarking on therapeutic interventions. Many psychotherapists believe that the development of a good working relationship is central for clients staying in therapy and contributes towards successful intervention outcomes (Prochaska & Norcross, 2007). A good working relationship has also been identified as an important factor in mental health recovery (Lapsley, Nikora & Black, 2002) and understood by social workers as a good medium for change (Saleeby, 2002).

An exploration of participants' accounts reveals that practitioners use four important strategies to build a therapeutic relationship when working alongside homeless people. The first approach was giving or *manaakitanga*, which is primarily achieved through meeting the basic needs of homeless people. The second was the practitioner's awareness of clients' socio-cultural history or lived experience, and the past negative experiences that Maori may have endured while in mental health services. Thirdly, the meeting ground, or place that homeless people felt comfortable to meet, was deemed to be important. Participants also talk about Maori models of wellbeing, or recovery and strength based approaches that are humanistic in formulation and focus on the inherent value and dignity of human beings.

TeAwhina discusses a practical approach to building rapport in terms of good will, practical assistance, and meeting basic needs first.

Give them something that they want. Give them a shower. We have got a shower here in our new building. At our old building in a southern region the psych assistant use to give the homeless people, who slept down at the river bank, cups of coffee...Sometimes give them money if they are in need.

This quote is revealing in that it brings the issue of material needs into mental health care practices. It also raises the importance of responding to the circumstances of clients in trying to build a bridge to, or relationship with them. Simple acts of kindness, such as allowing a participant to shower, reveal a practitioner's humanity and can be crucial in establishing the basis for bonds of mutual obligation.

Kahu also talks about meeting basic needs, and by focusing on a whanau approach he offers his client a longer term relationship than would be expected in mainstream drug and alcohol service. Kahu follows Maori ways of being, and takes his client in as one of his own whanau.

I mean for the guy, just giving him some kai. If you look past the mess, and when he came to the clinic he said that 'you are the first person I have come to, the first clinician who has given me a kai.' For example, Maslow's hierarchy of needs, if you look at a whanau level, it's about kai and a roof over your head. He is still in therapy today. He does have a few relapses now and again. But you see we have broken the whole cycle of going into a deeper darker place. This room was his place for maybe six months. He's moved on to bigger things now, from there he moved onto to University.

By initiating contact, offering food, and 'looking past the mess,' it is likely that the homeless person felt truly cared for. The act of giving evoked a response from the person, and provided a platform for trust and reciprocity. In this case, the relationship was established before the person entered the service.

In building rapport, both Kahu and Ihaka mention Maslow's hierarchy of needs. The first level of the pyramid model is meeting the basic requirements of human life such as water, and food. However, a starving person is in no less need for love and acceptance than a wealthy person. Just because a person may lack basic needs it does not mean that they have no need for higher order needs. Additionally, Maslow's (1970) concept of self-actualisation can be considered as self

determination or reaching one's desired goals, a process in which people have not been defined in a fixed way. Both Maslow (1970) and Rogers (1961) postulate that while one is still alive, they are in the process of becoming all that they are able to become. Not only is this compatible with indigenous concepts of self determination, the focus is on human strengths and human growth in preference to a more deficit type approach. The strengths perspective relies on the professional's understanding and belief that their client has an innate capacity to renovate their lives, whereas disbelief that people can change often inhibits growth and development (Saleebey, 2002). But, of course, in order to fulfil growth or potential, favourable conditions are needed (Seal, 2005). For Maori this is of particular importance when we consider the history of colonial relations, and current health outcomes. Incorporating strength based frameworks into practice is important for mental health practitioners who are about the business of caring for homeless people and keen to promote growth, maturity, and improved functioning. Conversely, a deficit approach or an over emphasis on client problems, especially where homeless people are concerned, may reinforce maladaptive beliefs of inadequacy or worthlessness, and may result in further isolation or social exclusion.

An example of strength based approach is provided below where one homeless practitioner takes into account the abilities and personal agency of homeless people to find and locate necessary resources.

Ihaka: Because we are here, and because we offer something at a very basic level, for example if you look at Maslow we are here with the food and some shelter, when you offer those basic needs, then on principle you might want to establish a reasonable relationship with the cook, never piss the cook off, then food and shelter is a really basic need for someone living on the streets. ... People who live on the streets are very good at resourcing themselves. Once you get rid of the notion of charity and all that, the drop in is a useful referral source, useful meeting ground, a safe place for them, a safe place for us to talk to a client, a place for us to get a measure of each other. If I am behaving like an asshole, whilst they will still come, there won't be a relationship there, they are coming for the food. But if I am behaving professionally or as a

decent human being then obviously there is a chance for something other than just a provider of food relationship to develop.

In preference to viewing homeless people as vulnerable or needy citizens, Ihaka refers to the personal agency and abilities that homeless people have in finding resources while living on the street. The NGO provides a safe environment where homeless people can meet others, form social networks, and secure basic needs. In providing a place where homeless people can meet they can also draw on the favours of others and circulate privileged information. The meeting ground allows homeless people to gain access to various opportunities. Part of the NGO's work is to refer homeless people to community resources. However, this does not belie the fact that for some of these people attention to basic needs such as food, fluid, warmth, or clothing are necessary prior to moving onto other important interventions.

Kooputa, who works as a clinical psychologist, also builds rapport with the awareness that more effort may be needed to break through any perceptions that homeless people have with regards to their past experiences in mental health service use. He does this by showing that he can be of use to the client through strength-based approaches such as appreciative inquiry, finding out what it is that the client wants to achieve, and working with the person to meet that need.

When engaging tangata whaiora - the person seeking wellness- the whole thing is what are they interested in doing; some of them it's not finding a house, it's nothing like that-- it's getting a job. Some of them need clothes, and you meet the needs to show that you can be of use to them. You need to remember that these people are used to a medical model hammering out "you need to be meeting this standard or doing that," and they just close off to you. Some of these guys have been through the system for so long that they tune out to their helpers.

As discussed in the introduction, Maori have been suspicious and untrusting, or have a lack of faith in Western models and methods of assessment that are culturally inappropriate (Durie, 2001; Taitimu, 2007). Saleebey (2002) asserts that this can create a special problem for professionals, regardless of ethnicity. In establishing rapport, Kooputa demonstrates a recovery-type approach by supporting client's resourcefulness and ability to achieve goals. In the previous

section there was a discussion around socio-political processes that contribute to how health care is understood and delivered in New Zealand. This links into to an acceptance of the recovery approach in the mental health sector since 1998 (O'Hagan, 2004). The same author maintains that there is still some way to go in making sure that service delivery is recovery-focused.

How participants went about establishing relationships with clients was in part dependent on the type of mental health service they worked within. Two participants were experienced working within crisis services where it was important to establish a relationship quickly. In such cases there was an inquiry into the nature of need, with an end goal of re-establishing equilibrium and safety for the client, or others, through appropriate interventions.

Kaiwhakaako establishes rapport by identifying some common ground between the client and himself to enable a response from the client. He is direct and to the point about what is on offer, finds out what the client needs, establishes there is a problem, and wastes no time in gaining the client's buy-in.

Kaiwhakaako: If I was short of time and had to establish some action fairly early, it was quite important to express what my expertise in the area was, like to say to the person I spent four and half years on the street. So if you want to talk about homelessness, I know what you are talking about. To ask them in very clear terms exactly what do you want from me? So find out from them what they want from us straight away. Then I would establish my bullish (laughter) situation and that is a type of contract that says 'you are here because you have recognised a problem, I am here because I've got skills that can help out. You have expressed that you want those skills. Right that's the situation of the contract let's go for it, no bullshit no crap, let's just go for it straight away.' People will often really appreciate that, because a lot of clients really distrust clinicians because the terminology and the presentation of clinicians is often so woolly and vague.

Finding common ground is important when initiating rapport. This can be seen as a type of reciprocity in that information is shared. Both the carer and the recipient give and receive information. It may also work to eliminate some of the power differentials in the therapeutic setting. However, this will also depend on the

openness or willingness of the client to share information, and the skill of the professional to draw information out.

In the context of a crisis intervention service where individuals self-refer, Kaamaka mentions that building rapport is not difficult.

Kaamaka: Some people are actively seeking assistance, in which case it is very easy to get that rapport and make suggestions as to how we can move forward in this situation.

In order for a person to seek assistance when there is a crisis situation, there needs to be some awareness that there is a problem, a belief that they are in need of help, and the motivation or personal agency to seek support or professional advice.

Contemporary Maori mental health policies require that practitioners take into account a number of factors such as indigeniety, or the right of indigenous peoples to retain cultural identity and some autonomy, the professional and cultural competency at the interface between practitioner's culture and that of others, a willingness to provide care in culturally appropriate ways, and the ability to provide health care that does not diminish self respect or undermine human dignity (Durie, 2005). This is linked into to how participants talk about taking a whanau based approach. The whanau approach Kooputa refers to follows Marae protocol and discussed below.

Kooputa: There are particular skills when engaging Maori...For example having an understanding of whanau, whakapapa whanau, and kaupapa whanau, so understanding the broadness of their links and resources, and understanding that bouncing from family to family, or from area to area, is not necessarily a pathologised thing. Meeting people face to face is very important, being honest, and that is working with everyone. I would take a whanau focus. By focusing on the extended whanau members you begin to understand that the whanau members' distress is sometimes the most significant stress in the picture.

Kooputa discusses how to approach Maori with an understanding of family and extended family, the sharing of resources, and the obligations between whanau members. A whanau approach and family support is relevant as whanau are at the heart of Maori social order (Te Puni Kokiri, 1996). In Lapsley, Nikora & Black's

(2002) study, whanau were identified as a key element for aiding recovery. Whanau involvement has also been identified as important as other family members can give insight into client history.

Another participant also talks about Marae protocols as a way of connecting and establishing relationships with others. He discusses some of the main ingredients for building sound relationships including respect, honesty, and integrity.

Kahu: Tikanga I use that formula, you are like coming onto our Marae, once you have been welcomed, and made access through following those procedures, you become one. That access into our building is free every time. In some ways part of that wananga I have with my colleagues is about looking at pragmatic ways of working with whanau Maori, again if your value base is sound, and you are genuine about that value base, it will reflect in your practice, again those things that are synonymous with Maori, if you have values of respect-whakariti, honesty-whaka pono, integrity-mana, you will have mana, because if you are passionate about those things individually and personally they are reflected on the people that you deliver that to.

Such characteristics also combine to form helpful or confirming relationships. Rogers (1961) includes trustworthiness, dependability, congruency, attitudes of warmth, caring, interest, and respect. Rogers talks about confirming relationships compared to a 'professional attitude' in which the professional can keep distance from the client. In talking about helpful relationships he does not limit this to the health field.

Conversely, while some participants discussed whanau interventions as being important when working with Maori, it has also been identified that for some Maori, unhelpful whanau relations inhibit the healing or recovery process (Lapsley, Nikora & Black, 2002).

Ihaka: Some Maori are very clear they don't want any connection with Maori or Mental health services at all....Some have had bad experiences with their whanau, there might be shame, or their experiences have not been good, and they might be strong in their own Maori-tanga and their own identity as Maori, so there is a real conflict there, on one hand yes and on the other hand no.

Research in New Zealand, albeit limited, has also shown that in some cases Maori homeless have disengaged whanau due to unhelpful relationships, or childhood abuse and early violent situations (Al-Nashrallah, et. al, 2005; Peace & Kell, 2001) which may also provide a reason for some Maori homeless not wanting their whanau or extended whanau members involved in intervention. However, it this does not mean that clients can not be asked if they want whanau involvement though various stages of intervention (Taitimu, 2007).

In summary, participants talked about four important themes in building rapport, including: 1. Manaakitanga/giving, 2. Awareness of clients' socio-cultural history or lived experience, 3. Meeting ground, and 4. Maori models of wellbeing or strength based, recovery type approaches. The first and most frequently talked about approach to building rapport was a pragmatic approach to meeting the homeless persons' basic needs. In most cases, participants gave food, money, shelter, or provided showers. For those working in mental health services, manaakitanga, or acts of generosity were also necessary to elicit some type of response from the homeless person. Acts of kindness, also reveals participants humanity, and was crucial to establishing the basis for a bond of mutual obligation. In crisis intervention services it was important to establish rapport quickly by finding some common ground, ascertain what the person needed, agree on the nature of the problem, and to ensure safety before moving on to other interventions.

Secondly, it was important that practitioners and therapists had an awareness of Maori homeless persons' socio-cultural history and lived experiences, including the multifaceted problems that homeless people may have endured over a life time. One participant illustrated his awareness of Maori homeless peoples' concerns with past mental health service use. This included awareness of the mistrust or suspicion that Maori may have towards more Western approaches to treatment, and subsequent resistance towards intervention. Understanding past grievances can inform service delivery and intervention. Being aware of past difficulties that Maori may have experienced with mental health services, and the plight of homelessness, may also bring about self awareness for the clinician and an acknowledgement of a more privileged position. Being aware of such things

can also be a medium for building rapport when a homeless person feels that a practitioner understands their situation, they are more likely to trust, open up, and share information. In this way the practitioner is in a better position to partnership in finding a solution.

Thirdly, meeting people in their own environment appeared to be conducive to building relationships with homeless people. Alternatively, providing a space where homeless people could meet and receive assistance for basic human necessities was also a favourable condition for establishing relationships. For example, the NGO participant described building a reciprocal type of relationship, where the person might receive food, shelter or clothing, engage in relationship with others, share information, and move onto other interventions. It would appear that the NGO provided an important setting where homeless people could gather together, form social networks, and provide a safe place where social benefits and exchanges in privileged information could occur. The centre also provided referrals to other community services that could assist homeless people.

Fourthly, throughout the chapter, a recovery focus, which informs mental health services in New Zealand today (MHC, 2002a), or strength-based approaches were used by some of the participants to strengthen the working relationship between practitioner and the homeless person. Two of the participants mention Maslow's hierarchy of needs, and this may reflect their training in counselling or social work. This model is slightly problematic as homeless people who may require basic necessities are in no less need of love and acceptance, or other higher order needs than those who are wealthy. While strength-based or recovery-type approaches have not always been the focus for practitioners, something can be learned from these approaches if it is in the best interest of Maori homeless people. For those working in mental health in New Zealand, the Blueprint (MHC, 1998a) underscores respecting the rights of, recognition of equality, especially where people are recovering from mental illness. The focus is on empowering the consumer, assuring that their rights are met with best outcomes, working in collaboration with, and increasing client/whanau control over their wellbeing so that they can fully participate in society.

Some of the participants worked from bicultural perspectives or whanau-based frameworks drawing from mental health service training, and their own cultural resources. Working from a whanau-based approach enabled one therapist to establish a longer relationship than would be normally expected in mainstream mental health services. Maori pathways to healing or recovery incorporate values of acceptance, supportive environments, hope, and are not time limited (Taitimu, 2007). In Kahu's account, he went out to meet a homeless person where he was at. The client responded to someone who showed he cared. As discussed previously, people who are homeless have often had a lifetime of poor experiences that would suggest otherwise. It would appear that 'looking past the mess' and giving extra care and support was instrumental for the client's resettlement. In a similar vein, Kooputa's service also enabled some of the practitioners to work out on the field by meeting homeless people in their own environment. However, not all mainstream mental health services allow their staff the time or the space to go out and meet people where they are, or to develop longer term relationships.

The goal of practitioners and therapists was to start building relationships by meeting primary needs, show they could be of assistance, and encourage a response from the homeless person. By meeting primary needs first, and or finding some common ground, participants were able to build a platform for reciprocity and obligation. Other responsibilities for practitioners included persuading clients to stay in supportive and therapeutic environments, and refer or assist homeless people to other services when they lacked the resources to cater for their specific needs. Regardless of whether professional participants were Maori or non-Maori, all participants gave illustrations of respecting their clients, being generous, or showing genuine concern and empathy. The term respect is consistently used in the Maori world to emphasise the value placed on relationships and being human (Smith, 1999). Building connections and relationships in a culturally appropriate way between therapists and clients is very important, however, unless there are broad policy changes at national, regional, and agency levels that reflect the opinions and broader needs of homeless people, the quality of, and provision of care for homeless people will be limited.

Clearly, a number of agencies are required in order to provide quality care and stability for Maori homeless people living with mental health concerns. While professionals find building relationships across services to be advantageous, there are a number of interagency boundaries and barriers that limit the effectiveness of services to provide necessary support for homeless people. Some of the barriers or gaps in service delivery are identified and discussed by mental health professionals in the following section.

Barriers to mental health care

Often homeless people living with mental health conditions have difficulties trying to access health services (Lezak & Edgar, 1996; Leggatt-Cook, 2007; Gravitas Research & Strategy Ltd, 2005), and this is especially difficult when more than one service is needed (Lezak & Edgar, 1996). In New Zealand there has been very little in the way of early intervention programs for homeless people (Leggatt-Cook, 2007), and there is a lack of services that can provide culturally appropriate interventions for Maori homeless (Al-Nasrallah, et. al, 2005). Participants talk about a variety of issues when providing quality care for this client group. They are aware that both structural and individual explanations contribute to poor outcomes for Maori homeless living with mental health concerns. Interestingly enough, Murray (2000) says that illness explanations often include structural factors that contribute to inequalities in health. This includes lack of access to health services, unemployment, or housing, but this does not negate that the individual has personal responsibilities for health, or ability to cope with illness. This places explanations for homelessness and poor mental health condition in external environments that are beyond the individual's control. However, participants also show that the personal responsibilities of homeless people also play a role in maintaining their situation and condition. An exploration of participant accounts reveals that problems include transitioning between and/ or out of services, agency and organisational policies and procedures such as criteria defining who can receive a service and who cannot, compartmentalisation, 'protecting the patch,' missed communications, incompatible database systems, slow transfer of information, lack of beds in detox, and lack of accommodation. Participants also talked about the individual

characteristics of homeless people that present a barrier to mental health care, such as illiteracy, drug and alcohol misuse, and lack of planning and general life skills.

Participants' stories reflected frustrations with gaps in services. These gaps contribute to poor quality health care. Below, participants provide some examples of how homeless people may 'slip through the cracks.'

Kooputa: From prison he is dropped off in Victoria street. Well done, that's it. What does he do? He has great difficulty setting up his account for money, he gets wasted, spends his money, gets in trouble and re-offends. He has family members who ring me wanting to know when he gets out. The person is mentally unwell, absolutely incoherent, and he is released. I mean for these guys that are offending there is not the right connection between probation, prison, and family, and obviously between mental health services and the prison...Maybe a referral has gone through but it's pointless. It's comical that it can happen this way. There is an obvious loop.

Kooputa discusses a 'loop' in which a homeless person with mental health concerns offends, is imprisoned, and then released back onto the street, with limited support, only to re-offend again. Research has shown that homeless people in New Zealand may be more at risk when leaving prison (Peace & Kell, 2001; Al Nasrallah, et al., 2005). Without subsequent intervention conducive to resettlement, people living on the street are more at risk for increased homelessness, increased drug and alcohol use, and ensuing crime (Fountain & Howes, 2002).

The difficulties of providing Maori homeless with a quality mental health service is in part a reflection of the diverse needs of this group, coupled with service compartmentalisation. Practitioners talked about this in various ways. One participant points out that sometimes homeless people with mental health concerns are burdened with the personal responsibility of approaching other services.

Kaamaka: Homeless people really don't get a good service from us, because quite often they will present, you deal with the immediate crisis and they slip through the crack.. You refer onto other services. The responsibility is put

onto the person. This is who you need to contact for this, and this person for accommodation. A lot of the time they choose not to do that, that is their choice, but sometimes I think that even some of these services have quite a lot of hoops to jump through to get the service and the end result. I've worked with this gentleman who has been homeless for a long time now and he pops up every couple of months and he needs somewhere to stay. We will go through trying to find some places that he has to apply for. But there is a delayed process, sometimes it is two weeks before they can get to see someone. I prefer to see something more instant; it doesn't have to be permanent accommodation for these people, just a place they could go and stay for a few days or week or two, however long, so we can say, look here is a place you can go to.

This participant is straight up with saying that homeless people do not get a good service; once they leave the service they are likely to 'slip through the cracks.' Professionals in the mental health field are concerned about their clients, and as Kamaaka demonstrates, the practitioner may often go the extra mile by acting as a bridge between the homeless person and other agencies. However, where the client does not meet service criteria, the funding stops and so does the intervention if they cannot access other services. More commonly, the responsibility is placed onto the individual, and this may reflect some of the belief systems that exist in society concerning health care. How are homeless people with chronic or debilitating mental health issues meant to be coherent enough to navigate their own way around community services? If they are able to manage, then it is likely that the first issue they will seek to address is survival, such as finding food and a dry or safe place to sleep for the night.

Trying to find shelter for homeless people, for even a few nights, was a common occurrence for some of the participants. This also represents a barrier for service delivery and intervention. In the introduction of this thesis there was a discussion on the many risks associated with sleeping rough, perpetually giving rise to psychological, physical, and emotional stress, and also counterproductive for any type of treatment. Participants identify that temporary accommodation is necessary.

For homeless people in particular we do have the women and men night shelters, fantastic services, but sometimes I wonder (because I am sure those who run voluntarily do a great deal) why should it be volunteer? Shouldn't people be paid to do this? I know they are in there at such and such time in the evening, and they have to be out by 7 a.m. in the morning. To me this is an invaluable service. It's like surely the government should be stepping in and making this better. It's things like that, and because there are so many services who all protect their little area as such, you start getting this protecting their patch, oh no they don't meet our criteria as such so you need to go else where.

The participant states the need for government intervention where homeless shelters are concerned. Conversely, it could be said that if the volunteer sector keep providing shelter, the Government may take less responsibility in dealing with this social issue.

Other barriers to quality care for homeless people that were identified by participants included interagency and between agency communication systems. Three of the participants mentioned having problems with information being transferred from different services concerning mutual clients on their case load.

Kaamaka: The difficulties for homeless people are that there are so many areas of need...there are so many different services that currently have to be involved, you have to organise that, and you know it is always this backwards and forwarding, then communication breaks down, and information is missed, then there is the paper shuffle

For this community service, time is extremely important. Dealing with potentially life threatening situations means that there is usually a small window of opportunity for practitioners to act. It appears that time is taken up with slow interagency communications, organising and arranging other services to get involved, assessments, filling forms, and fitting into service criteria. Such issues may contribute to poor health outcomes for Maori homeless. This also leads on to the next issue concerning ineffective communication systems in services.

The same participant discusses ineffective communication systems, such as non compatible database systems across DHB services and a slow transfer of information to other services who share the same clients.

Very much so I frequently get requests for information about where this person is meant to be, and you go through the file and fax it through, it's all very time consuming you know, it's doubling up on information. At the moment on our clinical results system if someone is under our community team here and it comes to attention over the weekend, we have that computer system and I can see, oh this is what has happened to this person just of late ok, carry on this process. But as I say each DHB has a different communication system and never the twain shall meet. To me it just makes sense, why not have the same system?

Taking into account the transient nature of homeless people, effective information sharing between and within services is necessary to aid practitioners and therapists in their work with homeless people, and to provide Maori homeless with a more effective outcome. It may be time consuming when information is missing or mental health professionals are unable to access the necessary information on clients. This also increases probability of errors in providing a service for Maori homeless. Compatible data base systems between agencies, and database system that allows, for instance, non governmental agencies to access certain pieces of information related to mutual clients would seem practical. The cost for such computerised systems should be weighed up against the time lost using non compatible systems, and incidents that may occur for human lives in the duration. Possibly, another barrier to interagency information is obtaining confidentiality across services, and this would also need to be considered.

All participants, in some way, mentioned organisational policies and procedures, or 'not fitting criteria' as barriers to service delivery. Interestingly enough, while standards in the health sector aim to reduce the barriers in health care through various agency policies and procedures that match funding requirements, they can also have the opposite effect by increasing barriers or excluding those in need. Some of these examples are presented below. There will also be an example of discrimination, as this contributes to barriers in service delivery and inequalities in health care.

Kahu gives an example of limitations in organisational policies below, but he also broaches the issue of discrimination that will be mentioned here. Such discriminating behaviours contribute to poor health and to the inequalities of health for New Zealand Maori (Harris, et al., 2006).

Kahu: What I have seen, or experienced, working under the guidance of the organisational policies and procedures, is that it excludes certain people, unless they come in for help. ..Sometimes from the front desk, even how the person presents, the whole huge judgment thing is going on.

A policy for reducing discrimination has been set out in the Mental Health Commission Act 1998. In section C of this article, there are specific guidelines for those working in mental health services about reducing stigma, and eliminating discrimination towards those living with mental illness (MHC 1998a).

Below two participants provide examples where homeless people cannot receive services when they do not have an address. This may be true for DHB Drug and Alcohol services. However, this may not always be the case across various DHB services in New Zealand.

Kahu: Another barrier is that if they don't have a home address then that is another barrier straight away.

Not having an address means that the person is unable to receive mail or appointment times. However, it may be possible to negotiate through NGOs and services for homeless people who to see if they will allow homeless people to use and collect mail from their address.

Kaiwhakaako: I know that mental health unit have this policy that they don't actually give treatment to anyone who is homeless...When ever homeless people with mental health problems get a home to live in, the professionals are usual quite excited by that...It is hard learning new advice of how to get control of your life when you are in a situation that you have no control of, living in an unstable environment. So all those lessons hover out as some sort of mental concepts in the head, but you can't put them into practice, so there is a logic to having an address... But at the same time there seems to

no allowance for other possibilities, it's an all or nothing thing, because if you have logic for one particular policy and if you are homeless with a mental health problem there is nothing for you at all ...

Homeless people living with mental illness have no less need of mental health services than domiciled people who live with mental illness. The participant makes a good point that treatment is some what futile if people are living in environments that are counterproductive to learning new techniques. Stable housing environments are vital for people living with mental health conditions and are essential for their resettlement (Goldfinger et al., 1999).

An exploration of participants' accounts show that drug and alcohol misuse amongst homeless people was one of the most frequently mentioned barriers to intervention. These findings are also consistent with Al-Nasrallah, et al., (2005) study in New Zealand that shows drug and alcohol misuse was a common theme amongst their homeless participants.

TeAwhina: Drug use appears to be a problem amongst the homeless. I think one of the issues is that you can't feed a drug habit and pay rent if you are a beneficiary. If you do find somewhere to live you bring your other homeless friends around there, and the place ends up being a total tip. You get evicted because you don't end up paying your rent. You spend the money on the habit...Sometimes getting them in drug detox is difficult as drug and alcohol service has the control over arranging who goes in and gets beds. As generic mental health workers we have been deskilled over the years as specialist services have developed. In years gone by we would have arranged for people to go to rehab or to detox, but for now we refer to drug and alcohol service.

Three issues arise in the above quote; the problem of individual drug and alcohol misuse contributing to homelessness, the difficulties of getting people into detox and lack of resources, and deskilling of psychologists over the years, which will be addressed later. For now, it is commonly known that there is a waiting list for detox. If the client is self-referring they will most likely visit a general practitioner, and wait a week for information transfer. The person will complete an assessment within another 10 days through drug and alcohol services, followed by the team's decision of whether or not they are suitable for detox. Because of

the inadequate number of beds in detox, there may also be a waiting time of one to three months before the person can access this service. This is problematic for homeless people as they remain on the street where drugs are rampant and kicks are free.

Not only does the misuse of drug and alcohol complicate treatment plans, it can also render people homeless, or at risk of losing their place of residence.

Te Awhina: Definitely some of the people we get into the detox centre, not very many but some, are people who their primary issue is drug and alcohol, and who have been admitted as suicidal, and once they've been admitted they become homeless, and we have held them there a few weeks more because they detox while they are there and we want them to go on to rehab.

A large UK survey found that drug and alcohol misuse can trigger homelessness, homelessness can also trigger drug misuse, and increased dependency on drugs often occurs over an increased time of sleeping rough (Fountain & Howes, 2002). Additionally, mental health concerns coupled with drug and alcohol misuse were identified in research as being one of the major factors that present a challenge for maintaining suitable living environment (Robinson, 2004). It is also very difficult to follow treatment plans and guidelines if one is misusing drugs and alcohol.

Conversely, Kaiwhakaako provides a rational explanation for drug and alcohol misuse amongst homeless people.

When you are homeless, the types of crisis that you live out every single day is so strong that drugs and alcohol are one of the most effective, palatable devices you have got, a lot of people in the general population think that drugs and alcohol are simply used because the people are problematic, but it is the situation that is problematic. We have to deal with the crap in our lives some way and if getting drunk means you can pass one more day, then you do it, simple as that. You have to survive. Obliviousness is survival and that is what you do.

Agnew and White (1992) show some evidence to suggest that drug use amongst youth offenders is used to manage the negative emotions caused through difficult relationships. This is relevant for some homeless people when considering long

term trajectories into homelessness that may have included abusive or violent family histories contributing to ongoing difficulties in relationships with others.

In 2006, there were 21 DHB contracted beds in Auckland providing detoxification services through the Auckland City Mission and CADS (O'Hanlon, 2006). According to the same author, the Blueprint guidelines for community detox services requires three detox inpatient beds for a population of 100,000. This equated to approximately 39 beds in the Auckland area with a noticeable short fall of about 18 beds (O'Hanlon, 2006). With the high rates of drug and alcohol misuse that has been reported in international and local research for homeless people (Fischer & Breakey, 1991; Fountain & Howes, 2002; Leggatt-Cook, 2007; Al-Nashrallah, 2005), along with the way that drugs and alcohol play a part in the perpetuation and maintenance of homelessness, one would think that there would be more beds available in detox for homeless people.

The stories that participants tell are constructed and influenced by broader political processes and dominant plotlines in society (Murry 1999; Mankowski & Rappaport, 2000). TeAwhina identifies the deskilling of psychologists and the introduction of specialist services as factors that that appear to have contributed to a slower process for clients accessing drug and alcohol services. Again, on a societal level of analysis, the introduction of specialist services can be traced back to policy changes in health care systems and the underlying ideologies of the day (Kearns, Smith, & Abbott, 1991) such as the commercialisation reforms of New Zealand's health care system in the early 1990s, privatisation, and ensuing management of health care. Managerialism appears to be implied in some of the participants' accounts, although no one mentions it specifically. The radical health reforms of the 1990s changed the way in which health care in New Zealand was delivered, the aims of management were to increase workforce efficiency, effectiveness, drive down costs, and cut workforce numbers with the underlying premise that health services were like any other economic commodity that can be managed (Easton, 1995; Clarke, Gewirtz & McLaughlin, 2000). To date there has been relatively little evidence to say this type of system works.

Other barriers to service delivery and therapy included homeless people's lack of knowledge of what services that were available, and how to go about accessing these services. In some instances, participants reported that homeless people had difficulties with general life skills, and that some were illiterate. This is not the case across all homeless people.

Kahu: Also when they want to access a service, when they don't know how to, or don't have the knowledge of services, unless there is some type of outreach going on out there, it is difficult. Sometimes they are happy to live that type of life until a health professional raises some awareness that they need some help. How do we assist her? It's going to take a special person to look past all that stuff, to look at the core need of the person. They will accept any care, anything.

On a more pragmatic level Kahu suggests that outreach teams would be beneficial as it would be useful to raise awareness of conditions, and inform homeless people about the mental health services that are available.

Kahu also promotes values that are humanistic and client centered in approach. These are compatible with Maori values such as respecting and caring for others, and recognising the mana of the individual. Ritchie (1992) has defined different types of mana that range from manamotuhake (sovereignty and status of the Iwi that is acknowledged through humility, deference, and respect) to manatangata which implies that every person has mana and deserves respect. Mana can be increased as a result of respect, and recognition given by others, or decreased through misuse of power, insults and injustice, or injuries to and from others (Metge, 1985). Kahu's story also draws attention to the positioning, and more common acceptance of the mental health professional as one who is knowledgeable and has professional authority, compared to the person in need. This not only reflects the differences in power, it also gives a nice illustration of how stories can be constructed within the context of one's culture, society, history, and the time in which one lives. By analysing these stories we arrive at a deeper understanding of how the stories we tell embody the past and the present. We may also see the positioning of a more dominant story over another.

Sometimes, participants also talked about individual characteristics contributing to barriers in service delivery such as not being able to read and write.

TeAwhina: Literacy is also an issue for some of the homeless people and they are not able to fill out the forms. There is a lack of planning skills....and often they don't see other ways of living...

That some homeless people are lacking in literacy skills may suggest, as Al-Nasrallah and colleagues (2005) found in their study, that disruptions in early childhood education, such as abuse, trauma, inappropriate family conditions, and removal by social services interfere with early childhood and adolescent education. It is highly unlikely that young people who are sleeping rough will put themselves through school. Lack of literacy skills may also pose a barrier to service delivery; not only would homeless person feel awkward seeing a professional who has been well educated, it means that the homeless person has to navigate through such differences with their own fears of stigmatisation and little social support from street life to service use.

One participant identifies a number of things that he considers as barriers for treatment from within an NGO service for homeless people. This included staff who were not trained to work with, nor recognise, various mental health concerns amongst homeless people.

Ihaka: A barrier of knowledge and training by the homeless practitioner, i.e., knowing what a depressed person will present, i.e. this is a person with schizophrenia and having that knowledge. This is the knowledge that within minutes of the conversation they know possibly where someone is at, so my questions and interactions will be guided on that assessment, I would go with that, that this person may have this mental illness. I think people know when something is happening, but not having that training and knowledge makes it more difficult. You know how hard it is to connect with mental health services, if we can communicate that information in a more appropriate way then they are more likely to pick it up. Then there is the difficulty of the person saying there is nothing wrong, when clearly they are not okay. Then there is the issue of fear the client has of either being branded a crazy person which goes a number of ways, no one wants to be branded as a crazy person, then there will be their experiences of previous mental health situations... i.e. didn't want it in

the first place, or the person was treated poorly. They will lock me up and take me away and I won't be able to do the things I want to do. Another barrier is the mental health issue existing along side drug addiction, or it might be that someone knows that they are not well but does not see how they can live but by getting introduced to mental health they have to come in from the streets, and they will lose their mates and lose a life style that they have become good surviving in, and so why the hell should they have to learn new skills and go to a new place which is all unknown and fearful and all that...

While a number of services are provided for Homeless people through NGO's, a lack of professionally trained mental health workers on site is also a problem for those working with this client group. Ihaka was also aware of a number of subjective feelings and past experiences that homeless people have had with mental health care in their past. This has also contributed to barriers in service delivery, as clients may not use services, or when they do, display some resistance to therapy due to views formed from past poor experiences.

In summary, research has shown that homeless people have difficulty accessing health services, especially when more than one service is needed, and that there is also a lack services that can provide holistic care for Maori homeless people in culturally appropriate ways (Al-Nasrallah, et al., 2005). In comparison, my participants mentioned numerous barriers to care that included both structural and individual explanations. They show that the quality of life for homeless people is also being undermined by personal agency (resistance) and lack of governmental policies. In mainstream mental health this included organisation policies and procedures or service criteria that were exclusive. Barriers to service provision occurs when people do not fit service criteria's, or 'fall through the cracks' when transitioning out of prison, detox, or hospital, as well as difficulties going between services. Going to detox was also a problem, especially for people who had previously been in renting situations and with no other way to pay their rent, lost their place of residence.

It would appear that in some cases, discrimination and stigmatisation may still exist in some mental health services. This contributes to another barrier (perceived or actual) for homeless people when attempting to access community services.

Some participants were aware of the histories of poor experiences that Maori had had with previous mental health care, and that they fear stigmatisation associated with mental health issues, and involuntary hospitalisation. They were also aware that for homeless people, mental health services can be very strange environments.

While professionals focus more on structural explanations contributing certain barriers in care, they also gave individual explanations for barriers to care as being a result of individual choices, such as over misuse of drug and alcohol. However, drug and alcohol use had also been explained as a coping mechanism to buffer against the many difficulties of rough sleeping. Personal factors related to drug and alcohol misuse, or illiteracy, and lack of planning or life skills also contributed to unstable housing situations, and interfered with treatment.

At an ideological level, the way in which mental health services are delivered is also a product of socio-economic and political beliefs over time. The commercialisation reforms in New Zealand's health care in the early 1990s that shaped the way in which health care was managed, has also shaped the way some of my participants view and talk about mental health care and service delivery. My participants often struggled with the compartmentalisation of services, when trying to meet the broader needs of homeless people.

Some of the participants also talk about health care in ways that include tikanga practices and Treaty principles. Such stories have been legitimised over time, having entered the public domain they are normalised, and discussed freely. Still this does not address the fact that there has been very little in the way of broad policy planning in regards to homeless people living with mental health issues in New Zealand.

Clearly, a number of services are needed to provide quality care for homeless people, as a range of professionals receive and refer to various services in the community. The following section looks at the importance of networking and drawing on the resources of other professionals and organisations in order to address some of the issues and to ensure that the complex needs of homeless

people are acknowledged and addressed in the care process. It will also provide some examples of services that would be more appropriate for homeless Maori.

Linking with other organisations

Participants identify a range of organisations they refer to, or receive referrals from. These are listed briefly below. Each provider or service has a function in terms of homeless persons' basic needs for food, shelter, and more complex needs for funding access, health, and mental health care, housing, and a stable lifestyle. Such stabilising work is foundational for effective therapeutic work.

TeAwhina talks about a hypothetical situation for a client with mental health concerns who is homeless. Along with the whanau, four community services might be involved, including the police, Crisis Assessment Team, Hospital, and the Night shelter.

TeAwhina: I don't know if Hauora would deal with more homeless people than we do, Kirikiriroa would from time to time take in people. I think what happens is that the mental health service is used at a time of social crisis, when a person has overstretched the resources of their family. If there is a crisis that involves violence, the police are called where the person then threatens to kill or cut themselves. The CAT team is called in and they are admitted to the ward. The family may say we can't have them back because they are intolerable. So they are then homeless up in the ward, so we then use the homeless men's, or women's shelter. We don't necessarily provide mental health service follow up for them because they may not have a mental illness.

In order to deliver quality care for homeless people it would be necessary to access and coordinate across services in a way that is timely. If there is no placement after hospitalisation, or Corrections, for these people, then mental health workers are compelled to seek out emergency accommodation from the volunteer sector such as NGOs, or night shelters. Unfortunately, once people become homeless, they are at increased risk of a number of social, physical, and psychological problems (Bang, 1998). Maori homeless people need a range of services to assist in funding access, housing, social support, health, mental health care, and other services central for stability. As previously mentioned, stability or

resettlement are foundational for therapeutic interventions and positive mental health outcomes.

Kooputa identified eight services he interacts with in his work with homeless people, such as Desert Springs budgeting advice, Vincent de Paul's, Work and Income New Zealand, ACC, Housing New Zealand, Te Runanga Kirikiriroa, Community Alcohol and Drug Services, and the Men's and Women's night shelters. He also mentioned receiving referrals from Adult Mental Health, family members, consumer services such as Centre 401, and Hauora Waikato.

The remaining participants talked about some 40 community services that they had contact with in order to meet the needs of homeless people.

It certainly was necessary, and participants identified the importance of working in collaboration with other services. Three participants thought street outreach services would be beneficial. There are also established NGO services for homeless people where mental health professionals could set up base.

Ihaka: I think it's hugely important that the mental health services work a lot closer to the coalface. We have a reasonable relationship with the mainstream mental health homeless team, there is only a few of them, we don't see them very often they don't come into the NGO just to spend time here, they have a good initiative going with life wise they offer a clinic...

Working closer to the coalface might mean that community service teams negotiate and share resources with non-governmental services that provide homeless services.

The participant below also emphasises the importance of collaboration between services, and connecting with other services. This has also been identified by those who are in the business of wrap around services, such as Dennis and Lourie (2006). However collaboration is not that easy, when "interagency collaboration is an unnatural act between non-consenting adults" (Dennis & Lourie, 2006, p. 129). The same authors believe that some of these issues arise because of education and learning from specific disciplines or service systems with little understanding, or cross over training that recognises the difficulties or advantages in each discipline.

This may also contribute to some of the reasons that professionals may find it difficult to find services for homeless people. If people in services refuse to work in collaboration, homeless people in need of services get caught in the middle.

Kahu: If I sent you to Te Rununga kirikiriroa would you understand it? I know about it, but would the rest of the colleagues know?...Perhaps only 60 percent know the name but don't know they do primary health care, dual diagnosis, youth mental health, tikanga processes, if you want to understand then you have to go out, and to do the whakawhanaungatanga, if not you are going to be isolated. In my organisation some are building relationships across services some are not. So we become isolated, so from this perspective it's about inclusiveness, it's about whakawhanuangatanga. It's about promoting and making available the resource to the whanau (client base), it's based on reciprocity, you need to be able to give and receive.

Collaboration across services is important as a number of resources and funding sources can be shared, problem solving by heads of departments, specialists, and homeless people may lead to creative outcomes; however, when people are excluded from the decision making process they may also be less interested in the intervention (Dennis & Lourie, 2006). It is evident that a number of services are needed to provide for homeless people, not excluding financial support, housing and education. Such stabilizing work is foundational for effective delivery of mental health care. In essence, a collaborative and participatory approach is needed to address the issues of homeless people.

In sum, there are a number of agencies that are involved in homeless peoples' lives. These range from community services, housing, NGOs, Maori services, and mental health services. Professionals are also aware of the importance of a more joined up approach or interagency approach is needed for tackling the broader and longer term needs of homeless people. As mentioned above there are a number of agencies that are involved in homeless peoples lives. They are also aware that without more collaboration homeless people are not likely to receive a good service that can meet their needs in a more holistic way, including emergency accommodation. The provision of basic needs such as housing and social support is elementary to therapist interventions.

What this analysis does not say, which is of particular importance, is that while mental health professionals build relationships across services in order to access care for homeless people, it might be easier if there was a service stream that was tailored around homeless people, and such a service could offer ongoing interventions towards resettlement. The implications of this will be discussed further in the following section.

Solutions suggested by clinicians

In the introduction of this thesis I referred to an international review on the health needs of homeless people living in developed countries that found that homeless people have poorer physical and mental health than those in the general population, and limited access to health services (Wright & Tompkins, 2005). In section three of this chapter, I explored numerous barriers and issues in the provision of care for homeless people. These included internal and interagency barriers, lack of policy development, and personal characteristics that contribute to barriers when providing for homeless people. A number of ideas are offered by participants that may contribute to 'looking past the mess' and trying to find a way forward. There will also be a brief discussion on the types of service models that may benefit homeless people.

One of the frequent themes that participants talked about regarding barriers to service delivery was drug and alcohol misuse. Below, one participant describes community interventions for those transitioning out of services, or coping with drug and alcohol misuse and other mental health concerns. He also implied that unless people can be committed for a substantial period of time, intervention may be ineffective for those who live with dual diagnoses including drug and alcohol misuse.

Kooputa: Say, for example, if someone in prison had their meds, and were settled, and the family could establish a safety net, instead of them coming out and having nowhere to go to, or being dropped on the street, there would be more success. ...They need to be long enough programs, some of them haven't been away from the community where they can access drugs, perhaps in prison, but it needs to be long termed. Living skills and being part of a

community. Assertive community treatment teams are key components in working with these people, as well as engaging their families.

Assessment Community Treatment Teams (ACTT) originated in the US during deinstitutionalisation, and these services have been implemented in the UK and Europe. It is a sturdy model of clinical case management that has shown some significant advantages for those with the most severe needs such as psychosis and high complex needs (Kent & Burns, 2005). Where people live with ongoing and severe mental illness, ACTT provides a team of multidisciplinary specialists, such as social workers, mental health professionals, psychiatrists, employment and rehabilitation workers, counsellors, housing assistants, and family support workers to assist individuals to live well in the community. As a primary provider of interventions, social services, and rehabilitation ACTT may minimise compartmentalisation with less time co-ordinating across services (SAMSHA, 2003). However, New Zealand has no such approach to homelessness.

While professional participants focus on providing better services for homelessness people, including accommodation, consideration must also be given to the homeless person's ability or desires to engage in services, and to move out of homelessness.

Kaiwhakaako: Living in a place has its own problems, often the support. After the will of getting out of homelessness you've got to have the opportunity of places to move to, and with our current property market prices this has become harder and harder. The third one is support, because when you move into a place many people find themselves being enticed out of that environment fairly early, because often you don't know how to relate to the people who live around you, usually in a boarding house. Sometimes you don't even know how to do your laundry, basic life skills. That means moving into a place of your own, or having a shared place like a lodging house, the pressures mount up almost straight away, so you move from one difficult situation to another. The obligation to rent every week and stuff like that, which you don't have to worry about on the street. If you are on a benefit on the street 100% is yours. Some people wear incredible clothes and some can be well dressed street people.

This quote shows that a certain amount of personal agency and motivation is required for homeless people to resettle, but this cannot happen without opportunities and social support to do so. The quote is interesting because it suggests that there is a certain amount of sociality that occurs for homeless people while they live on the street, versus living a flat in isolation. This may also suggest some type of intervention that is coordinated around groups, in preference to isolating people. There may also appear to be some short run financial benefit to sleeping rough in terms of keeping the money saved from a benefit versus paying the higher cost of domiciled living. It is also understandable that benefits do not sustain reasonable living standards due to low income received. However, the payoff for sleeping rough does not outweigh the many reported psychological, physical, social, and emotional risks people may encounter when living on the streets, which can in turn, exacerbate both physical and psychological health concerns.

As a solution to barriers in service delivery, one participant suggested having an agency or community service that would organise everything from living, finance, accommodation, mental health professionals, social workers and counsellors.

Kaamaka: It's interesting because I was talking to an English nurse yesterday and he was saying over there, rather than having a team of doctors and nurses to organise everything, they would have a team of social workers who would deal with everything, housing, accommodation, finances, mental health issues, mental health act, and it basically sounded like a one stop shop. If you need something you ring this team and they would sort it out.

As discussed in the introduction, the homeless population is characterised as having multiple problems, including mental disorders, alcohol and drug dependence, and increased risk of premature death (Wright & Tompkins, 2005). The same authors suggest that such problems need to be addressed with a focused primary health care system and a joined up approach. Accessing services in one place would certainly be beneficial for homeless people and eliminate many of the barriers to quality mental health care. However, one would also need to consider whether or not this would contribute to further stigmatising for homeless people. The participant also saw the importance of working in alliance with other community services, and using multidisciplinary approaches. If a psychiatrist and

psychologist were made available for the NGO homeless team, he believed that many of the barriers towards service delivery would be eliminated.

Ihaka: ... we do know in our own new project that we would like to become self sufficient; we would like a psychiatrist and psychologist and mental health/psychiatric nurses on board to integrate into a social work team or a tenancy support team. In that one stroke we would reduce many of the barriers that exist.

The NGO homeless service already provided a number of services for homeless people compared to mainstream mental health services. Consistently, mainstream mental health professionals also agreed that multidisciplinary approaches and outreach solutions would eliminate some of the barriers that exist in the provision of mental health care for homeless people.

Ihaka: Yes, my personal opinion is that mental health should have a more permanent outreach. That is expensive, we compartmentalise too much. I would much rather employ a mental health nurse who could also do some social work...To avoid waiting time and difficulties with compartmentalisation it would be better to have a team of workers on sight who are able to meet such difficulties.

Ihaka suggests that mental health teams should be mobile and out in the community more often. He also recognises the expense of such a situation, and considers a better option of having mental health professionals on site as part of the homeless team. It is evident that participants also act as a bridge to other services, but often they are met with agency boundaries and service fragmentation.

Two professional participants also felt that it would be necessary to have national data base systems that were compatible across services to access quick information on DHB service users.

Kaamaka: I meant to a certain degree if we had some sort of national data base system like here we have clinical result fuel data base, clinical notes computerised everything.

The same issue was also broached by an NGO professional. In consideration of the type of work carried out in the NGO homeless service, and their resources for, and focus on homeless people, it would be highly beneficial for DHB and NGO

services to organise and find ways of sharing information that does not undermine or disrespect the client confidentiality.

Ihaka: we look at the individual he may need some assessment we need to get knowledge about the guy and then feed into the regional data base, say is this person known? We do need to feed into a national database of some kind. For example if we had that information sharing, ie Joe needs help, do we have information on him, oh great we have been looking for him. If a client needs an intervention straight away, then that makes it more efficient.

It appeared that all participants were clearly active in networking with other organisations and building relationships across services. Kahu talked about going out so you know what other services had to offer, and building relationships across services so that you have links to other resources. It could be highly beneficial for NGO homeless coordinators, local Iwi, hapu, and whanau, mainstream mental health and Maori based services mental health practitioners, various social workers and counsellors, and homeless people to gather together and discuss the barriers that exist. Make a list of the types of resources that are available for homeless people including health and mental health care, volunteer services, temporary accommodation, work and education services (Saleeby, 2002). Take stock of what is out there and work collaboratively to find some solutions.

Most of the participants considered Maori models of wellbeing, or practical approaches to meeting and building rapport with Maori homeless people. There was also an identified need for more Maori health practitioners in homeless services by practitioners.

Ihaka: Yes our stats for Maori would say that Maori represent 56% but that is over a year ago now. We need to do that again. My personal view would be that it is very important to have Maori health practitioners. But I don't think it is important to have them employed via a Western Model which means they're at the base and people go to them. Ok they could be in the homeless team. But I think to take the full value of that person's professional abilities they should be based in the agencies that have daily contact.

In the previous section a discussion developed around the appropriateness of cultural specific interventions, and the recognition that culturally competent

practitioners are scarce. Consistent with this theme, the homeless social worker mentions the inappropriateness of Maori being placed in individualised housing, where they are left to feel isolated or alone.

Ihaka: That does not mean I have not seen good work done by exclusively Pakeha professionals, if we were to take that further then there is a huge lack of facilities that can provide accommodation for Maori in a way that speaks more powerfully to Maori. To put a young man who suffers schizophrenia into his own boarding house room, sure he might have contact with his mental health worker, and may be taking his medication reasonably well. Nevertheless, I do see a certain loneliness in his eyes, which may be the reason that they continue to come up here. Even if they are not interacting with other clients they still say giddy George, giddy Rangi etc...and I often wonder if one had the chance to dream, let's say the local Marae had some kaumatua housing and a couple of units where people had their own complete units, ..but shared the kitchen or dinning room. In terms of practical types of things and in terms of social cultural needs that would be great...

In providing services Ihaka also recognises that it is human contact and social relationships that people need. He also suggests there needs to be more culturally appropriate solutions for Maori homeless people that involve the Maori community and local Marae.

Below Kooputa talks about the transient nature of some Maori homeless people as not being 'out of the norm' given their background cultural context.

Kooputa "I got a call last week where a Grandfather dropped his grandson down by the river, because that is where the grandson goes to when there is trouble, so he's down near the... near the river, below the central service. The Grandfather just wanted me to know he was there. Some times they couch surf- go from whanau to whanau that's a resource thing. You don't have to freak out about it.

The example also highlights again the importance of working with whanau where possible, in connection with the homeless person.

As discussed previously, part of the solution to prevent homelessness would involve a joined up approach at a governmental level and through policy

development. Currently, New Zealand has no national or synchronised response to homelessness, and while efforts have been made by various organisations, responses are minimal. Kaiwhakaako discusses the possibilities of slowly emerging alterations in public policy:

There is also a slow alteration in public policy, even with the government for example the next census I think is going to be the first one they will ask questions about homelessness. How they are going to ask the questions about homelessness is going to be very difficult. Even people who sleep on the streets, it is difficult getting a census form for them. So it is going to need some sort of active pursuing of this group, and that means we can be consciously aware of their existence. Which has not been done in the past, and even if the statistics of how many people are homeless is not accurate it will head towards some useful type of figure, because there has been nothing in the past.

Engaging other services was important where mental health professionals aimed to provide care for Maori homeless people living with mental health concerns. However, where there are barriers to collaboration across services, for example does not fit criteria, it may impact onto some of the most vulnerable people in our society. This is a serious concern for Maori homeless people, and homeless people in general. Below one participant uses a metaphor that sums up, to some extent, something that seems to be missing in our society today, but compatible for Maori ways of thinking, with the underlying concept that hints at an attitude necessary for collaboration.

Kiawhakaako: I think that is something we have definitely lost the idea that everyone is an essential ingredient to the machine, every cog is important. In the white cultures we place great importance on certain people. But I look at a machine that works. I have a video recorder down there that stopped working, and you could look at this thing and say okay there are the recorder heads, and the play heads which are really important. There's the buttons that are really important, the power cord is really important. The one thing that didn't make it work was this tiny little spring, and at that particular moment that tiny little spring was just as important as anything else, if you took it away it didn't work. In the Pakeha culture we have lost sight of the fact that everybody is

really important to that mechanism. Equal importance, if you take it out, the whole thing has a different flavour. I think that is something that the Maori culture still holds on to.

Kaiwhakaako's metaphor provides notions of each person having a part to play in community and society, valuing one another, with a sense of equality based on our uniqueness. Respecting others, and the differences between, and working collaboratively is part of the solution when providing quality care for homeless people.

In sum, participants provide ideas for more effective services where Maori homeless people are concerned. It was acknowledged by most of the professional participants that a more joined up approach was necessary to address the complex and multifaceted needs of homeless people living with mental health concerns and drug and alcohol addictions. This included a one stop shop approach where a service could organise finance, accommodation, mental health services, and more. However, one would need to consider whether or not this would contribute to further stigmatisation of homeless people. Other solutions included a longer term intensive community intervention where homeless people with drug and alcohol addictions and mental health concerns could live, work, and access treatment options while developing necessary employment and living skills. One participant emphasised the importance of having a culturally appropriate service for Maori in collaboration with local Iwi where Maori homeless could live, receive intervention, and be supported to develop necessary social, work, and life skills. One community initiative provided by the NGO had a very good service for homeless people, and while collaboration and access to other services was important, having mental health professionals in the service would eliminate most of the barriers to quality care. It would appear that mental health professionals in mainstream services, the Maori service, and the NGO service were talking past one another. They recognise the importance of collaborative approaches, accessing necessary resources for homeless people, but working within the confines of certain organisational procedures and criteria presented a barrier to quality care. Clearly there needs to be development of public and health policy in this area, governmental funding, and coordination across a variety of services to deliver effective intervention for homeless people.

Chapter discussion

This chapter presents an analysis of the accounts of six mental health professionals working in three mainstream mental health services, one Maori based service, and an NGO service for homeless people. The chapter aims were to document the experiences of mental health professionals in how they work with, and provide care for this client group. Attention was also given to participants' experiences of the types of barriers that occur in service delivery, other organisations they linked with, and professional insights they offer in finding some solutions.

In section one, findings show that participants draw on a raft of experiences when working with homeless people, such as extended working histories, background cultural resources, religious affiliations, and personal characteristics. They had not received formal training to work with homeless people, and rarely mentioned their formal education as contributing to the development of skills. Further explorations of participant accounts show that skill development includes both temporal and spatial dimensions. The skills they bring not only contribute to how they go about working with homeless people, but can also add to service delivery, and a practical knowledge of other resources in the community that may be available. Past and present positive relationships formed in various services between professionals' means that there is already a platform for reciprocity, sharing information, and sharing resources.

Some participants demonstrated a bicultural approach in working with clients. They were able to draw from their background cultural resources, and in so doing demonstrated a certain skill in weaving two strands of knowledge together from mainstream mental health training and their Maori philosophical base. An inference can be made from participants' accounts that Maori who are familiar with, and practice tikanga are better positioned to provide culturally appropriate interventions when working with Maori homeless people. This is not to say that non-Maori cannot work with Maori; they often do. But it would suggest that for many non-Maori practitioners applied training, more time, and appropriate

cultural resources relating to their respective field of expertise would be beneficial.

Findings in the analysis also highlight specific attributes of the mental health professional that they felt were necessary when working with Homeless people, such as honesty, giving respect, dignity, patience, empathy and acceptance. These human values closely associated with the work of Rogers (1961) and Maslow (1970) focus on the person's strengths, and abilities, along with their ability to grow, and also underpin core beliefs found in the recovery approach (O'Hagan, 2004; MOH, 2002). Values such as honesty, empathy, giving respect and dignity, and working in relationship with others emphasise connectedness which is central to Maori social order (Smith, 1999). Therapists and practitioners need to be human in their approach as often the lifeworlds of homeless people reflect histories of trauma, isolation, and abandonment even at an early age. Conversely, humanistic approaches have been criticised for reinforcing Western values that place importance on the individual and a promotion of self (Prochaska & Norcross, 2007). A number of cultures place importance on personhood and external locus of evaluation (Seal, 2005). Polynesian societies place an emphasis on conformity, and of social values in their relationships, such as serving, helping, sharing, loving others, and using personal restraint in certain situations (Cowling, 2005). In the Maori world, reciprocity, hospitality, and acts of kindness are expected. The obligation to give and receive between parties, or individuals, extends also to the natural and spiritual world, and in more traditional times reciprocity was the bases of political, social, and economic relationships (Metge, 1985). Building the type of relationship that reflects humanistic qualities, is important to consider when interacting with Maori homeless.

We should also consider that even though it is vital for practitioners and therapists working in services to build a good rapport with clients, attention should also be given to the type of relationship that is being formed. As Seal (2005) points out, when a homeless person enters a service, their concerns can be translated into a number of issues that need specialised services, and with increased service involvement, the client is diagnosed with more deficits and in need of more interventions. Such a focus on services and intervention can be immobilising,

stunt the growth of the individual, and teach them to become dependent (Seal, 2005). A balancing act between helping and aiming to empower consumers, while increasing their autonomy and control over their own wellbeing is necessary (MHC, 1998a; 2002a; 2002b, MOH, 2000; 2002a). Although, even the word's 'help' and 'empower' suggest some interpersonal differences in position, such as those who are in need, and those who have the power or status to help. Some of the core findings that developed in section one also overlapped with building rapport in section two and will be discussed below.

Findings in section two show that participants used four main approaches for building relationships including Manaakitanga or giving, having an awareness of clients' socio-cultural history or lived experience, using an appropriate meeting ground, and creating relationships through Marae based protocols, or strength and recovery based approaches in their work with homeless people.

In order for participants to establish a relationship with homeless people, they were active in meeting basic needs. They did this through offering showers, giving cups of tea or coffee, food, or clothes. Such acts of kindness revealed practitioners humanity, but also functioned to evoke a response from the homeless person and build a platform for trust and reciprocity. In offering food, and 'looking past the mess' one participant demonstrated that the homeless person felt cared for, and by following a whanau approach and extending the relationship beyond professional criteria the client was able to resettle. This also enabled the practitioner to initiate and establish a relationship before the person entered services, which is also compatible with Maori ways of thinking and being.

Secondly, most of the professional participants demonstrated knowledge of Maori homeless persons' social context, and the grievances they may have encountered with past mental health service use. Because mistrust or suspicion of Western approaches to health care is not an uncommon feature for indigenous people (Durie, 2001; Saleebey, 2002, Taitimu, 2007) this can impact on the working relationship between therapist and client in the form of resistance. Resistance can be seen as a defence mechanism towards a threat, or a power strategy that gives the diminished party some agency in the relationship. Often it shows disapproval

of methods, or a resistance to what appears to be unfamiliar and threatening (Patterson, 2000; Rogers, 1951). Past poor experiences for Maori homeless people can inform service delivery, and raise awareness for the practitioner about the socio-cultural differences between themselves and this client group. This type of awareness can also act as a medium for building rapport when the homeless person feels that a practitioner understands their situation, and this may result in building trust, transparency, and information sharing. In this way practitioner and client are able to move together towards finding a solution.

Most of the participants emphasised the importance of meeting homeless people in their own environments to bridge the gap between the lifeworlds of homeless people and service use. Unfortunately, for practitioners in the mainstream this may be difficult where agency policies limit flexibility. In contrast, the NGO provided a safe meeting ground in the inner city where homeless people could build trusting relationships with others, and get some of their basic needs met. Hawe and Sheild (2000) state that trust between members of a social group makes for a smooth transition when it comes to social exchange, circulating information, and giving or receiving benefits.

Fourthly, useful approaches to building rapport included approaches modelled on Marae protocol, or using strength based and recovery type approaches. What seems to be clear from these findings is that clinician's and therapists propose more than one approach.

While participants were committed to working alongside homeless people, and demonstrated strong working relationships, findings suggest that there were numerous barriers to quality care. Such barriers can increase the likelihood of providing services that are less effective for Maori homeless people. This could also exacerbate any distrust that Maori homeless may have towards mental health services in general. Barriers identified by practitioners include both structural and individual explanations. Participants felt that some of the major barriers in mental health care were due to organisational policies and procedures that were deemed to be exclusive if homeless people did not fit the criteria, lived without an address, or when homeless people were released out of services with no ongoing

intervention. At times participants found it difficult to find accommodation for homeless people, even for a few nights. If we consider for a moment that mental health professionals are in the care industry, such policies may very well be in conflict with their beliefs about care of the person. They may be forced to come up with creative ways of providing services.

There were also a number of interagency and internal agency complications, such as poor or slow communications between services, protecting the patch, and less effective database systems. In talking about 'protecting the patch' this also illustrates that some of the responsibility is placed with the professional. One participant reported discriminatory and judgemental attitudes from front desk staff. This was not a common finding across services. However, it does contribute to inequalities in health care.

Other barriers were attributed to individual characteristics, or choices that homeless people made such as drug and alcohol misuse, often impacting on intervention, and on the individual's ability to remain housed (Robinson, 2004). Both international and local research report the high rates of drug and alcohol misuse amongst homeless people (Fischer & Breakey, 1991; Fountain & Howes, 2002; Leggart, 2007; Al-Nashrallah, 2005) which is complicated by a limited number of beds available in detox (O'Hanlon, 2006). On the other hand it has also been noted that drug and alcohol use often aids the stresses and strains of street life.

Core issues from section three are also analysed in section four, which explores how professionals linked into other organisations in order to obtain information and other resources to cater for Maori homeless. Participants often referred to, or engaged with other services in the community in order to address some of the broader needs of homeless people. A number of services were identified. Professional participants across services were well aware of the need for a more joined up approach between services to access funding, and other resources, and then coordinate service delivery to the individual concerned. However, because of time restraints, interagency and internal agency barriers, lack of resources, and lack of policy development geared towards homeless people, working in

collaboration and participation with all those concerned was not always possible. While problem focused, professional participants also offered some of their insights on 'looking past the mess.'

Professional participants offer a number of ideas about interventions that they felt would be more beneficial for homeless people living with mental health concerns. A positive community resource for homeless people was provided by the NGO where homeless people could meet in a safe environment, build relationships, and get some of their basic needs met. A number of professional services were offered here, along with onsite counselling and social support services. To minimise barriers to service delivery, the co-ordinator suggested having a psychologist and psychiatrist on their team, with preferences toward Maori practitioners.

Another proposal put forward by the crisis intervention coordinator working in a mainstream service, was the possibility of a 'one stop shop.' This type of system appears to be similar to the Assertive Community Treatment Team model (SAMSHA, 2003) used abroad, where a number of social workers, nurses, practitioners, therapists, housing, educational, and social support workers provide ongoing assistance. In comparison, both practitioners propose more holistic models.

There are both positive and negative criticisms of the ACTT type model. On one side of the coin, this type of service is effective in eliminating interagency barriers and ensures ongoing intervention (Seal, 2005). On the other, it may result in pathologising homeless people further, or teaching them to become dependant on services. Additionally, the later would mean reinventing the wheel in mainstream services, whereas the NGO already has a community hub up and running. It may be more practical and cost effective for Ministry of Health to find a way to fund Maori psychologists and a psychiatrist for the NGO homeless team. Consideration should also be given to homeless people. Often their lifeworlds have been traumatic, and having to expose their past experiences to a number of potential strangers, may cause whakama. Whakama is a concept that expresses a gamut of emotions ranging from slight embarrassment to an offence that is unforgiveable, beyond cure, and sustainable over generations (Metge, 1995). Still, none of this

undermines the fact that issues faced by homeless people are multifaceted, and without some kind of broad ongoing intervention with adequate pro-social supports in place, any specific agency intervention may be less effective.

Another option was to have a communal situation where homeless people could be committed for a long period of time to overcome certain addictions, and learn working and lifestyle skills at the same time. This may be helpful in assisting homeless people overcome and move forward, but there would still need to be ongoing intervention and social support when integrating back into the community.

Lastly, Kahu demonstrates a therapeutic approach that incorporates aspects of Marae protocol focusing on relationships, increasing mana, respect and dignity while working from a strength based perspective. According to Ringold (2005) increased Maori access and participation in health and social services is a result of efforts to tailor service provision toward Maori needs and preferences. In contrast to more Western models of health such as diagnostic processes, medication, and psychological interventions, Maori pathways to healing also include taking the sick person home, working with whanau, rongoa, and healing practices that draw on the assistance of tohunga, kaumatua, and ministers (Taitimu, 2007). To date, there are a number of Maori models in use in mental health.

To be sure, each service and each practitioner from their various streams participate in the process of resettlement, whether they know it or not (Seal, 2005). There are plenty of resources in the community for homeless people, but the problem remains on how to access those resources.

Before we go further we still need to discuss the emergence of tikanga practices throughout the health and disability sector. To do this we need to take a very brief look at some of the socio-political processes that have developed over time.

Societal context

It is important here to consider what Nietzsche described as studying the past in order to understand our present situation, that is to learn from past mistakes, and how history has some bearing on certain social issues in the present (Clive, 1965). Clearly, this thesis cannot go fully into all the socio-political history concerning pre colonisation, colonisation, decolonisation, and indigenous psychologies, however, a brief outline may be more in order.

In more contemporary times we have come to realise that the effects of colonisation for Indigenous Peoples are associated with disempowerment, alienation, cultural erosion, and socio-political deprivation (WHO, 2007; MOH). All of these factors included a loss of land, of voice, and dignity, and undermined wellbeing (Durie, 2005). We are also aware that these marginalising effects and inequalities in health involve multi-levelled processes at governmental, political, institutional, and economic levels (WHO, 2007). From the 19th century forward, colonising processes that were dehumanising in effect were often couched in terms that pertained to moral cosmologies of ‘civilising’ the other (Smith, 1999). In order to right the wrongs, especially in the aftermath of World War II, the signing of the Universal Declaration for Human Rights 1948 sanctioned principles of equality and non-discrimination for human beings, but failed to acknowledge the position of ethnic minority groups (Lyons & Mayall, 2003). International thinking at the time was such that minority problems were understood to be responsibilities of the nation states in which they occurred. Some nation states dealt with these problems through policies of assimilation and oppression, instead of solving matters through maintenance of cultural differences, and a sharing of identity (Lyons & Mayall, 2003). Up until the 1960s, assimilation policies, integration policies, along with the socio-economic changes such as urbanisation, resulted in a continuance of marginalisation for Maori (Anderson, et al., 2006). As a result of these legislative acts by the crown, Maori resources, social and political processes were redistributed (Anderson, Crengle, Kamaka, Chen, Palafox & Jackson-Pulver, 2006). In more recent times, there has been a challenging of dominant discourses or Western paradigms (Smith, 1999). Social movements of

the 50s and 60s on civil rights, has led to the politics of indigenous discourse and processes of decolonisation that aim to restore legitimised cultural ways of being and knowing that pertain to indigenous people (Smith, 1999). Since the cultural renaissance of the 1970s we have seen some great advances for Maori, and yet there is still some way to go (Anderson, et al., 2006; Ringold, 2005).

At a societal level of analysis, the way in which practitioners talk about, train, and develop skills in mental health care are a reflection of the various processes in society. The recognition of government's responsibility to Treaty of Waitangi principles (MOH, 2002), subsequent legitimisation of tikanga practices, recovery and strength based approaches, throughout the health and disability sector (MOH, 2000; Durie, 2005) not only reflect the way professionals support and reproduce such discourses in society (Foucault, 1972), it also shows that there is an expectation of how mental health services are to be delivered.

For those providing services for homeless Maori, this might mean more of a community approach that includes homeless people, finding out what resources are available, what types of services or interventions are culturally appropriate, and working on solutions together.

The over all picture that this analysis presents is a pattern of weaving together different philosophical perspectives or understandings in a way that attempts to present a whole. It is also reflective of the time and place that the researcher lives. The metaphor of binding and weaving represents how professionals bring their own subjective experiences and combine this with various mental health discourses and frameworks, to meet the needs of homeless people. It may also emphasise the certain skills they bring in building relationships with homeless people. Building rapport, whether with the client, whanau, or other services, is about developing trust and understanding. Building these types of relationships is foundational for reciprocity and obligation and is compatible with both Maori worldviews and humanistic traditions. The segregation between services that professionals talk about in health care also reflect socio-political and economic changes over time. Their stories reflect interpretations of what already exists, of course, I have also reinterpreted their interpretations.

Participants have revealed one side of the coin, in the next chapter Maori homeless participants will show the other side of the coin. The next chapter explores the lived experiences of homeless Maori people who live with mental health concerns.

CHAPTER FOUR

HOMELESS PARTICIPANTS

My overall intention in this chapter is to present insights into homeless participants' perspectives and lived experiences of mental illness and homelessness. In order to achieve this, three levels of narrative analysis offered by Murray (2000) are used as a device for exploring links between personal, relational, and societal factors contributing to participants' mental illness and homelessness. Attention is also given to the function of telling one's story of hardship, illness, and abuse in seeking health and recovery (Frank, 1995; 1998).

In section one, the analysis starts on a personal level where Maori homeless people share some of their initial awareness of mental health concerns, and subsequent pathways into illness and homelessness. These accounts are positioned within the context of the familial, institutional, and social structures within which they grew up. This leads to a discussion of their early experiences of abuse and how this has shaped their understandings of care and led to the development of a lack of trust in the system (see section two). Attention is given to how experiences of institutionalisation in youth rendered almost all participants homeless at an early age, and set in place a life-course of homelessness. Section three picks up on the ways in which participants are attempting to re-story their lives and understand what has happened to them. In the process they internalise dominant pathologising stories that render them abnormal in order to articulate a more complex understanding of themselves as victims of adversity. In the process they can shift responsibility from a dysfunctional self to a dysfunctional life-world. The following section explores how homeless participants conceptualise what practitioners can do to aid their recovery. The chapter ends with a brief summary of findings.

History: Stories of early experiences of mental illness and removal from home

Homelessness is a process of social exclusion and dislocation that began in childhood for most of these participants. The majority of participants recount dysfunctional familial backgrounds and histories of displacement from mainstream society. This section explores these accounts and how some of the participants associate specific life events with early experiences of mental illness and subsequent homelessness. Most of the participants came from unstable and abusive backgrounds. Early removal from their homes rendered them homeless during childhood. As a result of early experiences of adversity, they learned maladaptive coping strategies which contributed to homelessness later in life. Traumatic events are often compounded and repeated throughout the life course of homeless people (Robinson, 2003). Overwhelmingly, this includes chaotic stories of whanau/family backgrounds such as childhood neglect, family abuse and violence, isolation, and loss of a loved one. Research also suggests that many homeless have been the victims of childhood emotional, sexual, and physical abuse or that they are the children of parents addicted to drug and alcohol misuse (Breaky & Fischer, 1990). These factors contribute to poor mental health and pathways in and out of homelessness. In order for mental health professionals to address underlying core issues, it would be necessary to hear what homeless people are saying to gain a broader perspective on events over the course of a lifetime which are identified by homeless participants as contributing to mental illness and homelessness.

Participants recount instances in which they first became aware of mental illness. They do so in the context of stories about childhood adversity, family disruption, and fragmented social structures. Arona states:

Started when I was young; my mum passed away so my dad was left with a lot of children. It was hard with my father- he was an alcoholic. It was rough. I use to hide and try to become invisible because he used to give me a hiding quite a lot. How I encountered my first experience of mental health was when I hung my nephew, in the garage. I was about seven. We were playing. I was

angry with him because he kept crying and I was afraid I would get a hiding so I hung him in the garage... He didn't die. But that was when I found out I had a mental illness. That it wasn't a natural thing for a kid to do. They told me I was of mental status. ...Social welfare came to get me and they locked me up in...

On a personal level of analysis, people organise their perception of their personal experiences and behaviour from within the context of their environments (Murray, 2000). At the beginning of Arona's story, she makes sense of initial signs of mental illness in terms of her early childhood experience. In the middle of her story she describes a series of critical life events such as loss of a loved one, and a father who was alcohol dependent and physically abusive. She constructs her story linking traumatic events to subsequent behaviour. The narrative ends with removal from her whanau home by a state social system. In elaborating upon her experiences of childhood adversity, Arona said:

It was rough, so I ended up building a wall around me. I became like one of those kids that liked to be by themselves. I use to wrap myself in our old carpet at the back of the house so I could be invisible, so my dad wouldn't find me because he use to give me a hiding quite a lot.

Evident in Arona's story is how she found a coping strategy in which she could isolate herself from the emotional and physical pain that she experienced in her world. Arona's mention of invisibility and isolation can be compared to the lives of many homeless people (Levison, 2004). This participant's metaphoric example of building a wall around herself and wrapping herself in a carpet to become invisible portrays the notion of seeking warmth, safety, and security. These are just a few of the basic needs a child has when maturing. Nowadays, the international community has come to some consensus on what constitutes basic human rights against child abuse, and acceptable child care (United Nations Convention on the Rights of the Child, 1992). Research has also shown that ongoing abuse contributes to a range of internalising behaviours such as low self efficacy and externalising behaviours where children find it difficult to manage their emotions, the upshot of which may find its expression in uncontrollable anger, aggression, difficulty relating to others, and self harm (Carr, 2006).

At an interpersonal level of analysis, it is important to consider the context of the interview and possible interaction between researcher and participant in shaping the narrator's account (Murray, 2000). In order to normalise illness stories, people translate experiences into recognisable story structures and in the process present an image of the type of person they are, while minimising aspects of the illness that may present the individual as different from others (Radley, 1993). Another factor to consider is the meeting of two strangers for the first time where a certain amount of performance management occurs. Performance management is another way of saying that humans control the self they present to others in order to be seen in a positive light (Vaughan & Hogg, 2002). This is also comparable to an actor on a stage who takes up various roles for various audiences (Goffman, 1995). In giving a rational reason for some of the disturbing things people may have done to other human beings, one is likely to focus on external factors, and avoid taking personal responsibility for their part in the event.

In Arona's story, just for the sake of an example, I could say; that she rationalises that external critical events contribute to her experience of poor mental health and subsequent violent behaviour. The violent behaviour is minimised (e.g., I was seven, we were playing, I was angry because he kept crying, and he didn't die) and the story becomes more palatable in that she is able to continue to see herself as being a good person while projecting a reasonable person image to the interviewer. She may also avoid taking responsibility for her behaviour by omitting the fact that her behaviour was cruel to another human being, and criminal in nature. However, and in fairness to Arona, the question could also be asked who would blame her for acting the way that she did. It is possible that Arona was too young to know better and lacked the resources to cope in such a situation. Her father modelled physical violence, and there is no mention of interactions with her siblings, or where she learned this type of behaviour. This provides a good example of looking at the same situation through different lenses or frameworks. My strongest impression would be to say that Arona 'lived with, and experienced a number of disordered situations to which she gave disordered responses.' However, if I were to look at socially or external factors alone then I may be doing an unkindness where Arona is concerned. By not stating that people have some responsibility, I am also guilty of minimising an opportunity for raised

awareness, and growth where Arona is concerned, and I also remain biased in my own thinking.

While participants describe their initial awareness of mental health concerns in terms of early childhood adversity, dysfunctional family situations, and removal by state social systems, it also appears that personal characteristics may contribute to early experiences of mental illness.

Below, participants describe more of their personal experiences of becoming unwell. Again, they make some sense of their chaotic lives with reference to the history of their social backgrounds. Eruera states:

Umm it started when I was a young fellow in ... the year my grandfather passed away. I had been under CYFS since I was three... and ...social welfare thought there was something wrong with me. I had unusual behaviour... and I was screaming, yelling, picking up objects and throwing them, hitting people for no reason, running out on the road and trying to kill myself. That was because of my mother and father fought all the time. My mother... came from a background of violence. Her father use to beat her all the time, practically every day, just the way she dressed. ... She ended up coming to Auckland and living with a gang in the city here, they were a bikey gang back then...My father was a... sergeant of arms.... My mum has been under mental health before

Above, Eruera gives an account for his behaviour in the context of losing a grandfather, background of whanau violence, parental gang membership, and removal by state agencies at a young age. Consistent with Arona's story, Eruera rationalises that external events contribute to his initial awareness of mental illness, and in telling his story throughout his adolescent years there is also detailed paid to personal responsibility for actions taken.

It would appear that Eruera is the first person to imply a link between illness and inheritable factors when he says that his mother was 'also under mental health.' If so, Eruera may be drawing from a more dominant story line from within the context of the time and place in which he lives. The dominant narrative he draws

upon is found in the well established, medicalised mental health system that leans towards seeing the person-as-patient (Deegan, 1996; Mishler, 1991). Not only does this denote the difference in power relations between a mental health system and the person, it positions the person as more docile and in need of help. This story has been well accepted over time, and the legitimacy of such a story is also reinforced by society in the day-to-day language people use.

Illness is not limited to various symptoms occurring separately from other aspects of one's social life (Radley, 1994). Participants speak of external conditions such as familial conflict and violence that often emerge before classified symptoms and distorted cognitions. It would appear in participants' stories that their initial awareness of mental illness is not merely contained within the individualised body as some sort of malfunction or abnormality. Mental illness is placed within the context of, and is also a product of, history and the social realm in which we live. More common to participants' accounts are traumatic events that seem to crystallize as experiences of mental illness. Not only do these early traumatic events contribute to poor mental health, research has identified that disruptions in childhood such as violence, abuse, and foster care also contribute to homelessness (Al_Nasrallah, et. al, 2005).

Participants are able to construct their stories from the dominant stories in society. Common themes that arise when participants talk about in their initial awareness of mental illness focus more on the social sphere such as childhood adversity, dysfunctional family situations, removal by state social systems, than on personal characteristics or symptoms related to early signs of mental illness. The use of these narrative frames allows participants to present a particular image of themselves that is sometimes congruent with dominant ways of understanding mental illness today. Participants have learned the language of madness and construct their experiences through its use.

Below I explore participants' perceptions of initial mental illness further, and how their accounts combine personal, relational and societal factors in framing their experiences of mental illness.

Abuse: developing negative perceptions of care

This section explores participant accounts of abuse and adversity when in the care of others, and how this has contributed to a lack of trust and faith in social services. In articulating abuse, these participants offer an account of their mental illness as a result of personal tragedy. Common themes among participants' initial awareness of mental illness were related to the person and their family, removal by social agencies, and the lack of stable relationships in early life. These experiences lead to maladjusted views of the world and perceptions of care. Poor perceptions of care can be reinforced over a life time as people have further negative experiences when interacting with services and professionals. Abuse was also a common theme that started in early childhood and included sexual abuse, physical abuse, and emotional abuse.

Pounamu: I use to come to school with bruises and one day I went to school and I got this meanest hiding and my hands were really fucked, bruised, and I couldn't write. So they rang up social agency and I went home. Then the social agency just come storming in the door with a... policeman, and told me I had to pack my things and go... and...I went from CYFS home to CYFS home, I would go home and my parents would kick me out and drop me off to the families, and the whanau would get sick of me and they would drop me back home ... and ... When I was young I use to see colours but they use to be like little dots (back then).

Pounamu's story suggests that she was driven out from her whanau home, and comments about the whanau "getting sick of her". Such rejection may lead to feelings of inadequacy and abandonment. The narrative reflects common themes found in other participants' stories in terms of the person and their family, removal by social agencies, and the lack of stable relationships in early life leading to distorted views of the world and perceptions of care. Pounamu links mental illness with removal by a social agency, crime, and street life.

Mum, Dad, and they wanted me to move into CYFS, and since then I have been in and out of CYFS homes and in and out of juvenile. Then I eventually came out here [to the street].

Common themes in this section link mental illness with removal by social agencies, crime, and street life. This is consistent with New Zealand research (Al_Nasrallah, et. al, 2005).

Participant stories also reflect dysfunctional aspects of a social system that removes children without offering suitable alternative environments to live in. Eruera shares about his experience of social agency placements:

I was brought up in one Town and [a social service] took us from there. I went into a foster home in another Town. That was extreme. The family I was living with were violent hardcore. It drove me crazy... and...I've been to 22 homes in my life - from the age of three to age of 18 years. I was still running away from home when I was thirteen, and that is when I first came to the streets.

In Eruera's story it would appear that inappropriate or neglectful childhood placements also contribute to running away behaviours and early street life. This was a common pattern in four of the six participants' lives. Research also suggests that pathways into homelessness for young persons describe patterns of being involved in social welfare care due to a family history of abuse, alcohol and drug addictions, and then running away from foster homes (Fitzpatrick, Kemp & Klinker, 2000; Al-Nasrallah, et al., 2005).

Several participants mentioned abuse only briefly, while others shared in more elaborate detail. All but one participant mentioned they had been abused in early childhood. For several participants, this abuse continued into their adolescent lives. Two of the participants also reported being violently abusive themselves in their childhood/adolescent or adult life, particularly in times of crisis. Three of the participants reported sexual abuse at a young age; one participant male, and two female. Below, Eruera shares his account:

He touched me in the wrong way and sexual abuse. That's why I say to my partner, I have flashbacks and say back off, or when people touch me in the wrong way I react.

Participants also invoked emotional abuse due to neglect and abandonment, or verbal abuse. As Kakama states:

My old man use to call me dummy and I grew up believing it. ... It's the power of that word, it's like when people say something to you it's like a maketu.

A function of telling stories of chaos and illness may include removing one's feelings of guilt, and emphasising that becoming unwell was not entirely one's own fault (Murray, 2000). These stories externalise the causes of mental illness. Below, Pania pinpoints her initial experience of mental illness as result of sexual abuse, something she could not be held accountable for.

Probably started when I was about six or seven, I was molested. I was hearing voices. I was isolating myself... and ...I was fearing older men.

It was evident that for most of the participants, abuse materialised as a major contributor to initial awareness of poor mental health. It is also possible that many of these incidents can contribute to, or reinforce poor perceptions of care. Participants went on to recount ongoing patterns of violence and abuse in social institutions, which they had experienced after becoming wards of the state.

By using analysis at a societal level, we can explore how assumptions that exist in society manifest in participants' narratives and expressions of self (Murray, 2000). Stories of abuse are not easily told, nor are they easy to hear, or for society to cope with. Participants tell their stories in a time and context in which stories of past institutional abuse are already in the public domain. There have been many stories told about abusive conduct carried out in mental health institutions in New Zealand and internationally (MOH, 2006). It is now acceptable to talk about such events with less risk of stigma. Arona provided an account of repeated abuse in a mental health institution. It was also evident during the interview process that this was a very sensitive issue, one that caused her emotional pain upon sharing:

They raped me in there, sissy, they raped me in there. The guy who kept coming in everyday to give me my baths ... he used to always have the water running, and he would tell the other nurse to go and look after the ones in the

lounge, and he used to pick me up because I was in the straight jacket and take me across the way. I used to be so doped out and I could see what he was doing but I couldn't do anything about it. He used to get a flannel and he use to shove it in my mouth and he used to put me in the bath and play with me while he was washing me, and it was one of those nurses that use to look after us.

In years gone by, the validity of such stories would have been questioned or silenced. However, through the activities of service user movements, many of these abuse stories have come to light. Once they are told, various activities are employed such as media attention, investigations, political action, research, and subsequent laws or policies are developed which shape the way things work in society. As a result, disclosure of such stories is normalised, and this may explain why participants were transparent in disclosing abuse stories to the interviewer. As discussed earlier, abusive events can contribute to negative perceptions of care.

Research has shown that many of the adverse situations faced by those in lower socio economic status contribute to poor health and mental illness (WHO, 2007). Both structural and individual factors impact the lives of homeless people, and can contribute to, or exacerbate mental illness. These factors are also related to perceptions of racism. In this context, Kaiwhakaako talks first about his experience with social services.

...Mental health won't deal with you unless you live in a place. So you go to Housing New Zealand. Housing New Zealand won't deal with you unless you are in sufficient poverty. So you go to WINZ, and WINZ won't deal with you unless you are a reasonable psychological state of mind and seeking treatment through them. You're so badly off that you can't get a place, that you can't get due to all these other factors. Everyone of them will say, for example, WINZ says Housing New Zealand does not tell us what to do. Well someone has to tell them what to do. There is no co-operation whatsoever.

It is clear from participants' interviews that they attribute a number of structural causes for their mental illness and pathways in and out of homelessness. Most of

the participants' accounts reveal background abuse; however, it is not just families that can be abusive; social services can be abusive or neglectful. Additionally, signs of mental illness appeared to crystallize as traumatic childhood experiences such as poor family relations, violence, and abuse associated with their removal from the home by social agencies. For some of the participants, such experiences also lead to their running away from home, and are linked to development of criminal lifestyles. Consistently throughout the narratives of homeless participants there are shared understandings that they felt as though they had been victims of state imposed conditions. This had left them feeling disempowered, without a voice, discriminated against, and abused further.

Other structural factors included governmental systems. It is very difficult for practitioners and therapists to provide quality care to those in need if they are unable to access mental health systems in a timely and appropriate manner. It is also difficult for practitioners and therapists to provide care while competing with time schedules, policy restraints, and trying to meet contract funding requirements that might not include anyone who is not in the top 1-3% of need.

The gaps in services might suggest there needs to be policy development linking between housing, health, social welfare, and other governmental services. The implications of not providing this type of coverage may be increased mental illness among Maori people (Al_Nasrallah, et al., 2005).

Participants experienced services that were ineffective in meeting their needs. They talked about their frustrations when interacting with practitioners:

Eruera: He got me a psychologist and I talked to them all the time, it was during school time, so I had to go to a psychologist. I would stress out because of the stupid questions they would ask [psychologist said: are you alright, do you need to go back to the hospital] ..no... I ended up hitting one of them... I was not comfortable with a non-Maori person. I would have been comfortable with a Maori.

Some of the participants expressed a lack of faith in mental health systems, and others expressed feelings of being treated poorly by mental health professionals.

Kaiwhakaako talks about the difficulties of receiving mental health services as a homeless person.

Kaiwhakaako: If you have a relationship between homelessness and mental health difficulties, I know that mental health unit have this policy that they don't actually give treatment to anyone who is homeless.

People who are homeless often do not have an address; without an address it is difficult to receive DHB services. In discussion concerning practitioners sharing information concerning diagnosis, participants below voice their perceptions.

Kakama talks about discrepancy of power relations between practitioner and client. When I asked him about the information he was given concerning his diagnosis he said

...I don't believe they want to tell you, it's like keeping the power. It's like they want the power and control over you... and...you just go okay Doctor whatever you say. They are like god. That's what they want you to believe.

Arona talks about her perceptions of how she is treated at a mental health service within the last two years.

Arona: Some of the negative experiences I have had with practitioners and support groups is that we always have to be separate. ... They know what is best for us, but we are the ones who have got it, and now it's called separation, they are the ones who diagnose us but we are the ones who are feeling it.

Participants voiced their opinions about power imbalances where the mental health professional knows best, and the client is expected to dutifully follow through on recommendations (Deegan, 1996). The participants above illustrate distrust towards professional narratives, and Arona has shown that participants attending mental health services come with previous experiences of care, which can influence how they interact with providers today. She has interpreted the actions of mental health procedures as a process of exclusion and feelings of separation. The issues she raises with mental health services that are experienced

as overly clinical and dehumanising may reinforce core beliefs concerning the poor quality of care. It is also possible that homeless people with health concerns have shared similar stories in their community with people who have had similar experiences. Feelings of stigmatisation and marginalisation were evident. Below, two participants talked about how they felt regarding their contact with mental health services. These experiences are translated into an account of how they wish to be treated in the future.

Eruera: I would just like to say don't treat Maori like a patient treat them like humans. Everyone should be treated the same, but in a good way.

Pounamu: Another thing about the (clinic) is that they look at you as if you're sick. They don't look at you as a human being. The questions they come up with are just stupid.. and...I didn't talk actually, I was scared.... I wasn't use to talking for my own, if you understand what I mean. I was use to everyone else talking for me.

Pounamu stresses that being a client means you are being treated as if you are sick and not human. Having others talk for her means that she does not have a voice. Three of participants below refer to personal frustrations due to what they felt were silly questions mental health professions asked them. This might also illustrate how the expectations, perceptions, and experiences that Maori participants have had in the past might present a barrier in their interactions with mental health professionals today. Arona talks about her frustrations as well as the feeling that one has to almost defend their position of being healthy.

Sometimes they ask stupid questions like how is your day, it's like 8.30 a.m. the day hasn't even started yet and you are asking how my day is? It frustrates me. Sometimes people can't say what are they are doing today, you can't say anything, because it's going to be a lie, I'm going to Mac D's but it's a lie because you don't have money, or you say I am going to the library but it's too far, I don't know what I am doing, it's like what are you doing? I do get angry with people, I do, because you can't tell what is happening, but you still have to answer, answer, answer.

There is the notion of having to come up with answers to show oneself fit, proving oneself to be living a reasonable quality of life otherwise medication may be increased. As seen throughout this thesis, it is very difficult to live a quality life when homeless, and trying to live with a mental health condition. Tangata whiaora often reported having to fit into certain ways of being, usually planned, and following a strict routine. Furthermore, Arona illustrates that sometimes communication can get awfully distorted in a session with a practitioner.

Below, Pania shares how she felt about going to a practitioner for the first time several years ago.

I didn't go to hospital I went to see a doctor and they referred me on to a psychiatrist. Part of me wanted to go and part me didn't. [Diana: Let's talk about the part of you that wanted to go] "Just to get things out, that I needed to get out" [Diana: So you needed to tell your story?] "Yeah." [Diana: How about the part of you that didn't want to go?]. Well, I was attending college and I wanted to be normal like the other teenagers, I didn't want anyone to know that I was seeing a psychiatrist. I just wanted to carry on, but I knew I had to see him.

Above Pania describes her fears of not being 'normal' and fears of possible stigmatisation in the process. Other complexities exist due to governmental agencies, and lack of good timing with regards to being able to access services.

Kaiwhakaako: Went to an ordinary general practitioner who recognised the symptoms of severe depression straight away... They put me on the sickness benefit which was harrowing in itself, if you are ever depressed the worst thing you ever have to do is deal with Work and Income New Zealand...and...About two years later I was finally able to organise an appointment with the mental health unit through the Auckland hospital board. That was how long the waiting list was, unless my situation was urgent and they consider two attempts at suicide not to be urgent. I was told that if I tried a third time they would consider that to be urgent. The first clinician I went to there, at the insistence of WINZ, just sat there for the hour and twiddled his thumbs. Then he said I don't know what to do, and I never saw him again.

About three months later I was up with someone else from (clinic). At the end of the session she said to me “this service isn’t really for people like you, it’s for people who are crazy.” I thought two attempts at suicide and severe depression is not crazy?? What a sad thing to say you know (laughter).”

This participant shares his frustration of trying to access services for assistance. His understanding of crisis and the service’s understanding of crisis was not the same. This might illustrate how agency definitions may exclude those in need. Kaiwhakaako also comes from an educated background, and had worked as a mental health professional. Being homeless, clinically depressed, and feeling suicidal is a crisis situation in need of attention.

In this section common themes identified were early distorted perceptions of care due to a number of serious traumatic and abusive early childhood events. It would appear that in some cases, participants’ distorted perceptions of care were further exacerbated through social services and institutional settings, along with difficulties in accessing services. In the above section participants also expressed their frustrations about the types of questions mental health professionals ask. In some way, most of the participants perceived (actual or real) discrimination such as being spoken down to by service agency staff. This is comparable with Harris et al., (2006) study of 12500 people in the public arena where the experience of racism and discrimination was measured by racially motivated attacks, Maori reported the highest rates of racial discrimination. All of these experiences combined, are further cemented by segregated social, mental health, and housing systems, that were insufficient in meeting the needs of participants. For the mental health professional this might raise awareness concerning the development of negative perceptions of care where Maori homeless participants are concerned.

Making sense: internalising and resisting mental health narratives

Although the analysis to this point has presented a somewhat negative picture of social and mental health services impacting on the lives of participants, it is important to note that mental health provisions have changed dramatically over the past three decades. Concerns such as those articulated by participants are taken seriously and have been used to reshape services in a more client centred direction (MHC, 2006). Literature concerning recovery has been based on the experiences of people who had their first encounters with mental illness in psychiatric hospitals in which stigmatisation and social exclusion featured a key role in shaping their personal identities (MOH, 2006). Although professionals maintain dominant cultural stories about people living with mental illness, which clients may internalise and reproduce in their own stories, clients can also appropriate and resist characterisations that do not fit with their sense of self and history (Mankowski & Rappaport, 2000). This section explores the ways in which my participants draw on various narrative resources to make sense of and explain their mental health experiences. The section also functions as a transitional section to exploring issues of recovery, indigenous stories compared to dominant stories, and what can be done to better meet the needs of this client group.

It was apparent that for some participants, dominant cultural stories lingered in their own accounts. Some participants accepted and internalised what they had been told by professionals in the hope of finding a cure, and for one participant he used dominant cultural theories to defend his condition as a legitimate illness. Arona refers to her personhood as being attached to “mental health” and self-identifies as a mental health survivor, and she also expresses a certain acceptance for living uniquely.

We are mental health and we are psychiatric survivors and [concerning not doing things the right way] hey it's okay to be this way, to not do everything right, mental health people know that not everything is right with us.

The participant accepts that it is okay to not do everything right. It would appear that acceptance of self is part of the recovery process. Interestingly enough, below, she also tells of past hurts, perceptions of rejection, or being treated as less

than human. She illustrates internalisation of such messages and subsequent self harm.

I was diagnosed as suicidal, but really I wasn't, I was sound, I got an adrenaline rush, I'm too hyperactive, but when someone kicks me to the curb, my heart and everything just drops, I feel if I want to diagnose myself I would say rejected. I can't handle being rejected because I am rejected every time of my life, so what do I do when I am getting rejected I go out and hurt myself. No one wants me, don't want myself.

Not only do these experiences contribute to poor mental health, they are isolating incidents, leading to feelings of rejection, self harm, and also contribute to homelessness because they reflect the diminishing of social relations that are so important for keeping people off the streets. Arona resists a dominant story line of suicide, and comes up with her own theory that points to effects of dehumanising interactions.

Pounamu does not believe her practitioner, and Kakama internalises past experiences that contribute to homelessness, and includes a spiritual experience that would be more compatible to Maori experience, compared to a dominant story line that might, for example, refer to schizophrenia.

Pounamu: My [GP] a couple of years ago described me as a schizophrenic paranoid. [Diana: What did you think about that?] Participant: I totally denied it.

Kakama: There's been other times, because I felt sorry for myself and it felt like no one cared about me. I slept in cemeteries, the first time recently, not normal thing to do being a Maori eh? I slept in there. You see there wasn't anyone around to annoy me and I felt safe in the cemetery. Strange thing, sometimes I felt those people who have passed away talked to me. I think they were trying to help me.

Past traumatic events and stigmatisation have lead to internalising events, and on to pathways into homelessness.

Kaiwhakaako's application of dominant cultural stories concerning depression are illustrated below and were used to support his past condition by saying that suicide can be a logical and rational decision.

My particular sense of suicide was different from most people's, even though I had depression the suicide wasn't based on depression it was based on logic. For a lot of people at times in their life, they weigh up this potential for the future that we often get told about, if you keep on going you will find that things will turn out all right. Have hope for the future... For a lot of people the investment putting all other effort into sustaining of future at which the end, 30 - 40 years down the line, there may be something happening which says all of the crap was worth it, look at the balance sheet. A lot of people don't have that hope, and when they weigh up this vague possibility that people talk about of the future alongside the practical realities, it's just not worth carry on. So for many people suicide is extremely logical, it's almost economical in its formation.

The way in which mental health services are delivered has changed dramatically over the past few decades. At the centre of, and guiding mental health practice in New Zealand today is the recovery approach (MHC, 2000; 2002a; Lapsley, Nikora & Black, 2002). In Arona's story there is some evidence of hope, while mental health concerns may persist, she demonstrates a degree of acceptance for the condition that she lives with, and acknowledges that it is okay when things are not perfect. In Kaiwhakaako's example, it is apparent that he has been well educated, this is also a protective factor in that allows him to have some personal agency, and control in the process. This may also run against the stereo typical beliefs that some domiciled people might have concerning homeless people.

Recovery: therapeutic relationships and responding to adversity

On a personal level the telling of chaotic stories of abuse and adversity can be seen as achieving some degree of healing in the recovery process (Frank, 1998). However, the horrific events of the past do not disappear in a few months or years. As Deegan (1996) has emphasised, recovery from mental illness is relatively easy compared to the recovery time needed for the healing of deep

emotional wounds that have been inflicted onto the human heart. Deegan relates to her own experiences of mental health institutional abuse. Healing takes time, and for many of these people it is a long journey to wellbeing.

There is a need for long-term therapeutic relationships in which trust has been established and proven with clients who have learned to distrust caregivers. Participants identify the need for broadly focused services that address mental health needs in context of homeless life worlds. A Maori focused approach is presented as one option for addressing such issues that was emphasised by several participants.

The sharing of traumatic stories at the interpersonal level also became an emotional engagement between participant and researcher. I felt considerably burdened by some of the stories told. It was evident to me that in some of the interviews the participants were struggling to overcome a barrier in telling their stories. At times, not in all cases, there were cathartic releases portrayed in tears and silences. In consideration to the sensitive nature of the topic, it was necessary to allow participants time to talk, without making them feel as though it was necessary to do so. I remained open and friendly, empathetic, and genuinely interested in their personal stories.

In relation to the background experiences of homeless Maori participants it would be important for practitioners to consider how they engage with homeless clients. Practitioners and therapists often talk about the therapeutic relationship as being a key element in psychotherapy. One of the greatest single factors that psychotherapists do agree upon in therapy is developing a working relationship with clients, which is central to successful treatment outcomes (Prochaska & Norcross, 2007). Jung also emphasised the importance of an intimate therapeutic relationship between patient and therapist; he felt that it was not possible, nor helpful for therapists to be emotionally distant from their patients; similarly, Carl Rogers emphasised genuineness, congruence, and unconditional positive regard in his client centred approach (Sedgwick, 2001). Rogers (1949) illustrated the importance of creating an atmosphere where people can share safely, without feeling their communication is being evaluated. He also emphasised that diagnostic knowledge and skill do not necessarily make for good therapy,

implying that if people learned client centred therapy they would learn psychological dynamics and acquire professional humility and willingness to learn from the client:

The clinical experience could be summarised by saying that the behaviour of the human organism may be determined by the influences to which it has been exposed, but it may also be determined by the creative and integrative insight of the organism itself (Rogers, 1946, p. 422).

Rogers talks about the ability of people to discover new meaning from past chaos, to alter their thinking in the light of new meaning, and changing the philosophical basis so that therapists can admit that forces exist within the individual that can influence behaviour, which is not predictable through knowledge of prior influences and conditions. Frank (1995) also asserts that telling illness stories involves a type of self care including gaining recognition of what has happened, taking control over illness, and making sense of past chaotic experiences. Such stories have therapeutic benefits for both physical and mental health (Dimaggio & Semerari, 2001). These stories usually occur at the end of chaotic experiences when the individual is removed from the past trauma and hurt that has interrupted their life journey (Frank, 1998).

Kakama demonstrates the usefulness of telling his story. In the process, Kakama demonstrates a recognition that he needs to share his story with someone. This was not something he just suddenly came up with; he had been thinking on it for some time:

Diana: Who have you told about these experiences?

Kakama: No-one, this is the first time I am talking about it.

Diana: Are you comfortable talking about these events?

Kakama: Yes, because it helps me to release my sorrows and figure it out... and...In the past I thought I couldn't do anything, but now it's like trying to find a new life.

In acknowledging the hurt of the past there was a drawn out silence. I felt grieved that he had never had anyone to talk to about his past. Some of this was about his

lack of trust in others. He appeared to have developed a new sense of awareness, and started making sense of his past, and thinking about his future, and different ways of being. Kakama talks about beginnings of mental illness in terms of his background. He starts by accepting some responsibility for choices made, and his painful account of happenings:

Kakama; Younger day's burgs and things, I guess I wanted to do what I wanted to do, so they ended up putting me in foster homes when I was eight. It's a lonely world when you are young, when you had to walk past your house, hearing your brothers and sisters laughing in the house, and then go on to a placement home. It's a lonely thing for a young person... and...I grew up in boy's homes, family homes, since I was 8 years old and this was the life I was use to when I was younger. It's like working you up to prison, setting you up for it. I first found out in prison that I had a mental illness.

Kakama goes on to make links between mental illness and removal by the state with crime.

In the light of the participants' past traumatic events and severed relationships, it would also be necessary for practitioners to consider that it may be a long journey to healing for homeless. Rogers (1946) emphasises a practical humane approach to building relationships with clients that can be used with Maori homeless people. This includes developing a professional humility, treating people with dignity and respect, learning to accept people as they are, and understanding that people have various strengths and abilities, and come with their own sets of knowledge. Jung also stressed the importance of the relational spheres between persons in psychotherapy (Jung, 1993).

For good therapeutic relationships with Maori clients, practitioners need to move beyond dominant Western narratives of mental illness. In this section there is a contrast of dominant versus non dominant stories. By telling non dominant stories, often societal standards are challenged. One dominant story can be seen in clinical practice. Practitioners usually formulate stories to find a diagnosis to come up with a treatment plan. The practitioner elicits the history of the ill person, and the person is then assimilated into the impersonal and often abstract dominant

discourse of the practitioner (Frank, 1998; Mishler, 1991). These authors have argued that many health professionals are not simply concerned with providing the client with a time to talk about their suffering or to fully understand an illness. They also work to produce a diagnosis and in the process patients can be transformed into a category or character with a dominant narrative of mental illness. In exploring knowledge and power, Foucault (2001) theorises that powerful institutions have allowed practitioners to define what is normal, or abnormal, and when practitioners use their power to label the other, they become part of a larger network of agents who support and reproduce that power. This story is not unfamiliar to clients when visiting their practitioner or clinician. They come to know the client group to which they belong. Conversely, Foucault's theory has been criticised for not considering the personal agency that clients may have.

In talking about theories, we can use Kakama's previous example above to illustrate how dominant narratives of mental illness can be appropriated. For example, a Western psychological perspective one might consider Kakama's condition from the view point of social learning theory (Bandura, 1977), lack of a secure attachment (Bowlby, 1970), or genetic and biological framework that contribute to mental health issues and challenging behaviours. However, from a Maori cultural perspective, to provide another example, Kakama may have interpreted early traumatic experiences from his knowledge of maketu (curse) due to a violation in protocol between hapus or his ancestors of long ago. Maketu is often used to explain various types of illness, and is interpreted in various ways. Usually it depicts the Tohunga's ability to utilise the Atua's power to curse another whanau or individual (Taitimu, 2007). Maori participants contribute accounts that are different to standard measurements of illness, and related to seeing and hearing things that were not tangible. Research has identified that in the Maori world seeing or hearing things that others cannot, may be representative of a gift or connection to one's ancestors (Taitimu, 2007). Along these lines there is also literature that suggests Indigenous Peoples, and more specifically here, Maori have been over diagnosed or misdiagnosed in some cases (Saleebey, Lapsley, Nikora & Black, see also Taitimu, date).

I mean in the Maori world it can be common to hear voices, see visions, or see things beyond the physical world. There is more behind people's beliefs and other people choose not to see it. Perhaps it's a hand down from our ancestors, like tohungas. I saw my mother pass away exactly where she passed away perhaps a year before she passed away... I think they are right, I would like to learn more about myself.

It is also important to note that Kakama was not unaware that he had lived with mental health issues. He felt that the diagnosis that his GP gave him was right. However, the professional diagnosis did not provide him with a complete explanation. He also drew on Maori understandings in considering the wider socio-cultural significance of his experiences. Additionally, when practitioners or therapists interpret client symptoms as a specific disorder or dysfunction, difficulties may arise when crossing cultural boundaries, such as when symptoms are confused with cultural specific phenomena.

Four Maori homeless participants identified differences in Maori ways of being compared to Pakeha understandings of mental health, for example seeing things that are not tangible, such as visions of things to come, or seeing spirits, hearing and seeing ancestors or relatives who are beyond the physical realm in which we live. Kakama gives his example

Seeing such things in the Maori world that would be normal but in the European it would not be.

Kakama's statement also reveals that he is able to work from within a bicultural framework. Kaiwhakaako provides an educated illustration of contrasting stories, the dominant cultural story compared to an indigenous cultural story:

...In a Western framework we place ourselves in a particular position. We have this set of allowances for behaviour and anything beyond a limitation we consider to be insane, unstable, or inappropriate. This particular paradigm is one that does not sit particularly well with us in New Zealand. We are constantly being told that one in four New Zealanders will suffer mental problems in their lives.... That says that we are either using completely the

wrong model in terms of our mental health, or we are a very sick society. (...)So New Zealand itself, from a white perspective is pretty damn out of kilter. How much more so is it when we attempt to use the Western paradigm to describe mental health for other cultures that do not ordinarily belong inside that culture. Where their concepts of acceptable and unacceptable behaviour start and stop in other places ... Automatically they are going to be diagnosed as mentally unstable. They were at a different place to begin with. We might look at something like religion and say we find speaking with spirits is a sign of lunacy, however we accept up to the point of believing in God, praying to God and God listening to our affairs. But what happens if we are in another culture where we say we believe all living things have a spirit. For example your culture may worship the after birth of a mother. Immediately we say that this is a mentally unsound way of dealing with it.

Kaiwhakaako contrasts Western paradigms with Maori perspectives, and the concept of spirituality which may impact on individual results when considering standard measures used in psychiatry and psychology, spirituality has been divorced from the world of science. Yet, it appears that spirituality is intrinsically a part of not just Maori world views and identity, but of human nature. The Maori self/personhood ensures maintenance between the physical and spiritual realms, core elements include mauri, mana, tapu, and wairua (Taitimu, 2007). It would be beneficial for practitioners and therapists in their practice to continue with cultural competencies, and continue to consider the differences that may occur across cultures. Durie (2004) has been instrumental in advancing Maori research and the understanding that Maori health is best framed from within a holistic perspective. The same author has demonstrated that rather than science and indigenous knowledge being a cause of controversy, more collaboration can provide opportunities for expansion of knowledge and understanding of health and illness in New Zealand.

The example has also highlighted that Maori participants are able to work from within a bicultural framework. Three of the participants were keen on having Maori practitioners, and Maori mental health frameworks.

One final point for this section is the necessity for practitioners to reflect on their background beliefs and cosmologies that may have been shaped through dominant cultural stories linked to socio-political processes and professional training, that also impact on the subject or persons under investigation. Unless one is reflective about their own assumptions and realities, it would be quite difficult to move across or understand other people's realities. This might also be beneficial in meeting client orientated goals, and to gain a deeper understanding of what might be helpful for the client as per the Mental Health strategy (MOH, 2002) and other core competencies for professionals in their respective disciplines.

Three of the participants expressed a desire to see more Maori practitioners. One participant preferred Pakeha services for certain things such as receiving medication, and another did not mind seeing Maori or Pakeha clinicians so long as she could receive help. Arona said

I've been diagnosed by all types of nationalities except for Maori. Nationally, all Maori come together with the Maori whaiora, they will always come through about the issues of who is healing who, over seas people can see their own. But here Maori healers are claimed as witch doctors. Maori heal with rongo (maori medicine), but this is not a method of healing. I've been diagnosed from people whom I don't even know.

Arona is of the opinion that there are not enough Maori psychiatrists and or psychologists in New Zealand who would be competent in delivering traditional Maori healing practices, such as karakia, rongo, and mirimiri.

Below, Eruera expresses the same opinion as Arona:

I would like to see more Maori people than other cultures. I disagree on the European way, I always have and I always will. And they should work with other European who are in mental health and see what is different. Because I think there would be a bit of change if they work with other people, I just think it would work better. The Maori health has got something to offer.

Pania reported that she found both Maori and Pakeha services to be useful. In regards to Maori based service use, flexibility was important in where the

participant could meet with the practitioner. She also mentioned that she found a psychologist in mainstream mental health to be very helpful.

Homeless participants have expressed their thoughts about what is unhelpful when trying to access appropriate mental health services (while coping with mental health concerns). This includes delayed access to services such as waiting lists, and limited resources in state employed agencies. Additionally, homeless participants talked about their fears of accessing mental health services, perceptions of being treated less than human, and power discrepancies between practitioner and client. In all cases the participants have acknowledged their need for help. If homeless people living with mental illness are made to feel less than human, how are they expected to use mental health services that are for human beings?

One participant was relieved to find out that she had a diagnosis some years ago, and gives a reason why

It wasn't until I was 23 that I went to see a psychologist and they diagnosed me with schizophrenia... and...I was relieved ... I have something, and they can do something about it.

The participant needed someone to verify her feelings of that something was wrong, and feedback was important. She described feeling relieved that there was something that did have a label so that she could get help and someone could do something about it. Here she reinforces the notions of a legitimated discourse in society. Mental illness interacts with society in the way of legitimated discourses, not only reinforcing the practitioners' position, but enabling the person to seek help.

Pania talks about having a service where she can access her health workers in one place; she then goes on to talk about why it is good to have services in one place:

I have an occupational therapist, I got a nurse, I got a doctor and they gave me more people. ... Well I don't want to walk around too much you know, and my file is there so everyone can access it. I can talk about different people

about different issues, and the next one can see it and see what I've done and they can talk about that too.

This client enjoyed services being in one location. Homeless people living with mental health concerns do not often have cars; if the situation arises where they are in need of two or more services for mental health concerns, it would be reasonable to assume that it might add an extra burden navigating their way from service to service.

Participants appreciated it when clinicians and mental health workers spoke to them in a way that was respectful, could allow them to have an appointment that was not always in the office, or at a place where they felt comfortable.

Oh just the way she talked and her tone, the way she helped me, we did an assertiveness course. Well they take you out for coffee and all that... or they might come up and see me which is quite comfortable, because sometime in the office I don't feel comfortable. It's just the building. But he has my file there you see. But sometimes I prefer to be outside

Below both Pounamu and Eruera talk about what they felt comfortable about in receiving Maori based services.

Pounamu: I like him he's cool, because he knows how to make you feel welcome. It's just the feeling that I get around him.

Below are more examples of what practitioners can do to make Maori clients more comfortable in the assessment process, Eruera explains the importance of a karakia.

I would like to see a nice welcome. A karakia and when you give out your taki to see what is wrong with you, a karakia will help you through those things. It protects you, when you do the karakia at the end it takes it way from you, the tapu will go away from you, and the karakia tops it off. That is the whole idea. The karakia is the one that gives peace and keeps you from harm. (Make noa lifts tapu).

Arona had shared extensively on her past negative experiences with mental health service, and residential service use. In the following story she contrasts this with a positive experience that promoted healing in her own life. The story illustrates what most of the participants believed was appropriate for Maori entering mental health.

When you enter [a Maori service], they give you a welcome in, ... in the healing room, the tepunas are up on the walls. They welcome you with a powhiri, you have your doctor that you will have for your duration, key worker, and nurse, and the social worker. They talk maori, and all that. That is your doctor, this will be your nurse, we will be given some pamphlets and some cards so you know what we are about... They also joke with you. Then they get me to stand up as a whaiora. I say that I am born and bred in [place of belonging] my parents come from the north and the south. ... I am proud to say my whakapapa. Then its all hugs, even my doctor hugs me. Like a doctor it's amazing! Then they say come on let's go, let's go do some healing. Then we went and had lunch, they gave us our own little lunch. But you know what the greatest thing was – it was my case workers taking us out for lunch, and joking with us. That was positive, I kind of miss it eh? It's not the shouting for lunch but they were there for us. I also liked that they were bilingual.

Emerging from participants' accounts were common themes about being treated as a human being with respect and dignity when accessing mental health services. This was an important factor for their recovery, and is also consistent with human rights, New Zealand mental health strategy, and Maori world views. They felt it was important how they were welcomed into mental health services, people connecting with people regardless of status, sharing together over a meal or a cup of tea, giving sufficient information about the type of service one would be receiving, and having some say in the treatment process. While some of the participants emphasised the importance of Maori protocols and language, the focus was more on the relationship between themselves and the practitioners, or services they were engaged with, and about being treated with respect and dignity. Because Maori homeless participants (and homeless in general) have been treated as less than human, practitioners and therapists need to take a human approach

with homeless people. The following section discusses the findings of the analysis.

Chapter discussion

In section one the analysis reveals the impact of homeless persons' early life experiences that have led to poor perceptions of care. Most of the participants came from unstable and abusive backgrounds. Early removal from their homes by social services to seemingly inappropriate placements left them feeling alienated and unable to trust, and rendered them homeless during childhood even if housed through social welfare. While there are many pathways into homelessness, this can be seen as a process of social exclusion and dislocation that began in childhood for most of the participants. As a result of early experiences of abuse and neglect by both families and society, they learned to distrust others and institutions, to fend for themselves without regard for others, sometimes in violent or self-destructive ways. These experiences and negative expectations were exacerbated when they encountered institutional abuse, incompetent and disorganised social services, or felt marginalised or spoken down to by service staff. These experiences reinforce their lack of trust in mental health services and social systems. Consistently, throughout the narratives of homeless participants, there are shared understandings that they felt as though they had been victims of state imposed conditions. This left them feeling disempowered, without a voice, discriminated against, and abused further. It was also evident that there were gaps in service delivery, inappropriate social and mental health systems, poor policy planning and implementation, and inadequate housing. It was clear that policy development needs to be widespread linking between housing, health, social welfare, and other governmental services. The implications of failing to provide a more joined up approach will exacerbate mental health conditions for Maori homeless people (and homeless people in general).

In section two, examples were given of participants internalising dominant stories, this may be interpreted as clients seeing themselves as the problem and not part of the solution. Stories help us to make meaning of our lives, but we also reproduce the stories that other people tell about us (Monk, Winslade, Crocket, & Epston,

1997). Powerful institutions have the ability to define that which is normal or abnormal for others (Foucault, 2001) and practitioners and therapists have reproduced and spoken a dominant discourse for years, framing the ill person through the professional lens (Frank, 1998; Mishler, 1991). One participant accepted the label 'mental health survivor', another rejected her pathology, one participant who was educated used a dominant theme to outwit practitioners revealing some equality and agency in the pathologising process. It would make sense that homeless participants are empowered in the healing process, and have some choice in how to go about that process, as it would appear they have had little say over their lives throughout their childhood and adult years.

In section three there was a focus on the importance of building good therapeutic relationships, especially in understanding their past experiences, backgrounds, and various trauma and adversities that contribute to distrust in mental health systems. The need arises for long term relationships in which trust can be established and proven with clients who have learned to distrust caregivers, and recognition that clients come with their own knowledge, are able to discover meaning from past chaos, alter their thinking, and have certain strengths and abilities to contribute. At a societal level of analysis, dominant cultural stories in the mental health field remain and do not always reflect non dominant indigenous story lines. However, as we discussed in the first analysis, through socio-political processes, cultural stories are becoming more acceptable. In expressing their own understandings of mental illness, participants gleaned from both dominant story lines and indigenous narratives. It was also highlighted in the analysis that practitioners and therapists would benefit through reflective and humanistic approaches in practice, undertake collaborative approaches, and focus more on strengths and less on weaknesses in order to assist Maori homeless participants in the recovery process.

In section four, participants talk about what they found to be unhelpful interventions, and offer insights into how services can be improved. Emerging from their stories were common themes about being treated with respect and dignity when accessing mental health services. A focus on relationships was important, starting with good introductions and what was being offered in the service. Information sharing and working together towards healing was a stable

factor, that let participants know that the mental health professional was there for them. Participants felt that it would be helpful if practitioners had more of an understanding of the background of homeless people and Maori in general. While three of the participants emphasised Maori protocols, and language, these were not more important than being treated with respect and dignity, and being made to feel as though someone cared about them. These were simple things, but to a homeless person, they made a world of difference.

CHAPTER FIVE

CONCLUSION

In the opening of this thesis, and at various points throughout the analysis, I highlighted a number of welfare and health concerns that Homeless people face. Research shows that homeless people are more likely to ‘get sicker and die quicker,’ experience a sense of dispossession, isolation, and cultural dislocation, run a higher risk of committing suicide, and are many times more likely to be attacked and killed. They are also likely to experience stigmatisation, and exclusion from community services. Such factors impact on social, physiological, physical, emotional and spiritual wellbeing. Within the broader context of health disparities demanding a range of responses from society, including the provision of housing and welfare supports to medical care, this research focused primarily on Maori homelessness and mental illness. I had two primary aims. Firstly, to document the experiences of Homeless Maori people living with mental health concerns, their relationship with mental health professionals, and service use. Secondly, to document the experiences of mental health professionals and how they provide care for, interact with, and build relationships with Maori homeless. The skills professionals have, and the difficulties that they face in providing care were also considered. The information provided by homeless and professional participants is useful for improving service delivery and finding more appropriate ways of moving forward.

My interpretation of what is going on with mental health care for homeless people and what needs to be done is informed by many of the humanistic values (Maslow, 1970; Rogers, 1961; 1980) which underpin strength-based and recovery orientated approaches to mental health care (2002a; MOH; 2006). The rise of service user movements has led to the outcome of more appropriate care; the focus of recovery, strength based interventions, including being treated with respect and dignity, holistic approaches to care reflecting whanau health, and helping to find meaning in distress was initially documented in the blue print for mental health services, and mental health strategy for those working in New Zealand (MHC, 1998; MOH; 2000; 2002a). There is a requirement for an

increased awareness of service users' rights to play an active role in their care. In a similar vein, the cultural renaissance which occurred in New Zealand during the 1970s (Brooking, 2004), has also resulted in greater acknowledgement by the government of Treaty principles and levels of participation by Maori in the delivery of Maori health services (Ringold, 2005).

This orientation necessitates the acknowledgement that homelessness is primarily a social concern emerging out of traumatic and unsupportive lifeworlds. The mental health concerns experienced by homeless people and the efforts of health professionals to render assistance cannot be engaged in isolation from other domains of care such as housing, social support and welfare support. Further, without the development of broad social and health policies, much of the barriers encountered in service delivery will remain. These barriers contribute to, and exacerbate, poor mental health and homeless conditions.

Below, I will start with homeless participants' subjective experiences and early understandings of mental illness, and voiced concerns with regards to mental health care. Comparisons will be made with what mental health professionals say contributes to the barriers to providing quality care for homeless people. Professional participants' draw more on structural and external explanations, than individual characteristics that inhibit quality care. This will be followed with what Homeless participants found to be helpful in mental health service use. Common findings show that respectful relationships, generosity, communicating what is on offer, and that culturally appropriate services, or at least, recognition of cultural identity, were most beneficial for Maori homeless participants. This has provided some insight on the types of approaches useful for therapists and practitioners in building relationships with, and working alongside Maori homeless. This chapter concludes with recommendations.

Maori Homeless Participants: Beginnings and Concerns.

Narrative psychologists emphasise the importance of telling illness stories as a way of structuring and making sense of what has happened (Murray, 2000; Monk, et al., 1997). These stories also allow a type of self care, by taking control over

what has happened (Murray, 2000), and may function in a way that the narrator can shift responsibility to external systems beyond their control, and in so doing, maintain some sense of social identity. In a sense there can be a minimisation of taking personal responsibility if the narrator focuses solely on external factors, which helps one normalise an experience and cope (Chamberlain & Hodgetts, 2000). This is particularly important for homeless people who face stigma and are often constructed in public narratives as the causes rather than victims of social ills (Hodgetts et al., 2008). If we were to focus solely on the individual and locate the problem internally, this can lead to blaming the person and overlooking the structural and social factors related to homelessness and mental health. The findings show that participants' draw more on external, societal and relational explanations for their mental illnesses from these tropes (*cf.*, Hodgetts & Chamberlain, 2000). Participants construct their own unique stories, which render meaningful their own experiences and situations, by combining these tropes.

Common findings across Homeless Maori participants reveal a lack of stable relationships in early life leading to poor perceptions of care, and views of the world. Bowlby's (1988) extensive work on attachment theory reveals that when a child lacks confidence that a primary caregiver will respond appropriately to their needs, they experience and expect rejection, and can live a life without support and love from others (Bowlby, 1988). Alternatively, whanau that promote warm, nurturing, safe, and continuous relationships contribute to the wellbeing of their tamariki (Bowlby, 1998; 1953). Homeless participants' stories revealed that poor perceptions of care were further exacerbated by ongoing institutional abuse and poor treatment in social and mental health services. For most homeless participants, they recognise that all these factors, or a variety of such, contribute to mental illness, and pathways into homelessness. Furthermore, barriers to services may further undermine any faith they may have in mental health services use.

A number of difficulties such as delays to services, long waiting lists, limited resources and gaps in services were of concern to homeless participants. Consistent with findings on Maori and mental health service use (Durie, 2001; Lapsley, Nikora, & Black, 2002; Taitimu, 2007), participants' also talked about fears of accessing mental health services due to stigmatisation, and were

sometimes sceptical of Western approaches to mental health care. Maori homeless participants also expressed their distrust in services where they felt excluded, isolated, and feared being dishonoured based on ethnicity, mental health conditions, and or being homeless. Such experiences have contributed to participants feeling dehumanised. It could be said that Maori homeless living with mental health concerns may experience a triple dose of stigmatisation and social exclusion. The implications of such mean that in order for Maori homeless to use mainstream mental health and other community services their therapists or practitioners need to be human in approach, avoid clinical faces, and increase in cultural competencies.

On a relational level, participants expressed feeling uncomfortable with the power practitioners have to diagnose, having to go along with the diagnosis, making up answers to show oneself fit, or where clinicians' were overly clinical. Barriers to collaboration include an unequal balance in power where Maori understandings can be ignored, overlooked, or pathologised as abnormal (Lapsley, Nikora & Black, 2002).

Mental health professionals working across various settings also experienced a number of barriers to quality care, and service delivery. Many of the same barriers are similar to what international research has to say on the matter. Participants' accounts also show they draw on more external explanations than on individual explanations that contribute to barriers and less effective care for Maori homeless people. They mention organisational policies that were exclusive when homeless people did not fit service criteria, or when they did not have an address. There were reports on homeless people 'slipping through the cracks' after leaving Corrections services, or mental health services with no back up plan or appropriate ongoing intervention. Participants also discussed a number of internal and interagency problems that occur due to slow transfer of information, being unable to access client information, difficulties in accessing necessary community services, or finding temporary accommodation. All of these factors suggest that there needs to be links between services, a more holistic approach to care, some method of identifying ongoing needs before leaving services, and having a back up plan for people with a history of homelessness.

Clinicians also reported individual factors such as drug and alcohol misuse, lack of life skills, being illiterate, or lacking work skills as also contributing to barriers in service use. Existing literature suggests that drug and alcohol misuse can trigger homelessness, will increase over the time that one is sleeping rough, and does little to support a person in ‘sustaining and remaining’ housed (Robinson, 2004). Findings from the analysis and literature would suggest that drug and alcohol services need to be made more available for homeless people, but that this is not adequate enough if there is no ongoing intervention such as social support, mental health care, and housing.

The concerns and problems raised so far by all participants have demonstrated that the issue for Maori homelessness is beyond ‘bricks and mortar’ and exceeds the limits of CBT. Homeless participants have expressed their thoughts about what is unhelpful when trying to access mental health services, and mental health professionals have offered their thoughts on barriers to care. While many of these concerns were problem based, Maori homeless participants also shared what they found helpful in mental health service use. They more readily responded to humanistic and client centred approaches to care.

What Maori homeless participants felt was helpful in mental health care

Homeless participants also discussed what they found helpful about mental health services. Their focus was on good relationships, being treated as human beings with respect and dignity, and participating in the therapy process. This was not always related to Maori-based services. Services deemed helpful included introductions to the team, and a general feeling that some dignity had been restored through respectful approaches and social support. Maori-based services and tikanga practices were also appreciated, such as karakia, receiving good information about what was being offered by the service, using humour, feeling safe, courtesies such as offering a cup of tea or eating lunch together, and building safe relationships where acceptance and sharing was okay. These findings are comparable to Lapsley, Nikora and Black’s (2002) study that show participants

were responsive to effective Maori health service delivery which reflects a more culturally aware orientation to treating the person.

Arona provided an example of a Maori based service that was fundamental in the recovery process. She felt that her dignity and mana had been restored, and appreciated the recognition of her own culture being an intrinsic part of her being. From horrific beginnings and a long history of mental health service use, to accessing a Maori based service provider that focussed on recovery, Arona was able to engage social supports to assist her and her partner into appropriate accommodation. At the time of the interview she was training for future employment.

In the mental health field, recovery includes not just living well with, or overcoming mental illness, but overcoming internalised stigma, and the harmful things that may have happened to people in institutional or inpatient settings (Anthony, 1993; Deegan, 1996), such as poverty, inequalities in power, learned helplessness, second class citizenship, physical, sexual and emotional abuse (Deegan, 1997). Recovery emphasises the conceptualisation that human life is in a constant process of becoming. This notion of becoming, or having abilities and potential to grow and mature is closely associated with humanistic and existential values. Recovery in New Zealand is foundational to the National Mental Health Strategy (MOH, 2000; MHC, 2002a: 2002b; MOH, 2006) and incorporates principles of the Treaty of Waitangi including partnership, protection, participation and equal rights between Maori and non Maori. There is the requirement that all mental health workers in New Zealand are conversant with the recovery approach (MHC, 2002a; 2002b). According to this policy, Maori clients in mainstream settings are able to have their values, beliefs and customs acknowledged, and have Maori health practices incorporated into intervention. A recovery approach is compatible with Maori world views, not only does it promote service users being empowered, and enhancing participation socially, it is also consistent with Maori mental health models from the perspective of hinegnaro, tinana, whanau and environments in which people live (Lapsley, Nikora & Black, 2002). It is about having a voice and a choice in the type of cares that are provided. Additionally, the recognition of strengths is a fundamental value of recovery (Dennis & Lourie, 2006).

This also links into the Health Practitioners Competence Assurance Act (2003) for a range of professionals working in New Zealand, and the code of ethics for psychologists working in New Zealand (2003) that provides a framework for cultural safety, Treaty of Waitangi principles, and cultural competencies. This guides psychologists to work in partnership with Maori, be responsive to the needs of Maori, and be active in supporting Maori models of wellbeing. Having empathy and being able to build relationships with Maori in a culturally sensitive way is also important.

In this research, most of the Maori homeless participants demonstrated their skills of being able to work from within a bicultural framework such as Maori understandings and basic Western understandings of how 'wellness and illness' are conceptualised. Some of the professional participants demonstrated skills in weaving mainstream mental health approaches with Maori ways of thinking and being. The findings in this research suggest that those more equipped to provide a bicultural service were Maori practitioners who were conversant in te reo and familiar with tikanga. Findings would also suggest that if practitioners and therapists are to become more skilled in delivering culturally appropriate services, then more appropriate resources, including Maori trainer/therapists are necessary.

Both Homeless people and practitioners emphasise the importance of the therapeutic relationship and services that look beyond therapy when dealing with mental health issues. Therapy in isolation of other services or social relationships does not work. A broader approach to health care is needed. Professional participants expressed some of the difficulties that they faced in trying to find other necessary services, such as night shelters, or accessing other mental health services. In some cases they identified that Maori were not getting a culturally appropriate service. They were also aware that where the health dollar stops so does the intervention.

Therapeutic interventions and relationships

At the interface between client and therapists, work needs to address the history the client brings into the room with them, where they can tell and rephrase what has happened to them in the past. Not only can the client bring some order to chaotic pasts by externalising mental health issues and homelessness as at least, in part, products of adversity, or structural influences, then people can focus beyond the self blame, and start working through how they got to this situation and possible ways of moving forward. It requires the practitioner to not just look at the inside of the client for deficits, but also to their lifepaths and lifeworlds to understand their perspectives, strengths and abilities.

Narrative therapy is one way of achieving this, as we make sense of our lives through socially constructed meanings that are shared within a culture (Monk, Winslade, Crocket & Eptson, 1997). There are many ways of looking at the world, many discourses or social practices, but usually the most dominant discourse is the one that is heard. The view that meaning is socially constructed underpins indigenous movements and indigenous psychological views (Smith, 1999). The operations to deconstruct and reconstruct dominant Western stories and paradigms have been a process of recovery to restore legitimised cultural ways of being and ethnic rights for Maori (Smith, 1999). In a similar way, narrative therapy enables the client to externalise and to deconstruct their stories, creates a space for new perspectives and can, in turn, give direction to other solutions (Monk, Winslade, Crocket & Eptson, 1997). By externalising information and seeing societal perspectives it assists the client to move beyond, and be empowered to become active in finding solution for their circumstances. Narrative is useful for uncovering previously hidden strengths and abilities, or resources that can be used to move forward (Dennis & Lourie, 2002). It also separates the problem from being located in the person to where it may be located in unhelpful or powerful ways of thinking in society. If one focuses on pathologies and deficits it may only encourage the hopelessness, or the inadequacy that the client may experience (Saleeby, 2002).

Most of the homeless participants in this research have experienced social exclusion and disempowerment, lack fair access to services and resources necessary for their wellbeing. A fundamental thing in working towards successful care is working to empower and include them in decision making in the therapy process (Durie, 2005). This also links into broader contextual approaches such as community action approaches to health care (WHO, 2008). Health or wellbeing is a basic human right (WHO, 2007; HRC, 2004). Both community interventions and interpersonal interventions are compatible with each other, and mutually enhancing.

It has been established in literature that a good working relationship is a major contributor to positive change in the therapeutic setting, and has been identified as being essential to the recovery process. At the heart of the Maori social order is relationships, connectedness, and whanau (Smith, 1999). In the Maori world the obligation to give and receive, acts of kindness, and showing hospitality are central to Maori ways of being (Metge, 1985). Polynesian societies place a great deal of importance on social values in relationships, such as serving, helping, sharing and loving others (Cowling, 2005). Most of the Maori homeless participants in this research told horrific stories of dehumanisation. Therefore it is important to consider humanistic approaches when interacting with Maori homeless, or homeless people in general.

Helpful approaches professional participants used in connecting with Maori homeless include, manaakitanga or giving, awareness of the clients' socio-cultural history or lived experience, establishing relationships through strength based and recovery approaches that focused on client needs and goals. The fourth approach was a culturally specific way to approach relationships and is seen in Marae protocol (Durie, 2002). Such rituals also focus on the concept of whanaungatanga (Bishop, 1999). Maori perspectives can teach us that connection is central to the Maori world, and that social rituals that reinforce this type of relationship are 'culturally inscribed on consciousness' (Monk, Winslade, Crocket & Epton, 1997). Understanding the concept of relationship in Maori terms might show us that in connecting with Maori it would be important to take these processes

seriously (Monk, et al, 1997). Understanding the focus on relationships in the Maori world, and practicing this concept, is respectful in that it positions us to seek out the views of others in order to seek equality and work collaboratively.

Some of the participants used whanau approaches, that is to share and care like one would a family member. By offering food, and 'looking past the mess' one participant demonstrated that a homeless person felt cared for. By following a whanau approach and extending the relationship beyond professional criteria the client was able to resettle. This also enabled the practitioner to establish a relationship before the person entered services.

Research has shown that at the therapeutic level, client progress is made through simple subjective inner choices, having a greater awareness of self, and feeling different about one's situation (Rogers, 1961). Rogers (1961), Jung (1933), and Maslow (1971), all experienced clinicians, emphasised that knowledge is a combination of objective and subjective experience, and that all people have their epistemological bases or 'truth'. Furthermore, they held that human approaches avoid clinical faces. Mason Durie (2005) has noted that high standards of health care are not limited to advances in technology, diagnostics and treatment, and while the application of scientific knowledge is important, human feelings and belief systems are also an important aspect of the healing process. Carl Rogers (1951) acknowledges that science has the capacity to objectify the subject of study. Rogers also believed that science was an important tool for measurement however it should not take precedence over the human being.

While good relationships are important at the interpersonal level, at a community level professional participants made it clear that an interagency approach was needed to cater for the needs of homeless people. Findings in this research also highlight the necessity for broad policy development across governmental agencies to cater for this group.

Community interventions

Findings in this research show that practitioners and therapists working across various agencies were navigating their way around fragmented social and community services to provide a better outcome for homeless people. At a societal level of analysis the way in which health care is talked about, and delivered, is a reflection of socio-political processes. These processes have sometimes been linked to or criticised in literature as a product of the health reforms of the early 1990s; such factors include the specialisation and commercialisation of services, and the generic management of health care systems (Easton, 1995). The accounts of mental health professionals show how access to services is often limited due to rigid service criteria and funding contracts. Homeless people require a broad range of services. When services are provided by separate agencies funded by different funding streams, then it is left up to the individual to navigate across. This not only impacts on the quality of care that professionals try to provide; it also excludes some of the most vulnerable people in our society and contributes to inequalities in wellbeing. Professional participants' stories reveal numerous barriers to quality care, but they also offer professional advice on the types of services that would be appropriate to meet the broader needs of homeless people.

More commonly, professional participants agreed that working in alliance with other community services, outreach options, and using multidisciplinary team approaches would eliminate most of the barriers to care for this client group.

One participant suggested a self-sufficient community based program that provides a longer term place of care for those who have a history of homelessness and live with mental health concerns. The program could offer therapeutic intervention, participate in living skills, and living in community, while offering work programs. This may assist in reduction of people slipping through the cracks such as transitioning out of services with inadequate discharge plans, or no ongoing intervention. However, where drug and alcohol or mental health issues are concerned, unless there can be a guaranteed commitment to a longer term stay,

then people are free to leave. Additionally, this type of service would still need to address necessary social supports and services when integrating back into the community. In this way it may be more effective to identify any risks, or needs, and goals that clients have before leaving mental health or Corrections services, and provide ongoing interventions including positive whanau support, and links to appropriate mental health, social support, and community based services.

The second suggestion was to have a 'one stop shop approach' such as a community service that could organise everything from living, finance, accommodation, mental health professionals, social workers and counsellors. This type of service would be effective in increasing interagency approaches, streamlining a more rapid response, and eliminating barriers to mental health care, and gaps in services. However, we would need to consider whether or not this would increase stigmatisation for homeless people, or overwhelm homeless people who live with mental health conditions. Other factors to consider that were highlighted in this research would include Maori homeless persons' distrust of mental health service use, lack of cultural appropriateness, poor perceptions of care, and transient nature of homeless people.

The third approach suggested was an Assertive Community Treatment team approach. The one stop shop approach appears to be very similar to the ACTT model. ACTT (SAMSHA, 2001; 2003) has been adjusted over the years, however this model provides ongoing support to the individual from a wide range of agencies and disciplines, including rehab housing, employment and social support, which is not time-limited (Seal, 2005). The difference between a one stop shop approach and this model is that the focus of ACTT is on outreach to homeless living with mental illness in public spaces, building relationships, offering basic assistance, rehabilitation, treatment, social services, and bridging to other necessary services. This approach appears to be more effective than brokered case management (assessing needs and referring on to other services) (SAMSHA, 2001; Wolff, 1997). Assertive Community Treatment teams reduce the interagency barriers and ensure ongoing interventions.

Seal(2005) cautions that any multiple mainstream service intervention might result in further pathologising of homeless people, or may disempower people by teaching them to become dependant on services (Seal, 2005). Also, to use the ACTT or one stop shop approach may mean reinventing the wheel when the NGOs provide a range of professional and strength based services for homeless people in the community. It would seem practical to either have mental health services under the DHB visit NGO services on a regular daily basis. Alternatively, Ministry of Health could provide the funding for psychiatrists and psychologists in NGO services for Homeless people. Matching psychologist and psychiatrist's ethnicity with clients would also be beneficial in providing a culturally appropriate service.

Currently, we have a lack of policy planning at a governmental level concerning homelessness in New Zealand. Therefore we do not have services that resemble the US or UK models of resettlement for Homeless people. Resettlement requires social supports, and social relationships that go beyond housing needs, and is an ongoing service intervention that aims to enhance dignity and empower homeless people to 'gain and remain' in appropriate accommodation (Seal, 2005). Findings in this research show that there are resources in the community for homeless people, but the problem still remains of how to access those resources in a timely and co-ordinated fashion. Each community service, or mental health service that has contact with homeless people are in the business of resettlement whether they know it or not. However, a more joined up approach between various governmental departments and policy reflecting the voice of homeless people would intervene in some of the inequalities of care that currently exist.

National level: and cosmologies.

Better outcomes of wellbeing have been associated with the ability of governmental health systems to be responsive to the expectations of the public (WHO, 2000). This includes the person's dignity, confidentiality, and autonomy of whanau or individual choice concerning their health. Timely intervention, along with social support networks and a choice of one's provider are essential. According to this national review (WHO, 2000) most countries fall short of their

ability to provide effective health systems due to ineffective responsiveness to public needs, along with unfairly dispersed financial contributions. Often the poor are deprived, treated with disrespect, and denied basic rights, which contributes to inequalities in wellbeing. The ultimate responsibility for management of wellbeing lies with the government (WHO, 2000), and most health systems aim to reduce inequalities in health and wellbeing. The story of inequality in health and wealth is apparent in New Zealand amongst Maori homeless people and the homeless population in general.

Inequalities concern the unequal distribution of income, power, health, mental health, education, employment and can impact on quality of life; includes political social and economic disparities as a result of poor social politics and programs, and bad politics (WHO, 2007). WHO (2008) takes a structural approach to the social determinants of health and illness and poor living conditions and unequal access to health care; Action on inequalities is a global endeavour and must take the whole of government, civil society, communities and individuals.

Inequalities are not only a social concern; they are a social justice issue, a human issue, and a matter of life and death (WHO, 2008). Action on social determinants of health to empower communities and inequalities occur, as these factors are primarily structural and social in nature, and this is consistent with research around the world (WHO, 2007). Social determinants of health include factors such as social exclusion, work, unemployment, social support, early life, stress, food, addiction, and the social gradient (Wilkinson & Marmot, 2003; Marmot, 2005). Health is a human right (WHO, 2007).

If health of a population suffers then it indicates that there needs to be a change in the way things are done and social arrangements need to change” (Marmot, 2005, p. 1099).

Health policy should be a concern not just for those in the social and health sector, but all sectors (Marmot, 2005). It should also be a concern for Homeless people, as any policy made will impact on their lives.

According to Shinn's (2007) international study on policy development to reduce inequalities, social supports for those of lower socio-economic status is associated with lower levels of homelessness.

Social justice has been defined as opposition to inequality (equal distribution of common goods and resources), and common basic interests of members and democratic process (the empowerment of all members in society, along with transparent democratic structures advocating social goals) or political equality (Hofrichter, 2003).

Health or wellbeing include having some agency or empowerment to make certain choices, have some control over individual lives, have a political voice, and participate in outcomes (Nelson, Lord & Ochocka, 2001a; WHO, 2007). Empowerment is a theoretical concept not easily defined, but for community psychologists it is a process that applies to individuals, groups, and entire communities, denoting increase of control (Orford, 2008; Prilleltensky, 2008). Empowerment includes three dimensions, people have basic material resources, control over individual lives, and participation in decision making processes; for empowerment to work there needs to be a distribution of power through social action, empowering communities, institutions, and nations (WHO, 2007). Therefore people and communities including Maori homeless people need choices in how services are delivered.

Final words

This thesis has made use of narratives to access the horror stories and the histories of Maori homeless peoples' lives, and to open up a space for restorying their lives and getting on the road of recovery. By using the subjective experiences of Maori homeless participants and mental health professionals the information given has emphasised certain injustices, power relations and structures that exist in society. Stories told draw on structural, social, and individual accounts that contribute to homelessness, mental health concerns, and inadequate care. Maori homeless were able to draw on indigenous stories that have been legitimated through the health

sector, and the way that professionals understand and talk about mental health care can not be separated out from bicultural practices.

Stories are a dynamic construction that embody the social and cultural context (Murray, 1999). While both professional and Maori homeless participant give us a straight forward illustration of the various concerns and developments in mental health care today; their stories also provide broader insight into their subjective experiences that link to broader socio-cultural, and political spheres in which they live. It may be useful for practitioners working alongside Maori homeless to be cognisant of the social constructionist perspectives and the dialectical interplay between historical, political, and social contexts which impact the way we story our lives.

Levels of Murray's analysis (2000) were used in this research, however at times it was appropriate to use a more pragmatic approach. I realised that if I started my research with a theoretical framework then there was likelihood of altering the views of my subjects. The participants in this research have assisted in shaping the thesis outcomes, but not without a dialogical approach between the researcher and her supervisors.

Weaknesses of using semi-structured interviews and allowing participants to talk as much or as little as they wanted to with regards to Maori protocols meant that some of the interviews would extend to a few hours in length. This depended upon what the participants wanted to talk about within the various questionnaire themes. Depending on the nature of the stories told, respondents were also asked different questions when the researcher needed to clarify what was being said, often interrupting their story telling, and starting another story, the implication of this is that the data was non-standardised. This method generated a large amount of data in the interview process which made it difficult to know what to use and what not to use in the research. However, findings were not difficult to generalise between participants as themes had been set, and many of the stories had similarities as well as differences. Another limitation is that stories are often reconstructed each time they are told (Flick, 2006).

Recommendations

- Findings for Maori homeless suggest professionals need to create connections that are respectful and restore dignity. Relationships need to be human in approach. It would be advantageous for professionals to take seriously creating a connection in a culturally appropriate manner.
- Emphasis is placed on the need for client centred work that is human in nature. That is, it allows for client input, participation, and empowerment. This links in with Treaty principles, and the recovery approach.
- Most of the clients in this research have experienced social exclusion and disempowerment. In working towards successful care, practitioners need to empower Maori homeless by including them in the therapy decision making process.
- Participant approaches for building successful relationships include therapist generosity, awareness of Maori homeless lifeworlds and socio-cultural history, strength based and recovery type approaches, and the use of cultural models.
- Maori based services, and Maori professionals may be more beneficial for Maori homeless people.
- Maori participants were able to operate in a bicultural context. They also demonstrate unique survival skills, a certain amount of resilience in the face of adversity, are able to obtain basic resources, and come with their own knowledge base. Such knowledge bases, and strengths, can be an opportunity for collaboration in the therapeutic setting.
- A recognition and acceptance of other belief systems is necessary for cultural competency. Practitioners are required to be culturally competent. This means that scientific practitioners are able to work with other belief systems, and do not need to defend science as the only way of knowing things (Durie, 2001).
- It would be reasonable to expect that if practitioners and therapists are to match standards of cultural competency, then resources, appropriate time frames, and Maori who are conversant in te reo, and skilled in tikanga practices, and who have trained in mental health are needed.

- Narrative may be a good approach for counsellors and psychologists to use with Maori homeless people.
- Findings suggest there needs to be an interconnected system or collaborative approach between services. Outreach services, and multidisciplinary team approaches may be beneficial in addressing the broader needs for Homeless people.
- Ministry of Health may find it useful to fund a psychologist and psychiatrist for NGO services working with homeless people.
- Planning beyond mental health or ‘beyond the cell’ is necessary for those at risk of homelessness and live with mental health concerns.
- The findings on a societal level reveal the necessity for a broader approach to policy development and implementation in New Zealand. This needs to include the voices and choices of Maori homeless people, and homeless people in general.
- Policy development should be widespread linking between housing, social welfare, ministry of health, and other governmental services. The implications of not providing this type of coverage - exacerbates homelessness and poor mental health conditions for these people. It also contributes to inequalities in health.
- When provisions of care for this client group are left to the good faith of charitable organisations, and volunteer workers, New Zealand’s political and ideological base, along with the injustices that many homeless people face, are left unchallenged.

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Information Sheet (homeless participants)

PARTICIPANT'S COPY

Research Project: **Maori Homeless People and Mental Health care**

Name of Researcher: Diana Johnson

Name of Supervisor: Associate Professor Darrin Hodgetts, Dr Linda Nikora, Dr
Carrie Barber

What is the Study about?

You are invited to take part in a study of mental health care for Maori homeless people. The study aims to develop a better understanding of 6 Maori homeless people's experiences of mental health services. The approaches used by 6 mental health professionals when providing services to homeless people will also be explored. In order to understand the experiences, needs, and difficulties the study will focus on the relationships that are developed between the clients and mental health professionals.

You have been asked to take part in the study because you have used mental health services and have slept rough or in supported accommodation during the last 12 months. You do not have to take part in this study and may take your time in considering whether you wish to take part. If you agree to take part you are free to withdraw from the study at any time without having to provide me with a reason for doing so.

What will I be asked to do?

A private interview will take place with me in a private room at this social service agency. You are welcome to bring along a support person, friend, or whanau member to this interview. This will take about 40 minutes of your time.

During the interview I will ask you about your background and cultural links. I will also ask you about your homeless situation and specific mental health events in your life. I will ask you about the relationships you have developed with the people who have helped you with your mental health. Other questions will explore your level of comfort with mental health services and if you found services useful in addressing your needs.

If at any time you feel uncomfortable during the interview, we can stop the recorder. We can continue after a break, finish the interview at another time, or you may decide to not continue with the interview. You may also wish to talk with service staff with this agency if necessary.

At the completion of the study you will receive \$25.00 for compensation for your time and travel expenses.

Who is collecting the information and conducting the study?

I am a Masters Student from the Department of Psychology at the University of Waikato. I will be supervised by Dr Linda Nikora, Dr Carrie Barber, and Associate Professor Darrin Hodgetts. This research has been funded by the Health Research Council of New Zealand. It is also linked to a larger Marsden funded study of the lives of homeless people. There are some contact details for the principle researchers at the bottom of this information sheet. You are welcome to make contact with them if you have any questions regarding this research.

How will this benefit you?

There is a lack of information about how and when homeless people access mental health services. Little is known about the experiences and practices of mental health care professionals when working with this client group. The effectiveness of mental health services relies in part, on the development of information in these areas. Information provided by homeless people and mental health professionals can provide a basis for informing service delivery to support the needs of homeless people.

What are my rights and what can I expect from the researchers?

You can:

- Ask questions at any point during the study

- Ask for the audio recorder to be turned off at any point during the interview.
- Decline to answer any specific questions, withdraw from the research at any point during or after the interview.
- Expect to receive a copy of the final report, or at any time during the research project ask to have information you have provided changed if incorrect, added to, or ask to have information removed.
- Contact your Mental Health professional, myself or my supervisors if you have any concerns about the study
- Contact the people listed at the end of this document for further information or if you have any concerns about the study.
- Expect that the information will be kept confidential to the researchers and that other people will not recognize you in what has been written.
- Expect that information you provide will be kept in a secure storage after the study. No one has the right to this information except the researcher.
- If you have any further questions or concerns regarding this study please do not hesitate to contact the principle researchers

Darrin Hodgetts (07) 838-4466 Ext. 6456 dhdgetts@waikato.ac.nz	Linda Nikora 7 838 4466 ext. 8200 Psyc2046@waikato.ac.nz
Diana Johnson Dfj1@students.waikato.ac.nz	

If you have any questions or concerns about your rights as a participant in this study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Telephone (NZ wide): 0800 555 050

Free Fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT)

University of Waikato
Psychology Department

Information Sheet (Mental health professional participants)

PARTICIPANT'S COPY

Research Project: **Maori Homeless People and Mental Health care**

Name of Researcher: Diana Johnson

Name of Supervisor: Associate Professor Darrin Hodgetts, Dr Linda Nikora, Dr
Carrie Barber

What is the Study about?

You are invited to take part in a study of mental health care for Maori homeless people. The study aims to develop a better understanding of 6 Maori homeless people's experiences of mental health services. The approaches used by 6 mental health professionals when providing services to homeless people will also be explored. In order to understand the experiences, needs, and difficulties the study will focus on the relationships that are developed between the clients and mental health professionals.

You have been asked to take part in the study due to your work as a mental health professional with homeless people. You do not have to take part in the study and may take as much time considering whether you would like to take part. If you agree to take part you are free to withdraw from the study at any time without having to give a reason for your withdrawal.

Who is conducting the study?

A Masters student from the University of Waikato in partnership with yourself, your agency, along with Dr Linda Nikora, Dr Carrie Barber, and Assoc. Prof. Darrin Hodgetts will be involved in this study. This research has been funded through Health Research Council New Zealand. It is also linked to a larger Marsden funded study of the lives of homeless people. Please see contact details for the principle researchers at the bottom of this information sheet.

What will I be asked to do?

I would like to interview you about your experiences working with Maori homeless people and the approaches you have developed in this work. Attention will be paid to the types of skills necessary to build a therapeutic relationship with the clients, and where you learned these skills. You are invited to discuss some of the positive experiences and some of the negative experiences in working with homeless clients, and what you think contributes to poor mental health for Maori homeless people.

The interview will be audio recorded to make sure we have an accurate account. The recordings will be stored on a secure computer during the study and deleted at the completion of the research.

How is the study likely to benefit your service?

There is a lack of information about how and when Maori homeless people access mental health services. Little is known about the experiences and practices of mental health care professionals when working with this client group. The effectiveness of mental health services relies in part, on this type of information. Information provided by mental health professionals and homeless clients may provide a basis for informing service delivery and enhancing efforts of mental health professionals in supporting the needs of Maori homeless people.

What can I expect from the researcher?

You can:

- Ask questions at any point during the study.
- Read any reports written by the researcher and participate in a feedback session with the researcher.
- Ask for the audio recorder to be turned off at any point during the interview, decline to answer any specific questions, and withdraw from the research at any point during or after the interview
- Contact the people listed at the end of this document for further information, or if you have any concerns about the study.
- Expect that the information will be kept confidential to the researchers and that other people will not recognise you. The information will be stored securely.

- Expect the researchers to make the general research findings available to you personally.

If you have any further questions or concerns regarding this study please do not hesitate to contact:

<p>Darrin Hodgetts (07) 838-4466 Ext. 6456 dhdgetts@waikato.ac.nz</p>	<p>Linda Nikora 7 838 4466 ext. 8200 Psyc2046@waikato.ac.nz</p>
<p>Diana Johnson dfj1@students.waikato.ac.nz</p>	

Appendix C:

Client Question Sheet

University of Waikato

Psychology Department

Questionnaire Sheet (homeless participants)

PARTICIPANT'S COPY

Research Project: **Maori Homeless People and Mental Health care**

Name of Researcher: Diana Johnson

Name of Supervisor (if applicable): Associate Professor Darrin Hodgetts, Dr
Linda Nikora, Dr Carrie Barber

Core themes to be covered in the interviews with Homeless Maori participants
will include:

- Brief history of mental health experience
- History of mental health service use
- Relationships built with clinicians/therapists
- Cultural background and links
- Issues that you would like to discuss

Appendix D: Mental health professionals Question Sheet

University of Waikato

Psychology Department

Questionnaire (Mental health professional)

PARTICIPANT'S COPY

Research Project: **Maori Homeless People and Mental Health care**

Name of Researcher: Diana Johnson

Name of Supervisor (if applicable): Associate Professor Darrin Hodgetts, Dr
Linda Nikora, Dr Carrie Barber.

Core themes to be covered in the interviews with Mental health professionals will
include:

- Approaches used by clinicians when working with this client group
- How clinicians and therapists go about relationship building
- Difficulties or barriers experienced, and solutions.
- Linking with other professionals or organisations.
- Issues that you would like to discuss.