

Street health: Practitioner service provision for Maori Homeless people in Auckland

Authors:

Linda Waimarie [Nikora](#)

Darrin [Hodgetts](#)

Shiloh [Groot](#)

Otilie [Stolte](#)

Kerry [Chamberlain](#)

Contact Author: Linda Waimarie Nikora, Maori & Psychology Research Unit, University of Waikato, Hamilton, NZ

Email: psyc2046@waikato.ac.nz

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Contact details Dr Jennifer Fitzgerald, jenny.fitzgerald@uq.edu.au

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Chapter overview

As in other countries, the homeless population in New Zealand (NZ) is made up of a diverse population of men, women and intersex groups of various ages and ethnic backgrounds. Maori are over-represented among this population due to on-going processes of colonisation and socio-economic exclusion (Groot, Hodgetts, Nikora, & Rua, 2011). When compared with domiciled citizens, homeless people are more likely to experience a raft of illnesses and unmet health needs, violence, a sense of insecurity, exclusion, fear and are more likely to commit suicide (Hodgetts, Radley, Chamberlain, & Hodgetts, 2007). Homeless people often experience diverse illnesses including asthma, heart disease, diabetes, hepatitis, renal disease, dermatological conditions, malnutrition, oral disease, depression, schizophrenia, substance misuse and broken bones (Ellison-Loschmann & Pearce, 2006; Joly, Goodman, Froggatt, & Drennan, 2011; Moore, et al., 2007).

Research documents the complex care needs and difficulties homeless people face in accessing quality services (Blue-Howells, McGuire, & Nakashima, 2008; Ellison-Loschmann & Pearce, 2006; Moore, et al., 2007; Nickasch & Marnocha, 2009). As Moore et al (2007, p. 179) argue “Homeless people experience difficulties in accessing health services and health service providers have limited resources, flexibility and understanding to help the homeless”. Providing effective healthcare can be a complex enterprise at the best of times. It is even more difficult when addressing the needs of homeless Maori, a client population in which co-morbidity of mental and physical health problems are the norm. Reflecting the ‘inverse care law’ (Hart, 1971), homeless people are less likely to access health services despite having higher levels of need when compared to domiciled groups (Blue-Howells, et al., 2008). When homeless people do access care they face difficulties in complying with standard medical advice. For instance, adherence to medication regimens often requires refrigeration and ready access to clean water. Such basic resources generally do not easily exist in the daily lives of street homeless people (cf., Montauk, 2006).

Drawing insights from interviews with Maori homeless people, health professionals, and relevant local and international literatures, this chapter focuses on the provision of medical care to homeless people. In particular, we propose that health services orientate to accommodate the worldviews and circumstances of Maori homeless people. Below we consider colonialism and societal developments that have led to homelessness among Maori today. We then present a case study of ‘Grant’, which was compiled from common aspects of various Maori homeless people who access health services at the Auckland City Mission (ACM); an organisation with a long history of catering to the needs and hopes of dispossessed groups, providing food, clothing, advocacy, social and health services. The relational orientation of healthcare at the ACM is discussed, and leads to an exploration of ‘judgement-free service space’ for meeting client needs (cf., Trussell & Mair, 2010). Lastly, we focus

on how health professionals can respond to the multiple healthcare needs of Maori homeless people, in partnership with social services.

Colonisation, Maori health status and homelessness

Maori homelessness has its roots amidst the historical and cultural disruptions of the late 19th and early 20th centuries. Reeling from conflict with settlers, epidemics of introduced diseases, dispossessed of lands, food resources and spiritual landscapes, many Maori were left with no option but to move away from their tribal homelands, places of health, strength, relatedness and histories, to strange and newly established urban areas. Maori migrated to find work, accommodation and new futures. The emptying of rural tribal areas, and the flood of Maori to towns and cities that began in the 1930s was phenomenally rapid (Schwimmer, 1968) with migrants often overcrowding the homes of relatives or occupying inadequate dwellings and slums (Metge, 1964). Racism and discrimination bit hard, and, as noted by Harris and colleagues (2011) continue in the present day to plague health care service delivery to Maori and contribute to the overrepresentation of Maori within the homeless population (Groot, et al., 2011).

Maori have a life expectancy eight years shorter than their settler counterparts and are disproportionately overrepresented in all leading causes of death, including cancer, ischaemic heart disease and chronic lower respiratory diseases (NZ Ministry of Health, 2010). A common explanation for these high mortality rates among Maori are lifestyle factors such as excessive alcohol consumption, lack of exercise, bad food choices and risk taking. However, more sophisticated explanations, relating to relative deprivation and lower socio-economic status, account for much of these differences (cf., Jatrana & Blakely, 2008). When homelessness is the focus, the legitimacy of these latter explanations becomes strikingly obvious. The poor living conditions, economic struggles, stress, stigma, and social exclusion associated with homelessness get under the skin and into the minds of those affected through processes of 'embodied deprivation', often resulting in physical, psychological and emotional ailments (Hodgetts, et al., 2007).

Maori who become homeless often have histories of trauma from domestic violence, relationship breakdowns, abuse, assaults, accidents, imprisonment, and the early deaths of family members (Johnson, Hodgetts, & Nikora, 2012). To illustrate these issues, we constructed the case of Grant from our direct research interactions with 24 Maori homeless people and the physicians, nurses, counsellors and allied health professionals working in the ACM health service.

The case of Grant

Grant is 41 years old and has lived on and off the streets, moving between state care facilities for children, the streets and prison since he was removed from his family at age 12 by child protection services. Grant is lost culturally, disconnected from family

and has developed a number of mental and physical ailments as well as substance misuse issues. He is sitting in the GP clinic which was set up to meet the needs of homeless people and the urban poor in central Auckland, and is going over his list of ailments with Mark, the nurse. Compared to the cases presented in the opening of this book, Grant's needs are multiple and complex. Despite asthma and bronchitis, Grant smokes, and with the advent of winter has developed a 'mild' form of pneumonia complicated by his hepatitis C. It is hard to keep warm and dry under a bridge, and cigarettes offer some sense of respite from the elements. Grant points out that "My physical health is so much dependent upon my mental health, when I'm unwell I'm low". When he develops physical ailments the down side of his bipolar condition comes out. Grant is feeling particularly depressed right now and is thinking about suicide. He recognises that his health is deteriorating, he is losing his teeth, and he has ulcers from excessive alcohol consumption:

In the last year I've lost five teeth, so that's nine that I've lost in total. I've got another one that I'm losing right now. It is something to do with smoking, my eyes are deteriorating. This last six months, living on the street, I've lost quite a bit of weight and have bad cardiovascular health [Grant].

Grant is aware of how homelessness can undermine his health, but he also holds onto a positive outlook and strives to see benefits in his situation:

Being out in the open air is good for my mental health because I have to get up when depressed. I can get happier living out, even with the terrible mosquitoes because once I get going I have a routine. I had to be organised. If I didn't get to a certain place at a certain time I missed out on a meal, you know, that kind of thing. Although getting up is a mission with my rotten feet - it's pain. I haven't taken boots off for days cos I've gotta be ready to run for it if need be. The doctor is in for a treat [Grant].

Grant also reports not sleeping well due to his 'busted shoulder', which is contributing to his low affect. His arthritis is also keeping him up at night, as is the regular hassle of being moved on by security guards.

Below, two physicians at the ACM tells us about what she is commonly confronted with when Grant and others first visit the clinic:

I will see a person who comes in the door drunk and wants me to sign a sickness benefit. That will be my usual scenario. While I am signing his sickness benefit I will discover that he's just been kicked out of jail, he's actually got schizophrenia and he's got a major P addiction, his feet are in appalling condition, and he's got rotten teeth that are making him feel crook. And, he's got out of control asthma because he's a streetie... And, then just the usual routine stuff that goes wrong for everybody, it goes wrong for these guys more often. You will see lots of coughs and colds; lots of out of control asthma; lots of bad eczema; eyes. It's just accentuated [Louise].

Treating homeless people is rarely straightforward due to the enmeshed nature of psychological and physical health:

There's a huge psychological element to everything. So you've got an easy diabetes case, but you can't treat it as an easy diabetes case because the patient might have a thing about tablets, or not able to take tablets or not able to store them or loses them the minute they come out of the chemist because somebody pinches them. So, even just on compliance, things are different. If you're diabetic and you're living in a nice warm home with easy food then you're not likely to get the foot ulcers or the chest infections and stuff.

Aside from the physical and mental ailments, many Maori homeless people also sustain physical injuries from altercations on the street. More usual though are foot traumas and dermatological conditions caused by walking for long periods in ill-fitting shoes, or from standing or sitting for long periods (Hodgetts et al., 2010). Homeless people typically avoid taking their shoes off; a pragmatic strategy to ensure that valuable shoes are not stolen, but one that also 'hides' serious foot injuries.

Dilemmas in responding to the needs of homeless Maori

In Grant's case, and in the narratives of clinic staff, we learn that the health needs of Maori homeless people are complex and extend beyond traditional primary and emergency healthcare (cf., Elissen, Van Raak, Derckx, & Vrijhoef, 2011; Moore, et al., 2007; Nickasch & Marnocha, 2009). When food, shelter, warmth and safety are the primary concerns of a homeless person, healthcare falls down the list of priorities, until a problem becomes acute (Nickasch & Marnocha, 2009). International research on health, homelessness and indigenous and/or ethnic minority peoples documents common barriers to access humane and effective healthcare. A complex overlay of barriers to care include *financial* (spending what money they have on food and basic needs rather than medical consultations and medications), *structural* (limited access to health services that understand and orientate towards the specific needs of homeless people) and *personal* factors (including stigma, misunderstanding, disrespect, lack of compassion, discrimination and judgemental staff) (cf., Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008; Nickasch & Marnocha, 2009). A key barrier is the fragmented nature of different services within the health sector, alongside a lack of integration of health services within a nexus of social services designed to meet the basic (food clothing, shelter) and human (social support and meaningful interpersonal interaction) needs of homeless people (Blue-Howells, et al., 2008; Moore, et al., 2007). Further, homeless people often delay seeking care due to these barriers, and as a result they become heavy users of emergency services for preventable conditions (Crane & Warnes, 2001; Moore, et al., 2007; Nickasch & Marnocha, 2009).

Effective services recognise the chaotic nature of homeless lifeworlds and complexities of client needs, and emphasise the skills of staff in building rapport with clients, the adoption of a non-judgmental and inclusive orientation to working with them, and the linking of health and social services (Blue-Howells, et al., 2008; Christiani, et al., 2008; Crane & Warnes, 2001; Elissen, et al., 2011; Joly, et al., 2011; Montauk, 2006; Moore, et al., 2007; Nickasch & Marnocha, 2009). Health providers need to see themselves as key partners in broader efforts to address the

social determinants of health affecting the wellness of Maori homeless clients. Dialogue and cooperation between social services and health professionals in meeting the broad situational and illness-related needs, structural exclusions and psychosocial barriers to care for Maori homeless people is imperative (cf., Crane & Warnes, 2001). Providing a judgement free environment and linking clients in with aligned services is central to effective healthcare for homeless Maori.

Such recommendations are made with full consideration of the dilemmas in providing care to Maori homeless people and persistent gaps in services. For instance, while the ACM provides a Drug and Alcohol and detoxification service, the physicians see a real gap in serving the mental health needs of homeless Maori people. While 24-hour assistance for those who are suicidal or suffering acute psychotic episodes are provided by mental health crisis teams or hospital emergency departments (NZ Ministry of Health, 2012), there is less support for those experiencing on-going mental health conditions:

If they're over that acute attack and they've got what we call 'thought disorder', they don't think straight. There are no services for that level of people in our community. So, for example, this one poor guy can't think straight. The moment he picks up his sickness benefit, somebody robs him because he hasn't got enough cognitive straight-thinking power to manage his money. And yet, he's not mad enough to be admitted to hospital, so where does he go. There's no community to look after him. Why are mentally ill people walking along our streets and sleeping under bridges. That's where it's really wrong. And institutions were not the right answer, but we haven't found a better answer. Their illness won't reduce by just giving them free dental services. It is a sense of home and belonging. So what health services urgently needs is some sort of community fabric to look after the chronically unwell, who really aren't managing alone, but they're not acutely mad or bad enough to be taken off the streets... They can't manage to take their daily anti-epileptic tablets so they keep getting fits [Louise].

The philosophy of deinstitutionalised care can work well for those who are socially connected and in communities and environments supportive of those with a mental health disorder, but living on Auckland central city streets is not such a space. Staff at the ACM health service emphasise where the policy of deinstitutionalisation is lacking and results in service gaps.

Psychological conditions increase the difficulties for homeless people to function in daily life and engage in basic self-care and maintain interpersonal relationships (Moore, et al., 2007). As Montauk (2006, p.1133) points out: "Difficulties can arise when a physician tries to build trusting relationships in a population where histories of mental illness and abuse are often the norm". Even when trust is achieved, practitioners need to continually attend to the realities of homeless lifeworlds, and ensure that their prescriptions and recommended courses of client action to address an ailment are 'realisable'. If not, client buy-in and established rapport can be lost. It is important to realise that trust and rapport between health professionals and clients remain fragile for reasons of circumstance and history that lie beyond the professional client relationship.

Briefly, international evidence suggests that a key to the effective delivery of healthcare for homeless people is the adoption of a coordinated, flexible, informed and responsive service. Port and colleagues (2008) state: “The delivery of good health care services within clinical settings is predicated by an understanding of the needs of the stakeholders” (p. 132). This requires us to look beyond the treatment of individuals with disease and to take a more relational perspective in terms of the place of Maori in contemporary society and the dynamics of Maori engagements with health care. Maori accounts of health often place emphasis on a holistic perspective that is orientated around groups. This is not to say that contemporary Maori beliefs are not influenced by European medical or lay understandings. Rapport between a physician and Maori clients requires the cultivation of a sense of partnership and cooperation. Such rapport is crucially important in overcoming barriers to care and associated avoidance of medical services (cf., Christiani, et al., 2008).

A judgment free, flexible and integrated health service

The creation of judgement-free spaces, where meaningful and trusting relationships can be cultivated, is central to the delivery of health services for homeless Maori people. Effective care can be enhanced by the integration of health and social services in a manner that addresses barriers to care (Christiani, et al., 2008). Integrated services are essential for meeting the complex mix of mental and physical health and social issues associated with homelessness (Dennis & Lourie, 2006). Charlie (clinic nurse) reiterates:

Needs to be a ‘one-stop-shop’. And, I know that’s what the City Mission is aiming for, to have those sort of physiotherapy facilities, the blood-taking facilities, everything in one place. Because I think it’s known with this sort of transient population, you’ve got to catch them while they’re there and do everything [Charlie].

For homeless people, “non-integration of services is an especially taxing structural barrier” (Christiani, et al., 2008, p. 160). Joly and colleagues (2011) note that a one-stop-shop approach to meeting the healthcare needs of homeless people has been recommended at least since the 1960s. There is also nothing new in the proposition that good health outcomes for homeless people depend on the allocation of resources to referrals, and on integration across services to meet clients’ basic, human and healthcare needs (Elissen, et al., 2011; Joly, et al., 2011; Moore, et al., 2007; Nickasch & Marnocha, 2009). Service integration works best when transcending artificial distinctions between health and social services, given that both contribute to supporting the health of homeless people (Blue-Howells, et al., 2008; Joly, et al., 2011). This broader orientation is embraced in the ACM where primary healthcare services are combined with a pharmacy, outreach, crisis care, a drop-in service providing food and clothing, detox facilities on site, and a Maori focussed gardening project with a local tribal group.

ACM staff realise that many of their clients require the attention of external medical specialists, including such as psychiatrists, cardiologists and dermatologists. They

are also conscious of the barriers faced by Maori homeless people in accessing such specialist care. Homeless people themselves complicate their access, for example, by missing appointments with specialists. When they do present, they are often seen as disruptive and problematic, causing staff and other patients to feel uncomfortable and sometimes intimidated (Morrison, Roman, & Borges, 2012). Advocacy by the physicians at the ACM becomes an on-going, time-consuming, and yet very necessary part of healthcare. As Louise explains:

We are constantly trying to negotiate their way into services, and also we're trying to gap-fill. There are no free dental services. Where do they get their glasses from? We've got podiatry people – feet people coming in. You spend half your day on the telephone trying to negotiate these people into services or explaining to the services why they didn't get there! [sighs frustratingly]. The services just don't respond. There's a mismatch between what our patients need and what services there are.

While the ACM provides an advocacy service for homeless people, more often than not, it is the medical practitioner that holds sway with secondary services, not the receptionist, manager, nurse or social worker. Physicians work to create healthcare opportunities needed by homeless persons.

In sum, developing judgement free, integrated, flexible and responsive healthcare can nurture uptake by homeless people of the service (Joly, et al., 2011; Nickasch & Marnocha, 2009); and in the case of the ACM has empowered homeless Maori to view the ACM clinic as their own space. The clinic manager (Mark) recounts how clients voice a sense of ownership that he supports: "Patients would push me because this lot here [homeless clients] see it as our clinic, the 'homeless' clinic. And they have a very strong sense of ownership that this is their clinic and they're first". The quality and responsiveness of the service is reflected in clients 'coming' rather than 'being dragged' to the service.

Healthcare and the centrality of relationships

At the heart of the Maori social order are relationships that give rise to obligations to give and receive, and acts of generosity, trust, kindness and esteem (Ritchie, 1992). These are central to Maori expectations and ways of being (Groot, et al., 2011). Associated social rituals that reinforce respectful relationships and acknowledge the importance of history and life circumstance are culturally inscribed onto Maori consciousness, and have been found to enhance health (Durie, 2001; Lapsley, Nikora, & Black, 2002). Whanaungatanga is one particular social ritual, and refers to connecting and making relationships. While often acknowledged in health literature (cf., Durie, 2001), whanaungatanga is rarely enacted in practice. A fifteen minute consultation simply does not allow for it. Beyond the physician-patient relationship, it is clear that there are many others engaged in providing healthcare within a primary healthcare service, and when an on-going relationship is formed, the notion of whanaungatanga finds fertile ground upon which to grow, across the service and for subsequent visits.

The best way to inform the healthcare relationship required is for health professionals to have knowledge of the challenges that face Maori homeless people, the nature of their lives and living circumstances, and their capacity to respond to health advice. Health professionals who are experienced in treating homeless clients make the importance of relationships overt, where trust and cooperation can be fostered by staff taking time to build rapport through client-centeredness (Button & Baulderstone, 2012; Johnson et al., 2012). Good health professional relationships with clients are central to effective responses to the complications that come with homelessness and for achieving good health outcomes. Effective practitioner-patient relationships can give patients a sense that they have been heard and have the space to discuss their major concerns, as well as be shown respect, caring, empathy, positive regard and understanding (Johnson, et al., 2012). Louise emphasised the need for trust, on-going relationships and critical insight into the realities of homelessness:

...If you want to try and do anything at all for that guy's life, more than just their immediate acute need then you need to build a relationship. It is absolutely about building relationships that are fair on both sides and not taking us for a ride. You've got to build a really clear relationship with these guys.

Successful care relies on practitioners' listening, observation, diagnostic, communication and referral skills. It is crucial for health professionals to gradually work to address client issues in a progressive manner:

Now, if I saw that guy as a one-off there's no way I can deal with all of that. But if I tie him in and he develops a relationship with me, that he comes back and sees us regularly, bit by bit, I can start chipping it off. Because his immediate need is a sickness benefit to get money, I will always deal with that [first]. But his longer term needs are enormous, and if I can establish a relationship with him where he'd like to come back, we're not going to put barriers in his way. Slowly, bit-by-bit, we can start chipping off at all the other areas, so [Louise].

This critical insightfulness and compassion is also embraced by the clinic nurse. Charlie reiterates the importance of familiarity and trust in care relations, and his non-judgemental, compassionate and convivial engagement with patients makes for a socially comfortable, accepting and warm environment. More importantly, it sets up the possibility for a service where a sense of safety, trust, acceptance and connection is fostered. As Charlie states:

As you know, the majority of our clients are Maori and we're all Pakeha, and seen as middle class. So, they've got to get to know that you're okay. But once they find out you're okay, people started coming... They talk to each other and then the word got out, 'oh yeah well the nurse is okay'... They get to know you and know that you're ...non-judgemental and you're not going to push things that they don't want to know about. You can bring it up periodically but not keep pushing it [chuckles]. ... And, all you can say is, 'well, it's because you're not looking after yourself, drinking too much and your body is just telling you'.

Word of mouth is a particularly important factor in providing effective healthcare to homeless Maori. When services are non-responsive to the actual needs and situations of homeless people, clients vote with their feet. The opposite also appears to be true, in that when services are orientated to need and delivered in a non-judgemental and flexible manner word gets out and more homeless people respond by accessing the service (Christiani, et al., 2008; Joly, et al., 2011; Nickasch & Marnocha, 2009). Before the establishment of the medical clinic at the ACM, 90 percent of local homeless people were not enrolled with a doctor and many had not had a medical consultation in years. Now, 90 percent of local homeless people are enrolled with the ACM clinic, attend regularly and experience fewer acute episodes because their health has improved significantly. This reflects the finding that services that orientate in the manner the ACM clinic does, can attract many 'hard-to-reach' clients (Crane & Warnes, 2001). Moreover, it highlights the value of a care-for-care relationship. People have got to care about being cared for; they have to want to use services, and come to know when they need to access them.

In sum, crucial for providing effective healthcare provisions to Maori homeless people is a broad understanding of daily realities and health needs of homeless people. Such an understanding should lead to the integration of health services into a network of provisions meeting the basic, human and healthcare needs of clients in a responsive and flexible manner. It is vital for service providers with homeless clients to see health and social services as part of the same system that attempts to enhance the wellness of clients through the provision of integrated primary medical and social care. Further, central to the effective functioning of a health service is the cultivation of trust and cooperation between healthcare professionals, homeless clients and staff from other services (Elissen, et al., 2011). Medical practitioners remain a powerful group within the health sector and their advocacy for homeless people, particularly to secondary health providers, can mean the difference between access to services or not, life and death. The advice given by homeless people to health professionals to 'be compassionate' is crucially important (Nickasch & Marnocha (2009). The orientation towards care outlined in this chapter is in keeping with existing clinical guidelines and practice resources for addressing the needs of homeless people, including those of the *National Health Care for the Homeless Council* (<http://www.nhchc.org/>).

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