

Final Report

Understanding iterative homelessness: the case of people with mental disorders

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DISCLAIMER

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ABBREVIATIONS

AIHW – Australian Institute of Health and Welfare

CACH – Commonwealth Advisory Committee on Homelessness

CESIS – Centro de Estudos para a Intervenção Social

DSP – Disability Support Pension

DSM-IV – Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition

EC – European Commission

GP – General Practitioner

NGO – Non Government Organisation

NSW – New South Wales

PAH – Partnerships Against Homelessness

QLD - Queensland

SAAP – Supported Accommodation Assistance Program

SPSS – Statistical Package for the Social Sciences

UNCHS – United Nations Centre for Human Settlements

TERMINOLOGY

Iterative homelessness – is a term used to refer to the repeated and ongoing loss of, or movement through accommodation in both the short and long term contexts of homelessness. Iterative homelessness is used in this study to highlight the fact that most homeless people do not sleep rough on the streets, though they may do so at times. Many remain tenuously housed at continuous risk of street-homelessness in their cycle through many different forms of tenuous and unacceptable forms of accommodation such as hostels, licensed and unlicensed boarding houses, caravan parks, staying with friends, etc.

Mental disorder – is a term used to refer to clinical mental illnesses outlined in the Diagnostic and Statistical Manual – Fourth Edition (1994) which may be broadly grouped into four main categories: psychotic, affective, non-psychotic and substance abuse related disorders. It is important to note that while focus in policy and treatment terms is on psychotic disorders, this research utilises a wide understanding of mental disorder, specifically including the sometimes marginalised personality disorders.

Social exclusion – is a term used to refer to the complex compound of disadvantages which act to marginalise a person in terms of their access to resources and their capacity to be involved in their community. This term is utilised in this research to highlight the links between issues such as homelessness and experiencing a mental disorder in the perpetration of continued exclusion, and also to highlight the importance of cohesion, belonging and place in addressing the issues faced by mentally disordered homeless people.

Life or cumulative trauma – is a term used to encapsulate the repeated experiences of extreme trauma marking the lives of most participants in this study. This trauma often begins with childhood sexual abuse/assault with individuals experiencing repeated traumatic incidences such as rape, assault, kidnapping and so on, throughout their life course. The high risk lifestyle associated with homelessness, especially in the dual context of mental disorders, contributes to the production of a continuous cycle of trauma.

EXECUTIVE SUMMARY

In a context of growing alarm about the large amount of homeless people with mental disorders, this research project aims to examine the experiences of those whose accommodation histories or biographies are marked by repeated or iterative homelessness. The term 'iterative homelessness' is used in the research to indicate a specific focus on trajectories of unstable and often unsafe accommodation constituted by constant movement through many different forms of accommodation, from rough sleeping to private rental to imprisonment. The aim of the research is to develop a better understanding of the range of factors underpinning this instability in the lives of homeless people with mental disorders.

Working closely with staff in accommodation and support services targeting homeless men and women, fieldwork teams surveyed 185 people with mental disorders and carried out 28 in-depth interviews focusing on more detailed individual accommodation histories. Fieldwork took place in both Sydney and Brisbane and included men (60%) and women (40%) aged 14-63. The surveys and interviews focused on identifying the range of issues faced by homeless people with mental disorders, the supports people had, the different forms of accommodation moved through, the positives and negatives of particular places, the reasons for leaving accommodation, and the main barriers perceived to stand in the way of more stable accommodation.

In a context in which policy makers at national and state level are working towards the development and implementation of 'whole-of-government' responses to homelessness more generally, the documentation of range of issues contributing to repeated homelessness is critical. This research presents useful data as well as develops a conceptual framework for both understanding and responding to the dual contexts of homelessness and mental disorders.

Key Findings

- People with mental disorders who are homeless experience wide-ranging and compounded disadvantage and social exclusion. Not only do they experience unstable and unsafe accommodation, but they are likely to have poor education, poor general health, extremely low income and experience high imprisonment rates.
- This range of issues is compounded by fluctuating mental health which contributes to difficulties maintaining study, employment, housing, relationships with those with whom housing is shared, and so on.
- Fluctuating mental health and compounded disadvantage interact to sustain ongoing trajectories of inadequate housing characterised by extreme vulnerability and chaos.
- Traumatic experiences such as domestic violence, relationship breakdown, deaths of friends and family members, incest, abuse, assault and accidents, are often repeated throughout the life courses of homeless people with mental disorders, and have severe and negative impacts on mental health management and housing trajectories.
- Iterative homelessness is further shaped by institutional neglect, a lack of appropriate housing options for homeless people with mental disorders, and the alienation of this group from the mental health system.

Policy and practice implications

The study concludes that any attempt to respond to the needs and vulnerabilities of homeless people with mental disorders must consider addressing underlying or core issues of trauma and fluctuating mental health, as well as the development of targeted supported accommodation options. This research suggests the need for a *national* re-focus on the core issue of trauma as way of re-shaping a response to iterative homelessness which is focused on individual experience and suffering.

More specifically, the following two issues arise consistently throughout the research, and are considered the cornerstones of such a response at both the levels of policy development and service provision:

- Stability

There is a need for a point of stability – whether developed through housing, drop-in centres or support groups – through which to sustain and build relationships with individuals experiencing iterative homelessness and mental disorders. This should be viewed as a resource saving mechanism in the context of the demonstrated ongoing cycling through accommodation, prison, hospital, support services etc.

- Healing

Much more attention needs to be paid to the ‘fit’ of people with traumatic lifestyles with current policy focus and service delivery. Ownership of support and trauma issues needs to be taken at a Federal and State level. There is a need for integrated support, housing, and mental health care to be set within a targeted, case worker and key worker based service sector which can provide sustained one-to-one relationship building with clients.

INTRODUCTION

It is believed that in Australia one in five people suffer a significant mental disorder, with most of these people living and working with little difficulty (Robinson, 2001: 5). It has also been demonstrated, however, that within the inner-city homeless hostel system around $\frac{3}{4}$ of homeless people have at least one significant mental disorder (Hodder, Teesson and Buhrich, 1998: 9). So why do some people with mental disorders become homeless and remain homeless for extended periods of time? Why can some people with mental disorders maintain housing and employment while others struggle? Why are some people trapped in a cycle of repeated or iterative homelessness, moving from one form of inadequate accommodation to another? What drives this iterative process?

This is the Final Report of a research project which explores some of these questions. This report aims to flesh out in full detail the context of homelessness and mental health through the study of two large city sites – Sydney and Brisbane. Further, the report sets out the framework of the research process undertaken and the theoretical and analytical lenses through which data and field experience have been viewed. The previously published Positioning Paper and Work-in-Progress Report are significant research building blocks which underpin this Final Report, however, it is here that the engagement with data takes place and policy implications considered.

The research is unique in its focus on the causes *and perpetuation* of the iterative cycle of homelessness. In other words, the focus of the research is not on why people become homeless, but on why people *continue* to experience homelessness in its varying forms. It is recognised that there are a range of forms of homelessness and a range of experiences of homelessness; this research responds to the experience of those with mental disorders who have struggled to maintain housing over varying time periods. This is a specific focus in a context of growing concern about, and documentation of, the connection of experiences of homelessness and mental disorders and the 'risk factors' (Lezak and Edgar, 1996; Slade et al, 1999) which pre-empt this dual context.

What this research aims to add to current work on homelessness and mental disorders, is an understanding and depiction of the lived contexts of illness and the search for housing. This means that through retrospective 'accommodation biographies' (May, 2000: 615) and survey data, two central contributions of the research will be to demonstrate iterative homelessness as an ongoing process taking place through a range of forms of accommodation, and to consider the range of factors which shape this process. While the research will add to the understanding of risk factors for becoming homeless, the research aims to go beyond this, considering factors underlying experiences of risk and suffering over time.

Central in this is the development of the concept of iterative homelessness, a new term designed for this research and introduced in the Positioning Paper. As discussed, the function of the term is to encapsulate a sense of the movement and repetition involved in the experience of ongoing homelessness. This Final Report reflects how useful the term proved to be in drawing together discourses of homelessness and social exclusion as well as other significant factors shaping trajectories of ongoing homelessness.

Literature searches suggest that this research is unique in its focus on iterative homelessness and in its explicit focus on the experiences of those with mental disorders. Further, this research is unique in that it aims to communicate the dynamic interplay of factors which connect to form an individual's life path. 185 structured surveys and 28 in-depth interviews (accommodation biographies) as well as over 20 stakeholder interviews together form a substantial resource detailing the experiences, issues and complexities of individual lives, service provision and policy development. This body of data and its statistical (SPSS) and thematic analysis, is the basis on which this report is built.

As a whole, the research project is structured to respond to 5 core research questions, some of which are considered in more detail in earlier publications:

1. How can the concept of iterative homelessness improve understandings of living in the marginal housing sector?
2. What are the economic, social and cultural factors underpinning iterative homelessness? What further factors are important in understanding the dual contexts of homelessness and mental disorders?
3. How do social exclusion and homelessness relate, and how might this relationship be conceptualised as a useful tool for policy and research?
4. What are the current national and state policy responses to iterative homelessness, particularly in the case of those with mental disorders?
5. What changes in current service provision, housing and mental health care policies would improve the capacity of those homeless people with a mental disorder to secure more stable and sustainable accommodation?

Chapter One of this report briefly positions the research in the current literature and policy context. Chapter Two sets out the research methods and the approach to analysis. The chapter also introduces some basic data about the kinds of people who participated in the research. Chapters Three and Four are the substantive chapters of the report. Utilising the frame of social exclusion, Chapter Three presents basic data illustrating the range of issues which may underpin or drive the experience of iterative homelessness for those with mental disorders. Chapter Four builds on this through focused case study material to illustrate the complexity of iterative trajectories.

Chapters Five and Six combine as a powerful reflection on the conceptual and policy issues revealed by this engagement with everyday lives of homeless people with mental disorders. Stepping back from the complexity of experience, Chapter Five builds a new conceptual understanding of iterative homelessness in the context of mental disorders and names its core underlying components. Chapter Six recasts this conceptual contribution within the realm of policy and practice and details the implications of the overall picture developed.

As the original research questions suggest, the purpose of the research is to develop an understanding of what structures, drives and underpins the iterative experience of homelessness in the context of mental disorders and to connect this understanding to the world of policy and practice. This Final Report aims to make some of these links as well as provide information which allows others to engage in these issues in an informed manner. These aims are undertaken primarily by developing a detailed and powerful picture of everyday experience, by developing a conceptual typology of iterative homelessness in the context of mental disorders, and by making explicit some specific policy implications of the research findings. Preceding reports may be found at www.ahuri.edu.au.

1 ITERATIVE HOMELESSNESS, SOCIAL EXCLUSION AND MENTAL DISORDERS

The two aims of this chapter are to review literature and policy pertinent to the dual issues of iterative homelessness and mental disorders and to set the context for the particular focus and approach of the project. The concept of iterative homelessness is joined with current work on social exclusion and with the specific housing risks associated with mental disorder. A multi-dimensional understanding of homelessness is developed, incorporating an appreciation of repeated 'uprootings' as a central theme. Further, the research traces trajectories of upheaval from the contexts of traditional 'street' homelessness, through marginal housing to public and private housing. The connection between such an approach and current policy is strong. The chapter reviews current policy in the areas of homelessness and mental health and underlines the current focus on cross department collaboration and planning. Foreshadowing the empirical chapters, however, it is also argued that a closer engagement with, and understanding of, the experience of homelessness and mental disorder in individual daily life paths throws many challenges to the neat work of policy and academic theorising.

1.1 Iterative homelessness

Iterative homelessness is a term specifically developed for use in this project. The term was introduced in the Positioning Paper and a key part of this Final Report is to examine how useful it is in encapsulating the lived experience and dynamic of homelessness (see Chapter 4 in particular). The term was developed in response to a perceived gap in the ways in which homelessness was being imagined and therefore responded to through policy and practice intervention. Broadly speaking, it can be argued that homelessness research has reached an impasse. This impasse stems from a swing away from research which emphasised individual failings as the cause of homelessness to a practical and policy approach which focuses on the structural production of homelessness. This 'structural' focus remains dominant (in part as an effort to maintain pressure on governments to act on the issue) perhaps at the cost of new approaches or approaches with different angles.

While of course there is much research which falls between, across and outside of this very basic polarisation drawn here, it is clear that a context exists now in which homelessness research (and as Jacobs (2002: 103) argues, housing research more generally) must be seen to be structurally focused (policy relevant) to be relevant at all. A fear of returning to the victim-blaming approach which potentially releases government of the responsibility is perhaps part of a reticence to engage with the complexity of individual lives and the issue of subjectivity. The risk here is that homelessness research fails to fulfil its role of conceptual development, debate and challenge – all critical for pushing creative policy initiatives.

The starting point for this project then, is an awareness at least of the need to be able to imagine and act upon a notion of homelessness which is complex and dynamic. While simplifying or reducing an issue like homelessness might seem attractive, particularly for policy digestion, this assumption not only underestimates the capacity of experienced practitioners in policy development and in service provision, but ultimately still fails to get at the heart of the issue of homelessness which is the complexity itself. This complexity is only further highlighted in the dual contexts of homelessness and mental disorder.

Iterative homelessness is a somewhat imperfect term offered in this research to encourage a conceptualisation of homelessness as repeated uprooting, as a process of repeated attempts to establish a home physically and emotionally. Broadly, the term can be used to refer to the experience of homelessness which is ongoing and may involve moving from one form of accommodation to the next. Some people may experience this iterative or repeated cycle of losing, searching and maintaining accommodation for a significant part of their lives. Some will only experience it for short period of time. Iterative is word which describes the repeated move through accommodation experienced in homelessness, rather than the time frame of homelessness or the kinds of accommodation being moved through. The term is perhaps most useful in the context of ongoing or long-term homelessness, but as a conceptual tool is

useful for describing any experience of homelessness in which individuals move from one form of accommodation to the next.

1.1 Iterative homelessness and mental disorders

This project has a specific focus on the dual experiences of iterative homelessness and mental disorder. Like defining homelessness, defining mental disorder is not a straightforward process. This research uses a very broad understanding of mental disorders, including all disorders covered by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994). As a general overview, mental disorders may be grouped into four recognised areas as follows (see Commonwealth Department of Health and Aged Care and AIHW, 1999: 10; DSM-IV, 1994; Herrman, 1991:3; Herrman *et al*, 1989: 1181; Palmer, 2002; Parker, Limbers & McKeon, 2002: 5-6; and Robinson, 2001a: 6-7, for variations):

- Psychotic disorders – including hallucinations, delusions, thought disorders, behaviour disturbances, disturbances in feelings/emotions eg. Schizophrenia
- Affective (mood) disorders – including depressive disorders, minor depression, major depression, psychotic depression (with delusion/hallucination), manic depression eg. Post-natal depression, bipolar affective disorder
- Non-Psychotic disorders – including anxiety disorders, phobic disorders, post-traumatic stress disorder, personality disorders eg. Borderline personality disorder
- Drug and alcohol abuse disorders – including alcoholism, drug induced psychosis

As Parker, Limbers and McKeon (2002: 5) note, however, in practice it is important to consider the severity of symptoms in determining the degree of mental illness. In other words, diagnosis on its own cannot determine how effectively a person may manage their illness or the kinds and extent of disability, if any, a person may suffer. In a key study on homelessness and mental disorders in Australia, Parker, Limbers and McKeon (2002: 6) argue that while affective and non-psychotic disorders are seen as less severe than ‘major’ psychotic disorders, they are by far the most prevalent amongst homeless people. These illnesses have specific symptoms which impact greatly on everyday life and for which, unlike psychotic illnesses, medication is often ineffective or inappropriate.

In the lives of already vulnerable people, all mental disorders can have a broad range of effects which heighten the risk of homelessness and continue to impact upon daily life once people become homeless. Symptoms such as memory loss, anxiety, self harm, compulsive behaviours, hallucinations or periods of deep depression can make tending relationships and maintaining employment difficult (Parker, Limbers and McKeon, 2002: 11). This has a huge financial as well as practical impact on a person’s capacity to maintain a tenancy and live with others. Further, anecdotal evidence suggests that reduced hospital beds, a limited capacity to provide case work, and a hostility in the field of psychiatry towards those with a diagnosis of personality disorder in particular, present multiple problems and impact greatly on those individuals who do not have the luxury to make choices about the healthcare they receive. This situation is only exacerbated in the case of dual diagnosis (Parker, Limbers and McKeon, 2002: 11). Stigma and discrimination are widely experienced by those with mental disorders (Lezak and Edgar, 1996: 10); anecdotal evidence collected in the course of the research includes the areas of mental health and support and accommodation services as sites of continued stigma and discrimination.

In this context, the label ‘mental’ disorder is at a certain level misleading when it is clear that the focus must include the wider physical and emotional context of disorders. This research responds to the identified need to develop a dynamic understanding of the interaction of illness-related risk factors with other spheres of an individual’s life over time.

1.2 Iterative homelessness, mental disorders and social exclusion

Mental disorder impacts on every facet of an individual’s life, from their role in the community, to their capacity to work or budget for a household or maintain personal relationships. Likewise, as has been argued, homelessness is about the lack of stable and safe accommodation, but in the context of repeated uprootings, is also about finding a valued role, a validated sense of self and so on.

In the context of this layered dispossession and suffering, an understanding of the experience of exclusion not just from housing or employment, but from the fabric of social life is critical. This is not to argue that homeless people with mental disorders are asocial or do not maintain diverse and complex social networks and relations or to suggest that homeless people exist somehow outside the social. The power behind the notion of social exclusion in this context is the broadened focus on the full range of 'fronts' on which homeless people with mental disorders battle for recognition of the place and subject position and even home which they continue to occupy.

Thus, social exclusion may be understood to operate on two core levels:

Cultural exclusion – *relational* exclusion, such as inadequate social participation, lack of social integration and the need for social cohesion and solidarity to counter this. Exclusion here is seen as the 'breaking of the social tie' (Castillo, 1994: 614) and citizenship rights and in particular, employment, are seen as the core ways in which to re-establish this tie (see Blanc, 1998 for a current example).

Income inequality and material exclusion – *distributional* exclusion, such as poverty or lack of material resources. Exclusion here is seen as product of social inequality to be addressed through the extension of citizenship rights to ensure greater economic equality (see Levitas, 1998 for a current example).

Particularly with a dual focus on homelessness and mental health, the wider aspects of social integration and support as well as the structural issues of poverty, inequality and housing shortages are critical in understanding paths through homelessness. While housing, and the lack of it, is seen as a good vehicle through which to examine and locate the effects of social exclusion as a process (Somerville, 1998: 772), as has been stressed throughout, however, the 'answer' to social exclusion in the housing process is not necessarily in the provision of secure accommodation. As Somerville (1998: 774, 777) points out, it may in fact be the housing which is the source of social exclusion and indeed, as much research has found, homelessness may be seen as a strategic pathway for entry into the safest and closest community network a person may have yet experienced (for examples see the work of Downing-Orr, 1996 and Wagner, 1993). As Kearns and Smith (1994: 420) powerfully point out,

...perhaps within the tragedy of people living without shelter – and in fact pervading contemporary urban society – there is a more profound problem: the lack of belonging and connectedness with particular places.

1.3 Policy framework

The connection between the analytical purchase offered by the concept of social exclusion and sphere of policy is strong. As Parker, Limbers and McKeon (2002: 4) note, the sequencing and layering of risk factors is significant not only because of the multi-disadvantage which can be demonstrated but because of the range of avenues this then suggests through which to address the issues: 'The routes to homelessness are varied and services to assist the homeless mentally ill must stem them all in order for all strategies to be effective'.

Currently, the State and Federal policy initiatives developing specifically around the issue of homelessness recognise the added vulnerability of mental disorder and the current inadequacy of policy and service responses. The key Federal responses, the Supported Accommodation Assistance Program and the National Homelessness Strategy, emphasise the need for a collaborative approach. The National Homelessness Strategy (CACH, 2000: 7) explicitly recognises the linked problems of homelessness, including mental disorders and psychiatric disability, and the need for a holistic approach rooted in early intervention and departmental and community partnerships: 'It is clear that housing or employment alone are not the answer, but rather a multifaceted and integrated response is needed'.

It is also clear, however, that significant issues arise in the everyday management and implementation of responses to homelessness. In NSW homeless hostels in both rural and inner-city areas are full of people with significant mental health issues, with anecdotal

evidence suggesting that many more are turned away because of the incapacity of accommodation services to cope with high-needs clients (Bisset, Campbell & Goodall, 1999; Robinson, 2001). As the report *SAAP Linkages with Mental Health* (Commonwealth Department of Family and Community Services and the Commonwealth Department of Health and Aged Care, 2000: 6) suggests:

The SAAP sector has become a defacto support service, despite never having been mandated or resourced to provide support to homeless people with a mental illness.

At a state level in both New South Wales and Queensland, coordinated responses to homelessness aim to bring together most government agencies in recognition of the complexity of the roots of homelessness. The NSW Department of Health has also explicitly set out to consider how better collaboration with the NSW Department of Housing might impact on tenancy management, while clearly rejecting the responsibility for the provision of housing itself (see New South Wales Government Action Plan for Health, 2002).

It would seem that the core challenge arising for policy is in understanding the connection of housing with issue of the need for support. This is a core impetus behind this research project's aim to demonstrate the full range of issues homeless people face – perhaps the least immediate of which is housing. This has significant ramifications for all areas of policy; a grounded perspective of the connectedness of homelessness issues is required to throw into relief a sense of what working relationships are needed and where.

1.4 So why do this research?

At a theoretical and policy level it is easy to emphasise the need for a holistic view of and response to, the issue of homelessness and mental disorders. In practice, with little documentation of the everyday experiences of homeless people with mental disorders and little understanding of their tenuous housing pathways, the project of refining service provision and policy implementation is limited. The continuing large numbers of homeless people with mental disorders suggests a failure to respond effectively to certain aspects of individuals' experience.

The links between actual individuals and a collaborating network of services and government departments are much harder to conceptualise than the framework for collaboration itself. Just developing the idea of collaboration as pivotal, however, is only a recent exercise in itself and anecdotal evidence suggests that results of this collaboration are yet to be seen in systemic working relationships on the ground. In this current context in Australia in which services and governments are clearly searching for new ways to understand and respond more appropriately to the linked issues of homelessness and mental disorders, this research has the potential to provide a base understanding of key issues and a picture of what these actually look like in the full complexity of everyday life.

With a range of departments and services responding to only one segment of an individual's experience, this fractured focus can lead to a situation in which core or underlying issues are not addressed with the individual *or* built into instruments of response. This project aims to provide a detailed picture of how key factors interact to sustain lives punctured by destabilising movements between forms of accommodation, between cities and even states.

This is undertaken with the view that the bases of service responses, program development, and policy development need to be challenged and need to remain focused on the complexity of individual experience if issues are to be addressed with any effect. The role of research can act as a critical mechanism for opening up a range of dimensions of homelessness, particularly when a holistic interest in the lived experiences of individuals can be maintained over time. While this research is not longitudinal, an important part of both surveys and in-depth interviews is a 'retrospective accommodation biography' (see the following chapter). A key point made throughout this research is that a representation of whole of life experience (rather than segments) is critical to developing appropriate models of both understanding and responding to iterative homelessness.

2 RESEARCH APPROACH, ANALYSIS AND PARTICIPANT PROFILE

This chapter sets out the approach used to address the key research questions of the project. Given the very particular experiences of people targeted in the research, the design of the research was a lengthy process and involved consultation of service providers. The research design aimed to balance the need to collect detailed and extensive information about mental health diagnosis and support, basic profile data and accommodation trajectories with an awareness of participants' vulnerabilities. Given the context in which the research took place, the process was extremely successful – a success ensured by the extensive and un-costed support of service managers and staff.¹

2.1 Research Questions and Frame

Research conducted with homeless people with mental disorders was framed to address the following three of the five Research Questions:

2. What are the economic, social and cultural factors underpinning iterative homelessness?
4. What further factors are important in understanding the dual contexts of iterative homelessness and mental disorders?
5. What changes in current service provision, housing and mental health care policies would improve the capacity of those homeless people with a mental disorder to secure more stable and sustainable accommodation?

The core focus was on developing a dynamic understanding of both risk factors and underlying forces of homelessness *over time*. In other words, because of the focus on *iterative* homelessness, the issue was not to understand what brought people into homelessness but what *sustained* their movement through it. There is a current literature (Lezak and Edgar, 1996; Slade et al, 1999) which lists risk factors for homelessness in the context of mental health to which this research will add. Developing a picture of how these factors are layered and how they interact and impact over time, however, is the unique contribution of this research.

A decision was made to attempt a survey of 200 homeless people with mental disorders in two different city locations. The two state capital cities of Sydney (New South Wales) and Brisbane (Queensland) were chosen on the basis that they have the highest numbers of homeless people (Chamberlain, 1999: 43-46). Further, Kearns *et al* (1993) suggest that geographical location, in particular differences in local housing markets, may have a significant impact on the rates and experience of homelessness.

In designing the survey itself it became clear that the dual focus on the social, economic, and cultural factors underpinning homelessness and the need to actually record accommodation histories entailed a very long survey. In consultation with service providers and policy officers it was decided the survey was too long, particularly given the physical contexts in which the interviews would be taking place and the kinds of issues needing negotiation with each participant. On top of the 200 surveys, it was decided that undertaking 30 in-depth, qualitative interviews would be critical in supplementing a shortened survey (which still took around 45 minutes to one hour). These interviews were to cover similar information, but the more informal manner of data collection was expected to generate greater contextual depth.

2.2 Doing the research: An overview

2.2.1 Fieldwork preparation

Accommodation and support services (such as hostels/refuges and drop-ins) played a critical role in facilitating the research team and the interviewing process. Accommodation and

¹ See the Work-in-Progress Report for details of participation stakeholders and services and for further discussion of conducting research with this respondent group.

support staff were primarily responsible for recruiting appropriate participants and introducing them to fieldworkers. Given that some homeless people had negative experiences of mental health services or may not be in contact with mental health services, it was decided to work with staff in support and accommodation services who had current knowledge of their clients' history and current issues and behaviour. Services put considerable time and effort into coordinating 'research days' and into both inviting and screening clients taking part in the research. Staff arranged appointments with clients, put on lunches, morning teas and even arranged home visits for researchers or personally provided transport for clients in order that they could take part.

The research leader was the key contact for all services, undertook all in-depth interviews and some surveys, and provided face-to-face support for each fieldworker. Each fieldworker was based at a limited number of services and built up a rapport with staff and clients. Fieldworkers were provided with a space in each service in which to safely and comfortably conduct interviews. The survey was fully administered in an interview setting so that fieldworkers would be able to record data (many homeless people have difficulties with reading and writing), help respondents understand questions when necessary, and encourage respondents to raise issues important for them.

Accommodation and service staff also provided emotional support for all the researchers. Particularly in the context of this extremely stressful and distressing research, the lack of a standard procedure for professional debriefing was problematic. Ensuring that respondents also felt comfortable with the length and intensity of the survey also presented challenges for fieldworkers. The research team acknowledges the crucial and un-costed input of services in the success of the fieldwork stage.

2.2.2 Participant incentives

Participants in surveys and in-depth interviews were paid \$20 in recognition of their expertise, contribution and time sacrifice. This payment was seen as crucial by the research team and by service providers to encourage participation and to acknowledge the skills of homeless people in telling their own story and analysing their own situation. Further, the time spent with the research team was also time taken out of the day often spent searching for accommodation, employment or attending other appointments. It should be noted, however, that the payment was perceived by some homeless people as a patronising gesture. One person refused the payment, another accepted it on the understanding that it would be forwarded to the child he was currently sponsoring through World Vision. Several people indicated that they were just pleased to be consulted and that they would have been happy to participate without the incentive.

2.2.3 Sample of participants and acknowledgment of limitations

Given the very specific and difficult nature of this research, a 'convenience sample' or 'snowballing technique' of identifying services and participants was used. In other words, the research leader's existing knowledge of services was used to build contacts and request advice, referrals and introductions. This approach gave a specific selection of services and therefore clients. The research in no way claims to be representative of the experiences of all homeless people with mental disorders and it should be noted that the inner-city areas of the two cities was a focus primarily for ease of coordination and because most services are located there. There were a number of exclusions of gender and ethnic-specific services. No Indigenous specific services were included in this research, although they do exist in both inner-city areas. This is problematic given that research suggests that Indigenous people face many barriers in accessing the mainstream services which were the focus of the research (Coleman, 2000: 17-18; Keys Young, 1998: 99-103) and that homelessness is considered a bigger problem in Indigenous communities than in non-Indigenous communities (Keys Young, 19998: 45).

2.2.4 *Brief overview of the research process*

- University of Western Sydney ethics clearance granted for survey and in-depth interviews.
- Stakeholder interviews undertaken with key policy officers in the Departments of Housing and Health focusing on current strategies and gaps and barriers in service provision.
- Consultation of key service providers about key issues and barriers to accommodation and support faced by clients.
- Survey developed and sent to policy officers and service managers for comments.
- Survey length reduced, in-depth interviews designed.
- Meeting with service managers and staff to set up fieldwork relations.
- Interviewing teams trained in two states.
- Interviewers worked with staff and homeless mentally ill clients in designated services with the aim to conduct 200 survey interviews and 30 in-depth interviews.
- Debrief and final visit to thank service management and staff.
- Interview totals:
 - Sydney: 87 surveys, 15 in-depth interviews
 - Brisbane: 98 surveys, 13 in-depth interviews
 - Total: 185 surveys, 28 in-depth interviews

2.2.5 *Methodological reflections*

In practice, while each interviewer and participant handled the survey extremely well and all services were very happy with their participation in the research, service staff and the research teams were all strongly agreed that the survey was essentially inappropriate and a poor mechanism through which to capture the lived dynamics of individuals' lives. While interviewers were skilled in making the imposed structure of the survey seem as comfortable and natural as possible, the therapeutic benefit to participants seemed greater in interview contexts in which they could direct the flow of conversation and follow out thoughts/memories whenever they emerged. Particularly in the context of mental disorder and the discussion of extremely traumatic events, it is recommended that a qualitative approach is more respectful and inclusive.

While this is a very important finding, the survey certainly allowed for the inclusion and consultation of a greater number of participants and services. Further, the different kinds of data collected enabled a broad picture of people's lives to be developed and an understanding of the predominant issues to surface. While both forms of data are extremely important, in hindsight it may have been more appropriate to restrict surveying to straightforward questions and to have just focused on accommodation histories in the in-depth interviews.

The success of the research demonstrates the potential of collaborations between researchers, services and homeless people. Homeless people need to be consulted about their own issues and were keen to offer their own analyses of the hostel system or the mental health system for example. Future research in connected areas should consider how respectful and genuine engagement with service staff and with homeless people is critical to the overall success and relevance of research projects. Engaging over-worked and over-researched services requires time and relationship building and a willingness to involve services and their clients in the process of designing the research methods and how future contact will take place. Many services were wary of being 'steam-rolled' into research and reported negative experiences of previous research involvement. Demonstrating a capacity to communicate on equal terms with a range of clients, with service staff en-masse and with service CEOs was critical. Integrating individual members of the research team into each service was also critical.

2.2.6 Analysis

There were some problems with data collection. Seven people out of the 185 were not able to finish the whole survey and some people struggled at varying points to remember the order of places they had stayed or why they had left. Some people refused to discuss some elements or periods of their lives. In both surveys and in-depth interviews, some participants became extremely emotional, at times crying or shouting. Overall though, considering the complexity of the data being sought, more detail was given in both survey and in-depth interviews than hoped for.

Coding of the survey was undertaken after extensive preparation and consideration of the data. Survey results were analysed using the data package SPSS. Because of a relatively small number of participants and predominantly descriptive data collected, analysis was focused on frequencies and cross tabulations rather than on complex correlations for example. Some limited comparisons were made between the central categories of age, gender and the city in which the participant was interviewed.

Congruent with the attempt of this research to 'bring alive' the dynamic structure of homelessness, it was felt that qualitative interviews were required to supplement and triangulate the structured survey data. As May (2000: 614) argues, 'too often it can appear as though a person's homelessness is an inevitable consequence of either their structural position (with the specifics of how that position 'translates' in to homelessness left largely unexplored) or a specific set of vulnerabilities'. May uses what he calls 'accommodation biographies' (May, 2000: 618), a retrospective project given the difficulties of 'tracking' homeless people over time. May (2000: 633) notes,

A biographical approach gives space to a fuller examination of the complex ways in which people negotiate the opportunities and constraints shaping their access to housing, employment and welfare, and allows for a consideration of the ways in which such negotiations are themselves shaped by a person's individual circumstances, characteristics, vulnerabilities and experiences.

Both the methodological approach and analysis draw on May's notion of the retrospective biography. The interview and analysis follow an accommodation time line in a broader examination of other contextual issues. Identifying and coding key themes linked individual biographies and was central in developing the typologies presented in Chapters 5 and 6. The 'stand alone' thematic analysis was discussed at length with three practitioners, one working in the field of homelessness and two in the field of psychology/psychiatry, all of whom resoundingly supported the perspective developed. This thematic analysis was then brought together with the survey results, each body of data supplementing and triangulating the other.

2.2.7 Participant profile

The following data illustrates the main characteristics of survey participants:

- At the time of the interview, 18% were living on the streets/in squats/in caravans, 12% were living in boarding houses, 40% were living in supported accommodation (hostels), 23% were living independently with support.
- Around 85% of respondents reported that they had been diagnosed with one or more mental disorders. Schizophrenia, depression and major/manic depression were reported as the most common disorders.
- The age of respondents ranged from 14-63 years with the largest percentage of people in the 14-25 age bracket.
- 60% of respondents were male, 40% female and one person identified as transgender.
- Three quarters of respondents were born in Australia, with 13% of respondents identifying as either Torres Strait Islander, Aboriginal or both.
- Approximately 40% of respondents had one or more children, with half of these parents having their first child under the age of 21.

- Half (52%) of respondents reported current health issues and another half (53%) reported long standing illness or disability.
- Just 3 out of the 185 respondents reported wages as their main source of income and only 14 reported that they were in paid work. Over half of respondents reported the Disability Support Pension as their main source of income. Around a half (47%) of respondents reported a fortnightly income of under \$390.
- Education levels were low, with 34% reaching only Year 9 or below and a further 34% reaching only Year 10.
- Around 65% of respondents had been admitted to hospital because of their mental health and nearly half (46.5%) had been admitted to prison or juvenile detention.

This chapter has provided an overview of the research process undertaken and a discussion of some of the many methodological and ethical issues raised by such work. The participant 'snap shot' is useful as an early indication of the vulnerability of participants and should also signal the specific skills and extreme sensitivity needed to engage participants in discussions about their complex life experiences. Further, the profile foreshadows the following two chapters which aim to demonstrate the context and complexity of this factual representation. The aim of the next two chapters is to illustrate the ways in which these facts knit together in everyday life to impact on the shape of individuals' trajectories of iterative homelessness.

3 THE RELATIONSHIP BETWEEN HOMELESSNESS AND SOCIAL EXCLUSION

In the positioning paper of this research project, the case was set out for the use of social exclusion as a frame for understanding the compound disadvantage faced by homeless people. It was argued that the concept of social exclusion can be used to capture the *process* of dispossession and poverty and as such, is a powerful tool for any analysis seeking to understand ‘how’ experiences of exclusion, such as homelessness, are produced and maintained. This chapter refines and draws together original Research Questions 2 and 3 by using the concept of social exclusion to frame a fuller exploration of the factors underpinning iterative homelessness. With a focus on the dual contexts of iterative homelessness and mental disorders, and within the limits of data collected, the aim of this chapter is to illustrate the range of institutional, economic, social, cultural and spatial factors which impact on people’s capacity to find, and hold onto, stable housing. The chapter aims to demonstrate the ‘fit’ between dimensions of social exclusion and the range of issues faced by homeless people with mental disorders.

3.1 The relationship of homelessness and social exclusion: A way forward?

Pleace (1998) in his article ‘Single homelessness as social exclusion’ sets out a strong argument for joining together work on homelessness and work on social exclusion. While it may seem obvious that the experience of homelessness is an extreme exemplification of social exclusion, Pleace underlines the connection as a way through simplistic castings of homelessness caused by either individual pathology or by a lack of social housing (See Neale, 1999). In other words, Pleace is keen to re-locate homelessness in a range of spheres of disadvantage rather than seek ‘cause’ at the structural or individual level.

In a context in which work is needed to challenge constructions of homelessness, Pleace’s work takes on considerable significance. Pleace (1998: 57) ties social exclusion with homelessness to indicate that in fact the term ‘homelessness’ may obscure a view of the full range of circumstances from which it stems:

The homelessness literature is not inherently bad or inherently good, but the mere fact that there is a “homelessness” literature in its own right demonstrates a fundamental methodological flaw. It is not how the problem of homelessness is being examined that is the problem; it is the decision that there *is* a homelessness problem that needs examination that is the central problem.

Pleace’s statement not only has critical ramifications for the way in which we imagine homelessness as an issue, but of course, following from this, the way we imagine and plan responses to homelessness. In effect, while homelessness remains thought of as a ‘discrete “problem” that must have “causes”’ (Pleace, 1998: 57), focus will remain on housing as traditionally, homelessness as been pitched as an issue of the absence of adequate shelter. For example, Chamberlain and Johnson (2001: 47) argue for an ‘objective’ measure of homelessness based on the lack of housing which meets culturally acceptable standards.

According to the Centro de Estudos para a Intervencao Social (CESIS) (1999: 4-6), the unique extension offered through the frame of social exclusion is an examination of the non-monetary spheres in which poverty, and by extension homelessness, can be experienced and responded to.² While Chamberlain and Johnson (2001: 40) argue that homelessness should be measured as poverty is measured – by an objective scale – policy and research elsewhere suggest a development designed to *complement* such approaches: the consideration of elements of exclusion and homelessness not always tied to a measurable lack of resources (CESIS, 2000: 17-19; Rivlin and Moore, 2001). This may include for example, an analysis of

² CESIS is a research centre which was contracted by Eurostat (the Statistical Office of the European Communities) in 1996 to carry out a research project on the identification of ‘Non-monetary indicators of poverty and social exclusion’.

experiences of discrimination, dispossession and trauma (Coleman, 2000) or the skills and support required to engage in effective processes of home-building (Moore, 2000).

This chapter begins the process of examining the idea that there may be no structure to homelessness and that there is no discrete phenomenon of 'homelessness'. Overall, it should be clear that both analysis and findings are weighted towards a focus on 'a shift(s) away from bricks and mortar towards the personal, social and cultural transformations that may assist people in the move towards greater stability and social inclusion' (Kellet and Moore, 2003: 124). In other words, this chapter begins to flesh out the overall research approach that 'bricks and mortar' remain a central part of the response to homelessness, *only if contextualised appropriately in a wider field of need*. It is this wider field of need which this chapter aims to document.

3.2 Dimensions of social exclusion/dimensions of homelessness

Homelessness carries implications of belonging nowhere rather than having nowhere to sleep (UNCHS/Habitat, 2000: xiii).

This section uses the list of indicators of exclusion from work undertaken by the Centro de Estudos para a Intervencao Social (1999) to present a range of findings from both survey and in-depth interview data. The dimensions and characteristics of exclusion considered by the CESIS are similar to those used elsewhere (Percy-Smith, 2000; Howarth, C., *et al*, 1999).

Each area of exclusion correlates with a key social system usually acting to link and integrate the individual within the wider community:

Dimensions of exclusion/integration
1. Social: eg. Family, labour market, neighbourhood, society (global participation).
2. Economic: eg. Resources (wages, social security, savings, assets, etc.), market of goods and services.
3. Institutional: eg. Justice, education, health, political rights, bureaucracy.
4. Territorial: eg. Demographic (migration), accessibility (transport, communications, etc., society in general (deprived areas).
5. Symbolic: eg. Identity, social visibility, self-esteem, basic abilities, interests and motivations, future prospects

(CESIS, 1999: 21)

As the table above suggests, social exclusion/integration includes the social ties or relationships an individual has within their area of employment, family and the wider community. Economic exclusion/integration includes income poverty as well as the capacity of the individual to engage in consumption (of goods and services related to every day living and the maintenance of particular lifestyles). Institutional exclusion/integration reflects access of individuals to a range of institutional services and territorial integration/exclusion reflects the extent to which particular groups are spatially concentrated or marginalised in disadvantaged areas. Symbolic exclusion/integration underpins all key areas, indicating the degree to which an individual feels oriented by their place in society and feels a sense of belonging and social recognition.

Both in-depth interviews and surveys carried out with homeless mentally disordered people as part of this research covered many of these key areas directly and indirectly. In general, as in other studies (Anderson, 1997; Clapham and Evans, 2000) homeless mentally disordered people's lives were strongly characterised by indicators of social exclusion in all key areas. It should be noted, however, that the data also shows that the characterisation of homeless people as 'socially excluded' is far from straightforward. A selection of pertinent data is reported below.

3.2.1 Social Exclusion/Integration

The lives of participants in this study were strongly characterised by extreme grief over all kinds of relationships. Some people indicated that their family's lack of understanding and support of their mental disorder was a major reason for relationship breakdown and/or leaving family accommodation. For many, the family home had been a site of sexual abuse or violence, experiences of which were continued in relationships with partners, friends and other family members. More women (48%) than men (11%) cited physical or sexual assault/abuse as a reason for leaving accommodation.³ Overall, family or relationship breakdown was recorded as the third most important reason why respondents had left accommodation and 23% of participants indicated that they had stayed with family, friends or a partner *when they felt unsafe* but had had nowhere else to go. Conflict with neighbours, housemates and staff in accommodation services was also another reason why people moved on from accommodation.

In-depth interviews revealed extremely unstable and complex family backgrounds in which individuals balanced the need for the love and support with the need to avoid contact with violent and abusive family members. While parents and families were important in providing accommodation for people (16% nominating stays with parents, family and friends as a main form of accommodation in the last three years), overwhelmingly the family was a site of aggression, extreme violence, incest and sexual abuse which contributed to/caused mental disorder. Young people in particular moved around between family members and couples moved between both their extended families. These moves were often mediated by levels of violence and added to chaos of extended and blended family situations.

Most participants in the study were not in a relationship (80%), although 40% had one or more children of whom 50% were parents before the age of 21. In-depth interviews suggested that those with children were likely to be struggling with custody and care issues and this was an important cause of stress and trauma for many. Without accommodation or a place considered adequate for parents and children to meet, and in the added context of a high likelihood of relationship breakdown, many parents were not able to have contact with their children at all.

With 90% of participants unemployed and under a half (47%) receiving under \$390 per fortnight, it is no surprise that 41% of respondents reported that they spent most of their time in their room where they were staying. Loneliness and isolation were important factors in driving participants to find more appropriate accommodation with others or closer to support networks. Some people living in rural or regional areas indicated that the lack of services had left them feeling isolated and without proper medical support. Some indicated that it was an extreme struggle to be able to afford bus fares in order to keep appointments with psychologists and other professionals.⁴

Without engagement in a community at work and facing extreme difficulty in even maintaining contact with key support workers, for some isolation and loneliness compounded depression and other mental health issues. For others, seclusion or at least the ability to control contact with others was seen as important in the management of mental health. Given some people's experiences of compounded sexual abuse, incest, and related anxiety, personality and compulsive disorders, living with others could be excruciatingly difficult and lead to a spiral of self-harm or ill-health. In other words, loneliness was not just a straightforward factor of having few contacts. *Not* having the space and privacy to build 'wellness', confidence and communication skills was as damaging as being left alone without support.

Voluntary work, skills programs, and activities were seen as extremely important by many respondents with 20% of respondents engaged in some kind of voluntary work, often in a

³ These figures are based on data from surveys on the reason for leaving only *five* forms accommodation. In accommodation biographies, discussed in more detail in in-depth interviews, the issue of assault/abuse was even more pronounced.

⁴ As Coleman (2000: 166) argues, however, homelessness in general is not necessarily characterised by 'disaffiliation', particularly in the case of long term homelessness in which people may be part of a distinct local homeless and homed community.

support or accommodation service or related charity activity. Voluntary work was seen as an important source of self-esteem and skill building in a context in which, because of illness and/or disability, a commitment to full time work could not be made.

Interviews took place in accommodation/support services and 67% reported that they also used other services, predominantly drop-in centres. Discussion groups and activities were discussed as important for relieving boredom but also for just *talking*. Many people felt that being able to discuss their issues and experiences was critical for their wellbeing and development and clearly stated that they felt the opportunity to talk through issues in depth was not available within the mental health system. Support and accommodation staff were overwhelmingly indicated as the most important support people in terms of addressing individual's mental health issues.

Respondents were asked for details of their last four forms of accommodation. Overall, 639 periods of accommodation were recorded. The median length of stay (i.e. The mid-point of the data distribution) was just 3 months. In all, 69% of periods of accommodation were for only 6 months or less. Participants left/were forced to leave their accommodation most commonly because they had found some other accommodation (11.5%), because they were evicted or the tenancy was ended (10.5%), or because of a family or relationship break down (9.8%). Around 70% of participants spent in this context of movement, maintaining contact with health, employment and mental health services, friends, family or children, was extremely hard for participants to coordinate when well, and impossible if unwell.

Overall, it should be clear through this brief sketch that maintaining social relationships – within the family, work or institutions is extremely fraught in the contexts of mental disorders and homelessness. This is not because homeless people with mental disorders simply can't maintain relationships, but because their past negative experiences and a range of economic, cultural and other factors act as significant constraints to relationship and trust building.

3.2.2 *Economic Exclusion/Integration*

All study participants were engaged in trajectories of unstable housing at the time of their interview and most lived in cheap or subsidised accommodation:

- 18% were living on the streets, in squats or cars
- 12% were living in boarding houses
- 40% were living in supported accommodation (hostels)
- 23% were living independently with support

Finances were nominated by 44% of participants as a main barrier to stable accommodation. As mentioned above, very few people had employment (7.6%) and even less stated that wages were a main source of income (2%). Some three quarters of participants (74.4%) had a weekly income of less than \$228, with ¼ (25%) receiving less than \$170 per week. Participants expressed little hope of ever being able to save for bonds for more stable housing.

With this kind of income not only were the basics of shelter and survival limited, but participants choices on many other issues were also limited. One issue discussed by some participants was choice of health care. Given that some felt as though they could not receive the one-on-one care needed to address their mental health issues in the public system, some attended (or wanted to attend) counselling and therapy in the private system. In some cases, psychiatrists gave special rates or family members paid for the treatment. Most of course, were not able to access private care because they could not afford it. One woman went without food in order to pay costs of private therapy and public transport to and from appointments. For those requiring intense one-on-one therapy and/or support, the lack of choice of health care simply underlined a cycle of disempowerment and restricted exits from their situation.

In general, participants strongly related their low income with unemployment; due to their illness and/or disability many were unable to work, or could work only in periods of stability.

Taking up education or further study, which might lead to better employment opportunities, was also restricted by health and finances. Both work and education were also difficult to even consider in a context of unstable accommodation.

3.2.3 Institutional Exclusion/Integration

Homeless people with mental disorders reported extreme marginalisation in terms of levels of education, health, benefit requirements, and rates of incarceration. Low educational achievement (only 34% reaching Year 9 or lower, and another 34% reaching Year 10) coupled with a range of mental and physical health problems further compounded low income and exclusion from employment. Close to 55% of participants received a Disability Support Pension (DSP), 19% received an unemployment benefit (Newstart) and 16% received Youth Allowance. Assessment for a DSP was seen as an extremely traumatic process for participants who all required intensive support to apply. Being awarded a DSP was perceived to be critical because it is a more substantial payment than Newstart or Youth Allowance and also entails subsidised transport and priority for public housing. Without a DSP, the chance of securing public housing was seen to be nil. Department of Housing waiting lists and shortages were perceived by participants to be a major barrier to securing housing in general.

Around 85% of respondents self-reported that they had been diagnosed with one or more mental disorders. Schizophrenia, depression and major/manic depression were reported as the most common disorders: 78% of participants had been diagnosed with one or more of these. For medical help with their mental health 23% of people saw a general practitioner and another 23% went to community mental health centres. Two in five (38%) had been admitted to hospital more than once because of their mental health, with over 50% stating that towards the end of their last stay in hospital, hospital staff did not talk to them about where they were going to be staying. After their last (mental health related) stay in hospital, 13% of participants went straight onto the street at discharge. 16% got medical help from health staff visiting accommodation or support services. Accommodation and service staff were seen to offer the most support for mental health issues, with emotional support and time spent talking the most important kinds of support.

Over half of respondents said that they had had difficulty getting medical help for their mental health. In particular, finding a good doctor and accessing mental health care were seen as major issues. Half of respondents also reported current general health issues, around 40% of these were dental or mouth related, predominantly for men. Over 50% reported a long-standing illness or disability, 34% with asthma and 34% with Hepatitis C. Interviewers' impressions of users' rates of consumption suggest that at least 70% may have a high and regular drug/alcohol intake. When asked to list what the bulk of income was spent on, 27% of participants included drugs/alcohol. Alcohol (36%), marijuana (35%), heroin and speed derivatives (42%) predominated as drugs of choice, though 32% of participants did not use drugs or alcohol at all.

Around 46% of participants had been in prison or juvenile detention, with 27% of these people re-offending once or more within three years. Of all participants, three in five (60%) and one in four (26%) of women had been imprisoned. While in prison, only half said they had help with their mental health and 62% said that towards the end of their sentence prison staff did not talk to them about where they would be staying. At the completion of their last sentence, 20% of participants went straight onto the streets at discharge.

3.2.4 Territorial Exclusion/Integration

Despite the high rate of movement between places of accommodation, some interesting spatial trends surfaced in the data. Those exiting prison and hospital either to the streets or supported accommodation were moving overwhelmingly to the inner-city areas of both Sydney and Brisbane. Data collected on the current and last four places of accommodation show that progressively with each move, more and more people lived in the inner-city. In

other words, while participants were mostly interviewed at inner-city services, further back in their accommodation histories more people lived in rural/regional areas of NSW and QLD.⁵

Participants discussed poor safety and high crime rates in certain areas and their desire to move to safer and more desirable areas. Violence and conflict with neighbours or random violence within an area featured in housing trajectories. Some people believed that their long wait for public housing was due to their preference for housing in 'good' areas and others had abandoned hopes for public housing because they could not accept their potential placement in areas they considered unsuitable to live in.

3.2.5 *Symbolic Exclusion/Integration*

Both in terms of barriers to securing accommodation and the perceived impacts of mental ill-health, a key issue discussed by participants in both surveys and in-depth interviews was the inertia of depression and feelings of powerlessness. Organising appointments, sorting out benefit payments and searching for accommodation without finances and transport presents huge difficulties for homeless people in general. With a mental disorder, often with fluctuating extremes, small tasks may become at times physically and mentally impossible. Many people discussed low self esteem and anger as by-products of feeling trapped and dependent on the help of others. Some also struggled with violent or inappropriate behaviour attached to their illness and frustration and others discussed being unable to settle in one place.

Overall, participants seemed deeply traumatised and grief-stricken and struggled with desperation in a context of self-loathing, shame and fear. Participants felt strongly stigmatised as 'failures' as 'welfare dependents' as 'no-hopers' and discussed difficult personal journeys of trying to re-learn a sense of self-worth. Many connected low self-worth with failing to act to protect themselves or believing that sexual abuse, violence and substandard living conditions were all they deserved. Few dared think beyond their immediate situation.

3.3 Conclusion

In this chapter, the frame of social exclusion has been used to capture the range of factors potentially underpinning the experience of iterative homelessness for those with mental disorders. It should be clear that while not all areas of exclusion are covered in this research, in terms of health, education, income, employment, social networks and rates of incarceration, the chapter contributes a strong illustration of homeless people's endurance of extreme levels of disadvantage with few avenues or supports to develop skills and exit this situation. Even where contact was made with hospital and prison systems little seemed to be done to examine the existence and safety of accommodation for release or to put in place support for community reintegration.

Data reveals participants as a group with an extremely high turn-over of accommodation characterised by shifts to find better accommodation and also by a difficulty in settling in one place. The data situates iterative homelessness amongst poverty, trauma, unavailability of low cost housing, being housed with other stressed and disadvantaged people, little support for everyday living and organisational skills, multiple hospital admissions and so on. In other words, as Pleace (1998: 57) argues, viewing homelessness as a discrete 'housing' problem limits both an understanding of the full range of linked issues at stake and the range of potential avenues and sites through which homelessness may be addressed.

What remains problematic in the 'fit' of social exclusion discourse and the experiences of homeless people with mental disorders is a focus on employment as a key mechanism of integration:

Employment is the best safeguard against social exclusion (European Commission, 2000: no page number available).

⁵ Further research on rural/regional to urban migration is needed. See the work of Mike Darcy and Liesl Laker (2001) for documentation of homeless people's movement in the Sydney region.

Given the high numbers of people on a disability support pension, low education levels, and limited opportunities for skill development, employment is an unrealistic mechanism of *immediate* integration for many struggling in the dual contexts of homelessness and mental disorders. In other words, it would seem that for homeless people with mental disorders, no one aspect of social life, even housing, can be tackled in isolation with the expectation of attacking exclusion/homelessness overall. What this chapter demonstrates is the need for the continued development of housing and employment options *alongside an equal focus on all other issues*.

Having sketched out the range of issues confronting participants in this study, the aim now is to examine and illustrate the interplay of these factors with the iterative experience of homelessness in more depth.

4 ILLUSTRATING ITERATIVE HOMELESSNESS

Chapter Three set out to locate iterative homelessness and mental disorders amongst a range of related issues. The chapter demonstrated that iterative homelessness is a 'linked' rather than discrete problem. The aim of this chapter is to demonstrate more holistically how a range of forms of exclusion and marginalisation interact to sustain trajectories of iterative homelessness. Simply put, the key contribution of the chapter is a more detailed examination of what *drives* iterative homelessness in the experience of those with mental disorders. After a brief view of some survey data, three case studies will focus on accommodation histories set within the wider biographical context. These case studies have been chosen to illustrate distinctive paths taking place through a wide range of forms of accommodation from street shelter to private rental. A generalised analysis of key themes follows. While this analysis draws directly on in-depth interviews, it is also informed by the 185 short accommodation histories collected through surveys.

4.1 Brief view of survey data on accommodation histories

Each survey participant was asked a range of questions about their last four forms of accommodation. This survey data clearly indicates not only a high turn over of accommodation in homeless people's housing trajectories, but that trajectories can be grouped usefully by gender, age and location in particular. While a biographical approach has been selected to illustrate dimensions of trajectories here, it is recommended that further research examine these patterns in more depth. It should also be noted that in terms of targeting intervention more information about the specific accommodation characteristics of a group would be critical.

- Overall, 69% of periods of accommodation were for only 6 months or less.
- When asked what was good about these four forms of accommodation, 'nothing' was the most common response (16%).
- 63% were probably or definitely planning to leave their current accommodation.
- 11.5% moved on because they had found somewhere else to go to.
- In the last four forms of accommodation for men, stays in caravan parks and on the streets or in squats and cars featured more frequently than for women.
- Two times as many men (30%) than women (15.5%) listed their own drug and alcohol use or the drug and alcohol use of others a main reason for leaving accommodation.
- Of the people who stayed on the streets or in squats and cars in their last 4 forms of accommodation, 51% were aged 14-25.
- Caravan parks featured almost 3 times more frequently as an accommodation type in Queensland than in New South Wales.
- Private rental and a one or two bedroom flat were most frequently considered to be the tenure and housing type best suited to the participants.

4.2 Case Studies

The brief summary above foreshadows many of the issues which interweave in the every day lives of homeless people with mental disorders. As mentioned above, a biographical approach to exploring trajectories is being used in this research. This approach is considered most appropriate in a context of the availability of predominantly quantitative data and in the context of the desire to illustrate how a range of issues and types of accommodation mesh in individual experience. As May (2000: 615) argues, it is important to understand how individuals negotiate particular experiences of homelessness rather than seeing their experiences as simply the inevitable 'result' of compounded exclusion, for example. Further, as noted in the *SAAP Linkages with Mental Health* paper (Commonwealth Department of Family and Community Services and Commonwealth Department of Health and Aged Care, 2000: 14):

Research into the needs of homeless people with a mental illness, particularly within Australia, is limited and constrained by...[a] lack of qualitative approaches which tend to be undervalued in the wider scientific community, and yet are likely to be informative in this relatively under-researched area.

The case studies are a description of three people's lives with as much verbatim quotation included as space will allow. Though severely truncated, case studies are an opportunity to hear how, through dialogue with the researcher, participants chose to narrate or construct their accommodation biographies in particular ways. The case study material presented here is not accompanied by individual analysis. A thematic analysis of all interviews follows; the reader is invited to evaluate how the case studies fit within this more generalised analysis.

4.2.1 *Iris*

Catherine: So you've been diagnosed with depression?

Iris: If we're going to label, yes. Post traumatic stress disorder as a result of several years of sexual abuse from 4 to 8...I've also got a physical illness and one of its affects is also depression. I've got a hyperactive thyroid – Grave's Disease – and that also causes many of the symptoms...similar to depression: sleeplessness, inability to concentrate, a whole range of things like that...

Iris, 53, was living in Sydney in a share house provided with subsidised rent and support by a housing service targeting women with mental disorders. She had been living independently with support in accommodation provided by the service for 17 months. The program only provides support for 18 months. Her network of support was based in around the service; her best friend and her friend's husband had been killed in New York on September 11th 2001.

Sent away to boarding school after being abused in a church setting (as Iris noted, getting a 'bloody good education' was the only good thing to come out of her abuse) she went on to start chemical engineering and then switched to psychiatric nursing. Amongst other things, Iris worked in a welfare related industry (on low wages) for 9 years, brought up two children on her own, one of whom has a disability and 'issues' and ran away at 16. For 15 years she lived in the same place in the Eastern suburbs, raising her two children and battling with periods of illness. She managed to hold her accommodation partly because of an informal arrangement with a kind landlord who let her 'catch up' rent after periods of illness and time off work. Also, she forced herself to try and keep on top of things because of her two children.

The landlord died and his son took over the property and evicted her when rent was behind. One daughter was still living with her but she was still working, so got credit for a bond for a two bedroom apartment in the Eastern suburbs where she lived for four years. She had two major episodes of illness in this time. Her second daughter moved out and her boyfriend moved in for a year and began using drugs and became very violent. Iris ran away at 2am one morning; a bus driver let her sleep on the bus. She then found a share place where she again rented privately for a couple of months. At this point, Iris was very unwell although 'still functioning' until her flatmate had a psychotic episode and attacked her and another flatmate:

Iris: I'd come from a domestic violence situation and moved into a share accommodation where one of my housemates had a psychiatric episode and attacked me. That was it, I'd lost everything. I lost the plot completely and ended up a few nights on a bus and then rang the homeless line in the middle of the night and was sent to one of those men's places in Crown Street or somewhere and they put me in a hotel for a night and then brokered me out to Merrylands [in Western Sydney]. I mean I'd lived in the Eastern Suburbs for 20 years, I was a fish out of water out there and it's a whole different culture. I knew no one. I was totally isolated.

Iris stayed in a hostel for women:

Iris: the woman who is charge there was an ex-air force sergeant and she ran the place like a service, so you had to clean the right way she it cleaned, you had to water the plants at exactly the right moment as far as she was concerned and if you didn't she yelled and screamed and abused you.

Iris started seeing a psychiatrist and through him, applied for a place at the women's service where the researcher met her. Her psychiatrist was not aware of the service; Iris knew about it as she had referred people there in the context of her work.

Catherine: So what do you think might happen next?

Iris: We've got applications. When I first moved in, did the standard thing putting in applications for community housing, and obviously at the refuge I went on the Housing Department list, but they knocked me back for priority and part of my problem is because I'm only on Newstart 'incapacitated' because my intent is definitely to go back to work so I'm not on a pension, so Housing don't see you as needy because that pension says you can't work for two years. I haven't worked for two years, but all along it's been I'm going to go back to work, I'm not turning round and saying this illness is going to incapacitate me for the rest of my life. So by not going on a pension I guess I blew my chances with Housing. So I've got to get a priority support letters that will go to community housing, but again most of them have got waiting lists over 10 years. There's not housing out there. [Current accommodation service] don't throw you out 'til you've got somewhere else to go, but on the other hand it's not an indifferent thing either so if I can't get community housing then I'm not sure what happens. I mean I'm basically looking at homelessness here because in all fairness when you come into [current accommodation service] you know that there's a timeframe. I'm also aware that there's a hell of a lot of women on waiting lists that need these places too...

4.2.2 Ben

Catherine: So you said you left home when you were 11. That's very young isn't it?

Ben: That's cos my Dad passed away and I didn't know how to deal with it, so I just took off and my older brother was on the streets at the that time so I came to where he was which was here in the city and the Valley and stuff...I've never dealt with my Dad dying and I think that's why, and I've lost my two sisters as well, I've got a tattoo of them on my arm. I think that's why I'm still on the street and I can't get myself together because I've never actually dealt with bad things that have happened in my life, I've just turned to drugs and alcohol and the streets.

Ben's parents had split up and remarried before he was one. Ben lived with his father in South Australia. When Ben's father died, 'the welfare' sent him to his natural mother in Queensland.

Catherine: So your step mum didn't look after you once your Dad died?

Ben: She wasn't allowed to because my mother wanted me but she didn't want me because she just treated me really bad basically, let my step dad do what he wanted, treat me as bad as he wanted.

Catherine: Was there violence or...

Ben: Yeah with him. I've got scars all over the back of me head. He's slammed me into concrete and everything like that. I got a scar on me back. He threw a knife at me and he's done some like really bad things and within about a month three weeks to a month I ended up being driven away. I just didn't want to stay.

Over 9 years Ben (now 20 years old) had been living around inner city Brisbane in boarding houses, in squats, in unregistered cars, youth refuges, parks and was currently sleeping

rough outside a youth employment service with a large group of other young people. Ben suffered severe depression, had been hospitalised on several occasions and said his experience of adult prison was more positive than hospital. Ben and his family had been involved in a car accident in which Ben's two sisters were killed. Ben performed a high level of self-harm and had stabbed himself while living alone in a boarding house. Ben relied heavily on the support of a youth drop-in centre where he spent a lot of his time.

...I've got a two year old little boy and he lives about 30kms from here and I don't get to see him much and just the other day I had a big argument with his mum and she called the police and I'm not allowed, she put me on a DVO and I'm not allowed to see him until that order's over which is two years. So things like that make me give up and being on the street just makes it harder, makes it worse...The Government's really got to look after why people, they say, 'oh yeah, suicidal people, well who cares?' They've got to look at *why* people are like that. I mean I'm not always like that, but yesterday for example, if I wasn't here (youth drop in centre) I probably would have harmed myself again...That's why I'm doing it because I can't see my son and that really hurts, it depresses me...I stabbed myself in the stomach and that's just because it's too hard. You give up. Too hard to find a place to stay if you are under a certain age...

He and three friends had put in several applications for private rental in recent times and had been knocked back. He had no hope for Housing Commission. Commenting on the failure of his ex-girlfriend and son to get Housing Commission, he said:

...she's supposed to be on the priority list as well, and if a single mother with a two year old child can't get a priority house, what's a 17, 18 year old homeless youth going to be able to do?

4.2.3 Rachel

Rachel (27? years old) was on the waiting list for her current accommodation for 20 months. She was being housed by a service focusing on women with mental disorders in Sydney. She had been diagnosed with Borderline Personality Disorder and also had suffered severe physical illness for three years. She had survived a car chase in which she went through the front windscreen of a car. She was currently living in a one-bedroom apartment with subsidised rent and support from the service. She was on sickness benefits having been refused a disability support pension. Rachel came from a rural town and first came to Sydney in Grade 12 to stay in a psychiatric clinic. Rachel was physically abused by her father.

From the clinic she moved into supported hostel run by a religious organisation. She was drinking heavily from 16-18 and went to Alcoholic's Anonymous. She started working and then was accepted into university. She moved into her own rental apartment. She tried to study and work, became sick and then had to work even harder to catch up with rent and study. She packed shelves in a supermarket, worked in a florist and babysat and was hospitalised periodically.

It was very hard and I just felt like such a stupid failure every time that I got sick and different things happened to me that made it really difficult for me to study. Like [my boyfriend] tried to kill me and I was in a really bad car crash. I was sexually assaulted by somebody else, I was kidnapped by a taxi driver. All these little things that were big challenges and difficult to get through. And I was sexually assaulted by another guy and given a disease and had to go to hospital. So it was pretty scary just day to day, trying to sleep. Every noise. Just scary.

She was eventually forced to return to her parent's house but felt isolated, 'I wanted to get help in Sydney because there's so much more opportunity here'. She moved back to Sydney and stayed with a friend:

And then I came down, I went to hospital because...I...was staying in a girlfriend's house. Her and her husband had just bought a new house and so it was lovely of them to let me stay, but I was so uncomfortable there because I couldn't, I was just so scared I was going to, this might sound horrible, stupid or whatever, but I

was so scared that I was going to stab myself. I was just so scared that I was going to walk into their kitchen and grab a knife and stab myself...I didn't want them to think I was crazy. I didn't want them to think I was nuts. I didn't want anyone to think...and I accidentally, like I was just trying to make my mind quiet so I could just go to sleep so these thoughts wouldn't keep coming in...I accidentally took an overdose because I was just trying to [quieten rapid thoughts]...I rang the hospital and they said you have to do to the hospital, wake up your friend and get her to take you to the hospital and I'll call you back in one minute and make sure you've done that. And it was just so hard to go to someone who was sleeping. I was a guest in their home...I just felt so ashamed and so horrible and so rotten...

Time came for her discharge from hospital. Rachel was given a list of emergency accommodation phone numbers by the nursing staff, which she brought to the interview to show the researcher. Rachel had little money as she was being cut off from benefits and was instructed to use a public phone opposite a noisy nurses' station. Eventually she found a place in a women's refuge and was taken on as client there. She did an alcohol program and moved into a single room underneath a garage of someone's home in Rose Bay.

Catherine: So when you think back over all these different moves in the past, what do you think have been the main reasons why you've had to keep moving?

Rachel: Problems happening

Catherine: Other people doing things to you mean

Rachel: Yeah other people doing things to me. They're not the only times I've moved, I've moved about 20 times in Sydney since I was 17. Different places. I moved into a place and the guy used to beat me up and throw me on the pavement, all these sort of things and I was too proud to ask for help and my father told me I'd never make it in the city anyway and I wouldn't ask anyone for help, didn't know I could, there was a refuge that I could go to. And he would lock me in the room and do horrible things to me and I didn't realise there was anything better, that I was entitled to anything, that there was something wrong, that I deserved to be treated better than that. And he went to Long Bay Jail and then I moved elsewhere, where did I move next? I just stayed with people, so I suppose being caught up with the wrong people probably due to lack of life experience and also being too trusting, being too giving, too caring and gentle and always giving people the benefit of the doubts.

A lot of things have happened to me and I'm very lucky to be alive. Some days it's really hard to go on but other days you feel good, but it's difficult because you don't know when you're going to feel good or bad I go up and down and that's difficult for me to cope with. It's difficult for friends too. I try to pretend I'm ok whenever anyone asks me – 'I'm ok, I'm well thanks'...So it's, I'm so used to putting on a face pretending I'm ok but inside I'm crushed, fragile, or worried. I just don't know what I'm going to do, so it's difficult telling people you're all right...

4.3 Thematic analysis: What drives iterative homelessness in the experience of those with mental disorders?

As earlier stated, this chapter sits alongside the previous chapter to provide answers to original Research Questions 2 and 3. These research questions were refined, the concept of social exclusion being used to frame an examination of the wide range of issues linking to the experience of iterative homelessness. This chapter takes up elements of exclusion covered at a general level in the previous chapter, aiming to 'bring them alive' by showing how they are lived in everyday life. As Rustin and Chamberlayne (2002: 3) argue, 'The purpose of the sociobiographical approach is to avoid the overgeneralisation and abstraction of many other social research methods, which often lose sight of the coherence of individual lives'.

The case studies illustrate the random acts, violence, chaos, poverty and fear surrounding accommodation choices and constraints. These stories are remarkable in their depiction of

the extremities of people's experience and yet are completely unremarkable amongst the 28 accommodation biographies collected. The following thematic analysis of all interviews provides a range of analytical tools which can be applied to the case studies.

4.3.1 *Living with a mental disorder: Vulnerability*

The extreme and ongoing vulnerability of participants, both within the family home and when moving through tenuous housing, is illustrated very clearly in the case studies and other interviews. Compounding the actions of others were the symptoms and suffering caused by illness. Experiences of abuse, for example, simply acted to underline even further the isolation felt by those with mental disorders – with extremely negative effects on maintaining stable housing or stable relationships within households.

As well as feeling uncomfortable, particularly in share housing, feeling unsafe was a common theme, as were actual events of violence, intimidation, or invasions of privacy. At a basic level, people reported simply being unable to control who entered their room or house (particularly terrifying for survivors of sexual abuse) and some had been unsure who was taking rent money from their bank account. Others suffered because rental or housing commission properties were rented in their name but were evicted and penalised because of the behaviour of ex-partners, housemates, friends and so on. Several commented on the negative experience of being placed in housing commission or community housing or boarding houses with other extremely disadvantaged and mentally ill people.

Jamie (23):...it was more people...and even worse. A lot of domestics, lot of low socio economic groups... a lot of drug problems. A lot of domestics [domestic arguments/violence] around the whole area because there'd be a whole bunch of people with the same problems stuck in the same area and it was just too much for me because I, and I still do, I always believed I could live better even knowing I didn't have much dignity in the first place...

Josephine (51) living in a boarding house in Sydney, said that as well as having to deal with the violence from other tenants, what she found most isolating about her situation was that most other tenants were too ill and depressed to hold a conversation. Maree (55?) left a lodge in Brisbane because of violence: 'I stayed a couple of days and I left. I couldn't put up with it'. Petra (45) reported,

Like another lady I was talking to out back [of a women's refuge], like she paid out her whole [pension] cheque to a place and they overdosed them on medication to make them sign up their pension over to them and in the end they're not happy with their accommodation because they're scared of getting raped or bashed or something like that and the people don't care as long as they're getting their money.

While there was an incredible range of incidents that any one person experienced, a core issue was that living with a mental disorder reduced the range of exits from stressful, dangerous and unhealthy situations. Vulnerability had economic, emotional and physical dimensions. At an immediate level, the lack of exits seemed related to a lack of low cost accommodation *which was safe*, discrimination occurring when potential clients indicated their mental health status to potential landlords, and the effects of illness and trauma experienced by the individual.

These immediate factors were of course further reinforced within the context of poverty, general health issues, low education, unemployment and so on, discussed in the previous chapter. Desperation and few choices could lead people into further difficulty. Further, as Rachel's story suggests, being vulnerable at many different levels made people easy targets for sexual abuse, financial rorting and emotional blackmail.

Overwhelmingly the actions of other people – neighbours, friends, family, landlords – featured as key reasons for people having to leave accommodation. Apart from standard experiences of violence, abuse and rape within family and sexual relationships, participants shared incredible stories of their housing simply being taken over and lived in by other people, of

bashings and stalkings by neighbours, of problems with local drug dealers, of threats from landlords, of standover by other tenants, of eviction for refusing sexual favours, and so on.

4.3.2 *Living with a mental disorder: Resilience*

In the context of poverty and often repeated experiences of violence and abuse and the near impossibility of finding stable and safe accommodation, all study participants showed incredible resilience and a capacity for survival.

Maree: I got a place that the people that owned the property...put their own relatives in. I had to leave because they wanted to put their own people in it so that was fair enough - not that I was happy. It's hard enough leaving and it's hard enough finding a place but everywhere it's so full and it's just unbelievable. I've walked, got cabs, buses, trains. I tried to get different places and nothing. Not a word of a lie, nothing. And I was so tired and tired of walking and I felt like I was run down and never getting anywhere of finding a place. This is the worst part of it, the place bit, and the money situation to fit the place. Food, clothes and what-not and it's just unbelievable, it's not enough to live on. And you say to yourself, you're on your own, even a little part time job or something a few extra dollars to see you through. But the way I felt, I sort of felt there was nothing, but there is something, you can't say nothing. Nothing, nobody wanted me and I got real upset and I sort of felt down and really upset about it but there is something if you really try and work on it you just can't sit down and mope you've just got to do something about it...

Participants discussed 'doing the geographical' (moving from place to place), for example, as a way to control drug use, to manage symptoms of mental disorder, to start afresh, to move closer to support networks, to move away from dangerous or unhealthy situations and so on. Jamie, for example, simply walked out of her community housing flat because she felt unsafe in the area and she felt she needed more support for her alcoholism and mental health. The key point here is that while participants were living in extremely poor conditions, their movements through forms of accommodation were not only determined by becoming ill, lack of finances, the actions of others, bad luck etc. Accommodation trajectories were shaped to a large degree by strategic choices albeit within extremely dire circumstances.

In many cases, however, the range of survival mechanisms open to participants in fact contributed to the loss of, or difficulty of finding, housing. Drugs and alcohol were used to medicate the extreme pain of traumatic events as well as to 'quieten' aspects of mental disorders such as hearing voices. Bill (57) commented that without drug and alcohol use, he could not have survived the terror of having to sleep rough and would have committed suicide. In Tara's (33) case, despite having had a stroke and blot clots related to alcoholism, her abusive husband encouraged her addiction to valium, cerapax, rohipnol and 'benzos' (benzodiazepines) as a way to manage behaviours associated with obsessive compulsive disorder.

'Survival behaviours' such as drug and alcohol use, self harm, being aggressive or hostile, a reticence to engage in communication or fear of relationship building, however, did contribute to the loss of accommodation because of effects on relationships, families, housemates or duty of care to other residents in hostels or boarding houses. Further, the cost of drug and alcohol addiction entailed a whole range of lifestyle and general health issues – not having money for rent and food could sometimes be the minor side effect.

In general, mechanisms of resilience and strategies of survival could in many cases increase the risk and vulnerability of participants. In the context of specific symptoms of illness and unstable accommodation, however, safer or more positive options were extremely limited.

4.3.3 *Chaos*

The tension between extreme vulnerability and the often negative impacts of the means through which people sought to protect themselves or control their lives contributed to the construction of lives of total chaos. Combined with the side effects of abuse/trauma and mental disorders, such as active commitments to self destruction, self-harm and low self-

esteem, the context of vulnerability and survival in many cases fed into cycles of ongoing movement, abuse, and annihilation through drug and alcohol abuse. In some cases, this culminated in breakdown and hospitalisation.

Again, the extremity and complexity of participants' experiences and associated accommodation trajectories are best communicated by participants themselves.

Roxie had survived overdoses and a heroin related incident she wouldn't discuss. In the past she had broken into medical facilities to steal prescription drugs. She had several diagnoses for Borderline Personality Disorders. At the time of the interview she had enrolled in a silver smithing course and was successfully working on her drug and alcohol issues with support.

Roxie (28): I think I lived on the streets, that's when I came here [women's refuge, Brisbane] for the first time. I got kicked out of here twice for violence and drug use. I was banned from here...I went to rehab [in NSW], I was homeless for a while....I ended up with [a supportive boarding house program]...and I lived there for about six months and I was using drugs there. I changed drugs though from heroin to speed...I started going to Alcoholics Anonymous and they cleaned my act right up and I stayed clean for nine months and I got transferred from the boarding house...to a one bedroom unit. I lived there for nine months and I got a job...and I bought a car...I moved over to a unit...a private rental with a couple of friends and I lived there for about nine months and then I started using drugs again and I lost my job...and I lived out of my car for 8 months until it ran out of registration...and I was back on the streets...

At the time of the interview Jane was 6 months pregnant and 8 months stable on the methadone program. She had lost the top halves of three fingers from injecting Normison (a sleep drug) into a main artery. She had been admitted to hospital for a nervous breakdown and prescribed anti-depressants. She was in crisis accommodation for women and saving money for her baby.

Jane (23):...so the two of them moved in with me in the flat and they were only 16 at the time, so I was the only one over the age of 18, so the whole thing was in my name and...went up in smoke. The fact that they were young and the first time out on their own – parties galore – and because I was very rarely home at night time from working and school and stuff...eventually within less than two months we'd been evicted...I moved back home.

Catherine: You went home to your parents?

Jane: To my mother's house. So there was myself, my boyfriend, my mum and sister and brother living there but then we had these two destitutes [homeless drug addicts] with two kids move in as well in a 3 bedroom place. So it was just chockers and I don't know how I convinced my mother to let us all stay...[The friends stole money from her mother and were later evicted]. [Her boyfriend] ended up getting kicked out after being busted shooting up in my mum's garage and we had a huge domestic, coppers were called and I was stupid enough to leave with him. Then the whole thing just kept going. Drugs was a way of life. I got a habit, not just amphetamines, but everything else as well, pills and stuff...From there I moved, we ended up, we were all on the streets, the four of us [with the couple who had stayed at her mother's house] and two kids and for about two weeks we ended up meeting a young couple and crashing on their floor and then [her friend] managed to get a house in Caboolture. It was an absolute shit hole. Just a place to live. We ended up getting a bond loan and stuff like that. The place had, because it was so close to the river, it had cracks in the walls because of the foundation moving, so it was a bit dodgy but at that stage we lived there for a few months and it was just a full on non-stop speed stop, every speed addict in town used to come to that place, and it was just chockers full of addicts all day every day. You'd have 6 people in this room, 4 people in that room and kids running everywhere...

Jamie:...so it was sort of like: my parent's place, friends' places, then couldn't live like that, then went into housing commission, community housing, then to rehab, then from rehab to parent's place, and parent's place to grandparents, grandparents to [current accommodation].

Catherine: So how do you feel about the whole process?

Jamie: It's just, you can never settle. You're never able to move on...like everything in my life's temporary...I didn't know what my home was...that's what would cause a lot of my problems is that everything's temporary, even love...

4.3.4 *Breaking the cycle: A point of stability*

The excerpts above show the complexity of housing trajectories, demonstrate the appropriateness of the term 'iterative homelessness', and highlight the range of forms of accommodation which might make up trajectories of tenuous housing. Illustrating the chaos of individuals' lives through transcripts is critical in demonstrating the need for a holistic approach to the issue of iterative or repeated homelessness. For many, the combination of factors of disadvantage and exclusion act as a cycle for which a linked and multi-level response would be needed to construct any viable exits. As Tara illustrated, the multiple issues both affected by mental health and affecting mental health can create a cycle of compounded exclusion and perpetuate a spiral of suffering:

Tara:...it's hard to get jobs and that's what gets me depressed, that's what gets my mental illness into depression. Cos looking for work and getting knocked back all the time, and then you get bored. So what do you do? Pick up a drink. You don't live in the real world...Just applying for cleaning jobs and waitressing...I go in dressed appropriately and everything. Just go in and pick up the paperwork...and you know, cos of all the questions, a lot of the questionnaires now, 'Do you have a police record [Tara had had two sentences, including 19 months for armed robbery], drug and alcohol problem [Tara was trying to be clean after having been an alcoholic since age 12 and a multiple drug user/addict] or mental illness [Tara was diagnosed with schizophrenia bipolar mania and obsessive compulsive disorder]. So I mean, what do you do? I be honest, that's what the program [Alcoholics Anonymous] teaches me is I have to be honest with myself. So I answer those questions honestly and I never hear back and then I go, I might as well go out there and have another, go and have a smoke or a shot or a drink or get pissed...It's just one big vicious cycle.

While many participants had similar stories of entrapment and periods of unbelievable chaos in terms of accommodation and connected issues, what also surfaced strongly in the interviews were the powerful effects of points of stability. Because participants were interviewed at support and accommodation services, many had moved through a chaotic period, were engaged with staff in implementing changes in their lives or at least had a point of respite in which to reflect on their lives. Others simply identified their need and desire for a point of stability, although, because of the specific symptoms of their mental health, would perhaps never experience such a point.

Catherine: And how do you feel about this last stretch of moving around and being in different share houses...

Annie (23): I want stability. I want my own place to live in for a couple of years. I just want a little flat. I just want to set up shop and do my thing and don't have to be back by curfew. I don't drink or anything, but drink if I want to and just have a normal life. I felt like it hasn't been normal for the last couple of years, just moving and never liking it there...

Catherine:...what do you mean by stability?

Annie: Just routine things that you do every day in a flat or a shared flat, whatever...having a cup of tea, having stability...I mean by things all being there

that are mine and that remind me of myself. Like yeah, just stability in being familiar, having familiar things around me.

Iris:...at [accommodation and support service for women with mental disorders] we pay 30% of our income. That covers our bills as well so we don't have to worry about the electricity, the gas, phone, and you're safe, you're secure...You have the freedom and the space to actually attack your problems which you don't have when you're fighting to have a roof over your head, or fighting to find \$25 to buy a weekly so you can sleep on buses or whatever and when you're not on the pension you can't do the \$3 ticket and ride to Newcastle and back on the train...

Jamie: It's [mental health] better than it's ever been. It's stable and this is the first time that I've ever had security and I've been able to, my perception's been, the first time that I haven't had abnormal thinking and stuff. Because your thinking and your attitude has a lot to do with your surroundings; it sort of flows into your surroundings...Like I didn't have much dignity before and I have a cycle of abuse and abusive relationships and just be around, just sort of better the devil you know that the devil you don't sort of thing. And I would just accept that my surroundings is not very safe or whatever, whereas these days, I don't settle for anything that ruins my self-esteem or those boundaries sort of thing. I'm getting the help I need.

Not being able to settle in one place, or feeling as though things just weren't right, were common themes in both the in-depth and survey interviews. Feelings of not belonging, of the need to move on, of searching for peace as Tara put it, were part of many explanations of housing trajectories. Ironically, as Jamie pointed out (above), through constantly having to move, she couldn't *move on* with her life. It was only through finding a point of stability, as she argues above, that she felt able to establish boundaries and look forward. Feeling 'rooted' in a place was a key reason for the success of tenure.

As Annie suggested, finding a point of stability was about finding stable housing and being able to reinforce a sense of identity through the creation of familiar space. As Jamie's story suggested, however, stable housing took a particular shape. Although holding both housing commission and community housing flats in the past, it wasn't until Jamie had support with her housing and medication and what she described as *validation* that her situation became more stable:

I guess I found that in being validated is the biggest thing. Rehab was the start of it...It was ok to complain there, where it's not when you come from a middle class family [where] having problems is foreign...I was never validated because there wasn't any problem.

Through rehab, counselling and through the support of the accommodation service, Jamie felt that her abuse within her family and her illness were recognised. In the accommodation service, an understanding of aspects of her illness, for example her 'hoarding problem' were accepted. She felt accepted: 'I found...when I had nothing to prove, they had no expectations, I...find that I move so much more, I moved further than I've ever moved before.

In other words, while a point of stability was often discussed simply in terms of a need for long term accommodation, there were in fact many factors which needed to come together to construct that stability, including good medication, validation and support, affordability, location and acceptance. While the mix of factors might be different for each person, the fundamental point is that given the multiple issues each participant discussed, a point of stability needed to be worked towards at multiple levels, not just through accommodation or through medication.

4.3.5 Trauma and Healing

Traumatic experiences of abuse, violence, relationship breakdown, accidents and death peppered most accommodation trajectories and were key reasons for breakdown in accommodation. Traumatic events might be repeated (for example, abuse) or random (for example, one participant had a family member killed in the Port Arthur Massacre in Tasmania

and was a part of the local community). What was perhaps most startling was the repetition of these experiences throughout participants' life spans, short or long.

Repeated through interviews were comments about the need for community, the need to talk, to work through the grief and trauma often at the heart of, or a critical trigger of, mental disorders. Part of moving towards a point of stability as Jamie's comments suggested, was being able to share experiences of abuse and feel acceptance and understanding of symptoms of mental disorders, rather than sustaining a temporary lifestyle in which movement through accommodation matched temporary measures to block out symptoms of illness or experiences of abuse.

It was clear, however, that in their experiences of mental health care, many struggled to have the links between mental disorders and other issues recognised or dealt with. Jamie, for example, discussed being helped with symptoms of her mental disorder, such as drug and alcohol abuse or physical injuries. She slit her wrists and said that she was sewn up in Emergency and sent back to her violent family situation. Overwhelmingly, a critique of the mental health system was the failure of mental health staff to spend time with clients, a lack of interest in getting to the root of important issues through talking or counselling, and a dependency on medication to produce a quick fix:

Adrian (45)...they're using what they call the medical model, which is basically medication, and that's it...there's more to treating the illness than medication.

Iris: ...the community mental health centre don't provide case workers unless you're really in a major mental health problem and that's only a bridging thing until you get stabilised. And then you drop out because their case loads are so huge that they can't afford the preventative thing of having a regular contact with people...

Zac (22)...in the psych ward...they just turn around and say, 'Off you go! Have a nice day!' as soon as you have some sort of medication and calm yourself down. And a couple of months later, it happens again and it keeps happening and happening...

Petra...they seem to over medicate people. Like I came up against a lady the other day and all she really needed was to cry...I took her out into the dining room area and she just wailed hey, cos some of the horrific things that had happened in her life...She needed someone more professional there to bring her out and I realised she had a mental problem from when she came here...There's not enough services available for those types of people and they're abused.

Roxie: I think if I had of just been given counselling or something...I don't think being put in a psych ward is right...I was thrown in with adults...

Ben: I was at the mental health ward at the hospital the other day. You're enclosed in a room that you can't get out of and you've got a mattress on the floor...That's not going to make you get better, that's not going to help you...Jail would probably be nicer, because yeah, you're locked in a room, but at least you've got – if you can afford it – at least you've got a TV in your room and you've actually got a bed...You're not left alone all the time. During the day you're out and about in the yards and stuff...

Tara...you know, the patients in mental health, truly, my experience for hospital was we helped each other. There was nothing in there that them nurses did except give us medication...and your doctor, like I said, ten seconds and away you go and you don't dare try and get into something because you know you're not going to get time to finish it. Then if you go out and carry that shit...for the rest of the day...and it might be quite detrimental to where you're at...

Tara...we don't talk about the shit that needs to be dealt with. And it's not going to be overnight...I've got 33 years of my life to work through!

4.4 Conclusion

The intensity and complexity of each individual's life experiences are overwhelming. While it is clear from interviews that points of stability are central to breaking cycles of trauma and incidents of unmanageable illness, limited supported accommodation and limited holistic approaches to mental disorders reduce the likelihood of possible exit points. In in-depth interviews and in the survey data, it was accommodation and support services for homeless people which appeared to provide core and holistic support for participants' mental health issues.

Chapter Three provided an overview of the structured disadvantage underpinning iterative homelessness. Revealed were low educational levels and unemployment, poor general health, poor experiences of high rates hospitalisation and incarceration and so on. In terms of examining what drives trajectories of iterative homelessness, sustained poverty and illness can be seen as the basic motors of experiences of prolonged movement through tenuous housing.

What this chapter develops is a finer examination of issues and experiences surrounding the instability of accommodation. The translation of poverty and illness into immediate life experience shows the roles in trajectories of iterative homelessness of, chance [the death of a kind landlord], a context of chaos, trauma [sexual abuse, car accidents] and violence [a random psychotic attack, prolonged domestic violence] and the vital breathing space/reflective space provided by points of stability [Alcoholics Anonymous, supported independent accommodation].

At the immediate level, vulnerability, survival strategies, chaos, the search for stability, trauma and the fundamental need for healing were all key factors which shaped movement through accommodation, the length of stay in accommodation, and the types of accommodation individuals sought out. The decision to move could be related to the restlessness associated with Obsessive Compulsive Disorder or the fear and difficulty of maintaining relationships associated with Borderline Personality Disorder. The decision to move could be a strategic choice or be driven by desperation and addiction. Movement could be decided by others – by eviction, violence and crime. Illness itself might force the temporary abandonment of independence and a return to the care of friends and family or hospital. Multiple factors may lock together to sustain periods of intense chaos and transience.

It is clear that no one factor propels people through accommodation. No one factor propels people in their search for points of calm and stability. Further, it must be remembered that accommodation trajectories take place over time and within the context of exclusion outlined in the previous chapter. There is no one factor that sets a trajectory at a particular tangent, but multiple incidents and factors that connect with different life stages [with youth, with parenthood, with marriage, with old age], with bad luck, with random events, with haunted pasts and with the sometimes unknowable and unpreventable rhythm of periods of mental illness.

The central aim of this chapter has been to illustrate key elements of the lived experience of iterative homelessness in the added context of mental disorder. The concern has been to demonstrate how multiple factors combine to perpetuate the search for housing which can at last become a point of stability. The following chapter extends analysis begun in this chapter and the previous one by seeking to make further sense of the array of immediate and underlying factors which drive this search.

5 THEORISING ITERATIVE HOMELESSNESS

Having indicated the need to understand individual iterations of homelessness, such as those presented in the previous chapter, as well as patterns within the iterations, this chapter presses on with the task of developing a broad conceptual understanding of the dual contexts of iterative homelessness and mental disorders.

Understanding the very specific dual contexts of iterative homelessness and mental disorders requires an understanding of how structured disadvantage is lived in the everyday. A listing of key areas of disadvantage is critical; seeing how these factors interact is also important. Seeing the translation of the structured disadvantage of poverty and mental disorders into experiences of sexual abuse, violence, crime, drug use and grief, highlights the need to see often branded 'individual' characteristics as structural ones.

Illustrating the connectedness of issues in every day life is also an important step in developing intervention and support which make common sense to people like the participants in this study. Further, seeing an issue such as unemployment *in context* suddenly highlights the range of other issues which simultaneously need addressing for someone like Tara, for example, to find work.

Perhaps most importantly, seeing the cumulative effect of structured disadvantage in everyday life is to see the development of compounded trauma. In other words, in order for Tara to find employment, for example, not only do the issues of stigma, discrimination, Tara's behaviour and drug management need working through, but there is also a need to work with Tara's sense of hopelessness, an expectation of rejection, and the continuing effects of years of domestic violence compounding years of earlier abuse from her mother. As Tara says, 'I've got 33 years of my life to work through!'

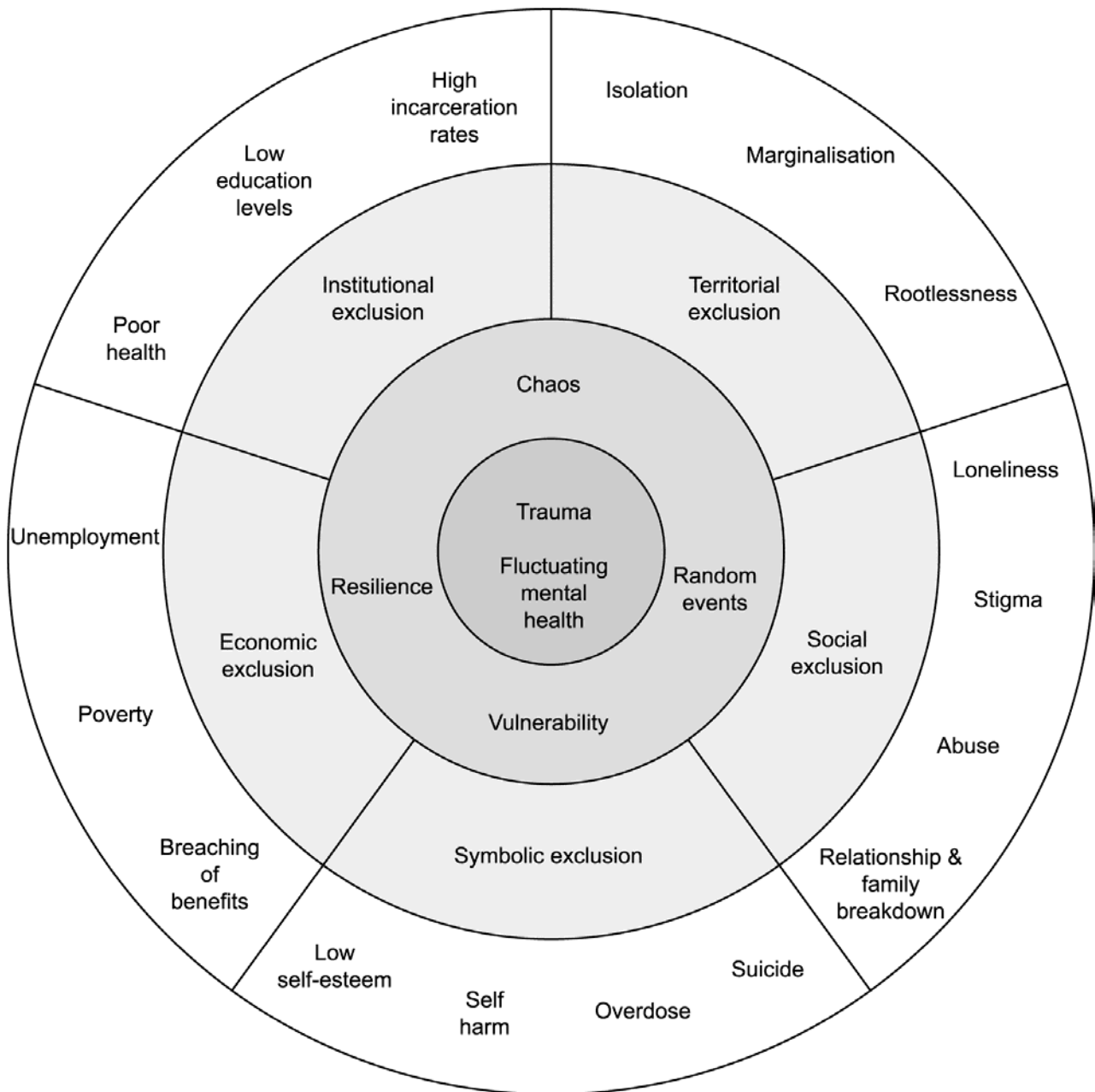
Harris (personal communication, 5th March 2003)⁶ argues that trauma passed from parent to offspring results in the development of few appropriate coping mechanisms. In each area of life, the child begins to suffer because of their lack of management and relationship skills. This situation is further compounded by experiences of trauma, rejection and failure that the child then experiences as he/she grows older. In Harris' experience of working with homeless people and in mental health, the need to provide a point of stability from which to work on coping mechanisms is absolutely essential. She argues that working on health, income, education/job skills is also essential. Without the simultaneous development of positive and appropriate coping mechanisms, however, even in an improved situation in which an individual may have been supported to find housing and organise income, for example, an immediate return to homelessness is inevitable as soon as the individual encounters a significant event such as the death of a parent, relationship breakdown, a period of stress, and so on (see Roxie's comments, p.27) (Harris, personal communication, 3rd March 2003; Palmer, personal communication, 24th January 2003).⁷

While of course, the path each individual takes is unique, as demonstrated below the central conclusion of this research is that breaking the cycle of iterative homelessness not only becomes a matter of addressing poor health, poor education, poor employment and limited housing options as linked issues, but a matter of working through improvements in health, education, employment and housing *to heal the individual*. The stumbling block then, is that this requires more than medication, more than housing placements, more than training courses.

⁶ Amanda Harris, Psychologist, Baxter Detention Centre

⁷ Caryl Palmer, Clinical Nurse Consultant, Rozelle Hospital

5.1 Factors underpinning iterative homelessness and mental disorders



Adapted from Coleman (2000: 20).

The aim of this typology is to draw together and situate a range of issues and factors at play in the iterative experiences of homelessness of those with mental disorders. This is not an exhaustive listing of the key elements of iterative homelessness, but is an attempt to systematise a way of thinking or imagining the layers of factors which sustain the ongoing struggle to maintain appropriate accommodation. The typology consists of 12 key elements:

Iterative homelessness – a concept introduced in this research meaning the repeated and ongoing loss of, or movement through accommodation in both the short and long term contexts of homelessness. This concept has been proved useful in a context in which 69% of recorded periods of accommodation lasted for only 6 months or less. It highlights the range of housing and shelter (marginal housing, public and private housing, rough sleeping) through which homelessness takes place, and highlights *movement* through accommodation as a key indicator of homelessness.

Fluctuating mental health – mental ‘illness’ is an extremely fluid concept covering a range of varied symptoms which impact differently on each individual. Most people in the study managed their disorders day-to-day but suffered periodic incidents of intense and incapacitating illness. The unpredictable nature of mental illness contributes to difficulties in maintaining relationships, stable housing, employment, education etc.

Cumulative trauma – underpinning most accommodation biographies collected in this research were extreme and repeated traumatic experiences. It is argued here that trauma has a cumulative effect on the individual and can be considered a key factor in the maintenance of trajectories of iterative homelessness.

Vulnerability and resilience – homeless people with mental disorders are vulnerable economically, physically and emotionally. Emotional and economic vulnerability create a context in which the abuse, violence and standover of others (friends, family and strangers) is often repeated and difficult to escape. Further, the tension between extreme vulnerability and often problematic strategies of survival can compound vulnerability and place individuals at increased risk. Feelings of being unsafe or actual experiences of violence were key contributors to movement from accommodation.

Chaos – the linked nature of dimensions of exclusion and the tension between vulnerability and resilience feeds cycles of transience and networks of tightly interwoven factors which make it nearly impossible for people to make changes in trajectories of unsafe or inappropriate accommodation. At times, this intense entrapment may produce feelings of hopelessness triggering self-harm and suicide or may result in triggering periods of incapacitating illness.

Random events – these become very important in homeless mentally disordered peoples’ lives because of the already existing context of intense vulnerability and fragile coping mechanisms. Events might include the death of a friend or family member, a car accident, assault or theft and may necessitate or prompt movement from accommodation or contribute to a period of illness.

Dimensions of social exclusion – social exclusion, economic exclusion, institutional exclusion, territorial exclusion, and symbolic exclusion are five key areas of disadvantage which link to homelessness. It was earlier argued that homelessness could be usefully reconceptualized as a form of social exclusion to draw attention to the range of issues which coincide in the maintenance of iterative homelessness, as illustrated in Chapter Four.

Presenting issues or ‘symptoms’ – self-harm, over-dosing, drug, alcohol and inhalant use, aggression, depression and suicide attempts may be understood as ‘symptoms’ of forms of social exclusion as well as of deeper issues of cumulative trauma and mental disorder. These symptoms all have problematic impacts on housing and housing relationships.

Paralleling Coleman’s (2000: 20) conceptualisation of a ‘healing framework’ in the context of indigenous women’s experiences of homelessness, the key elements of iterative homelessness are arranged in layers on a wheel. The healing framework is used at this point to demonstrate how different factors relate to each other, with ‘core’ or underlying issues at the centre fanning out to what Coleman (2000: 21) calls ‘presenting issues’ or symptoms at the rim. In this adaptation, inside the rim of presenting issues is a layered core of key issues:

- a layer of forms of **social exclusion** (each of which can be connected to particular resulting symptoms or presenting issues),
- a layer of **immediate, every day issues** through which forms of exclusion are often experienced,
- and at the centre, fundamental experiences of **trauma and fluctuating mental health** (often associated with each other).

While the approach has been adapted and expanded for use in the specific context of iterative homelessness and mental disorders, Coleman’s (2000: 21) understanding of the framework remains pertinent for this research:

Addressing the outer rim can bring about change in that part of the wheel only. By addressing the central issue, and the losses radiating out from there, changes can occur in both the outer rim (the symptoms) and the centre of the wheel (causes).

In the contexts of iterative homelessness and mental disorders, this research clearly demonstrates that the core issues of trauma and fluctuating mental health need addressing for any work on other related issues, such as self-harm, unemployment and suicide for example, to be productive. It should also be clear from this permeating network of underpinning factors that housing is just one aspect of the process of iterative homelessness. The diagram also suggests, however, that dealing with core issues in depth may in the long run reduce the huge range of issues each individual may face; and it is in this process of dealing with core issues that for many, housing will play a central role. In other words, while housing may be last on a long list of issues an individual needs to address, housing or accommodation options developed, not as 'the solution' to iterative homelessness, but as a central part of a holistic response, *will be critical* in the development of stability and health.

The current research has demonstrated that there is an important temporal dimension to homelessness that is often ignored in favour of more static definitions. This investigation has also identified a number of critical points in an iterative cycle where a framework could be drawn upon to assist with the prevention of an iteration of homelessness. A substantial number of respondents exited hospital, prison or juvenile detention without appropriate support or an understanding by policy makers of the issues and factors that virtually ensured they commenced yet another iteration of homelessness. In the future, the framework could be applied to the circumstances of each individual at these critical points to assist with the identification of the factors that characterise the homelessness experience. The healing framework (see Chapter 6) can then be used to tailor solutions that will address a person's unique constellation of vulnerabilities.

The framework is the central contribution of this research and draws together the key issues and research evidence. In summary, the framework highlights,

- The complex nature of trajectories of iterative homelessness.
- The multiple layers or dimensions of social life which both impact on, and are impacted by, iterative homelessness.
- The need to focus on the individual and their specific experiences of mental disorder and trauma.

6 RESEARCH IMPLICATIONS: 'I'VE GOT 33 YEARS OF MY LIFE TO WORK THROUGH!'

This chapter aims to work through the implications of the analysis and typology built through the last three chapters. The chapter specifically addresses the fifth and final research question by considering changes needed in current policy and practice to improve the stability of accommodation of homeless people with mental disorders. Issues within health and housing are discussed including recommendations made by participants. An important contribution of this chapter is the development of a framework for an appropriate response to iterative homelessness and mental disorders. Overall the aim of the chapter is to raise questions about the 'fit' of the needs and issues of participants identified through the research, with the current policy and service response.

The value of this research lies in its graphic depiction and analysis of the key factors interweaving to sustain experiences of iterative homelessness for those with mental disorders. Further, this research demonstrates the range of housing an individual may move through in his/her trajectory of unstable housing. The experiences of individuals as they struggle with finding accommodation which meets their needs have been highlighted as well as startling figures indicating the commonality of exclusion from work, education, good health and income, high incarceration rates and so on.

At the centre of the analysis presented here is a focus on the experiences of trauma accumulated by the individual. These traumatic experiences are structured through a range of exclusions and vulnerabilities and in themselves become a key barrier to the maintenance of accommodation and the consistent management of mental health. Coleman (2000: 25) refers to accumulated trauma in the lives of homeless indigenous women as 'lifestyle trauma'. This is a concept which has direct relevance for homeless people with mental disorders. Lifestyle trauma and specific traumatic events feature clearly in accommodation biographies and survey data as key contributors to trajectories of unstable and unsafe accommodation.

Three key issues stem from these findings:

- Given the overwhelming impact of traumatic experiences on everyday survival, there seems to be relatively little recognition, understanding or exploration of these experiences in relation to homelessness.
- The link between experiences of trauma and the management of housing and mental health is not explicitly made at a policy level or coherently pursued at a practice level.
- The answer to the question, 'Who has responsibility for addressing life trauma?' is unclear.

6.1 Whose issue is life trauma?

An important and developing step in State and Federal policy is the recognition of the linked nature of problems facing homeless people with mental disorders. As the Commonwealth Advisory Committee on Homelessness (1998: 11) argues,

Homelessness among people with mental disorders is a multifaceted and complex problem for which the causes are numerous and inter-related. Responding to the social and health factors giving rise to this phenomenon is the responsibility of not one instrumentality...'

This research demonstrates resoundingly the need for, and value of, such a 'multifaceted' approach, particularly in the areas of prevention and early intervention. While it must be recognised that the partnership approach is a new one and there is still much more to be developed in implementing it, a key implication of this research, however, is that the core part of the issue of iterative homelessness seems to fall outside the division of interests of policy.

The research findings seem to suggest that the ultimate segmenting of individual's needs results in the leaving of difficult, time consuming core issues, to 'someone else'. The cumulative and independent effect of all forms of exclusion, rejection, generational poverty

and abuse, assault, accidents – trauma – *at the site of the individual* remain inadequately addressed. And yet it is argued by those with experience working with homeless people with mental disorders, that unless grief is addressed and attention given to the development of core, positive coping mechanisms, for example, then stability gained in any ‘slice’ of an individual’s life may be short lived.

6.2 ‘Someone else’ should provide what?

The research shows that homeless mentally disordered people have little faith in the mental health system and a widespread belief that there is little capacity within the system to provide meaningful case management or therapy or counselling. The operation of a ‘medical’ rather than a ‘therapeutic’ model is seen to be the key issue. Overwhelmingly, support with mental health and related issues was sought and given through services targeting homeless people. It is clear, however, that few of these services are equipped to handle the specialised support needed, particularly in the case of homeless people with mental disorders. Further, it is also clear that under pressure some of these services may exclude mentally disordered clients because of their ‘high needs’ and contribute to the cycle of tenuous accommodation by ‘moving on’ difficult clients.

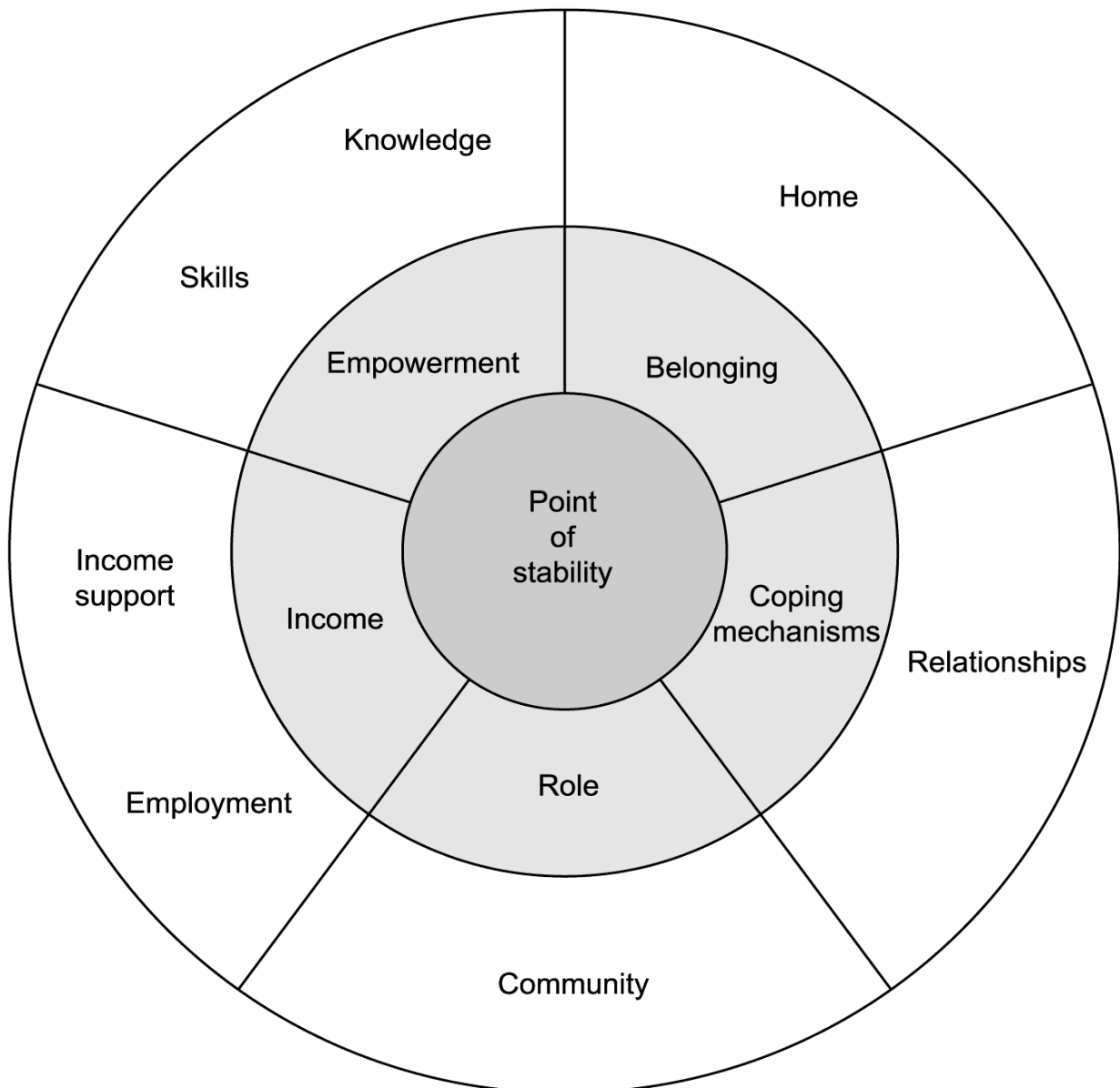
Despite an awareness of the crisis in current accommodation and support services, an outline for a strategy of collaboration by NSW Health and NSW Housing, the NSW Government Action Plan for Health (2002: 13), states,

It is important that consumers have access to health services that are provided independently from housing services, therefore housing should not be provided by NSW Health. More over, health workers are skilled in the provision of healthcare services not the management of property or assets...Accommodation support services should be provided by the NGO sector.

It would seem that for many of the people taking part in this research, however, mental health, accommodation and support services are *all* being substantially provided through the NGO sector. Surveys showed that accommodation and support services, which often struggle for funding, are providing the core daily contact needed to encourage the trust that might open more sustained and therapeutic relationships. These relationships are central in providing a context of support and guidance; at its most basic level, this is a context needed to keep people out of prison and out of hospital.

At the heart of these issues is the inadequacy of the current system to respond to the needs of homeless people with mental disorders because there is an inadequate conceptualisation of what these needs are. This research supports the ‘Down and Out’ study (Hodder, Teesson and Buhrich, 1998) undertaken with clients of inner-city homeless services in Sydney which found that 100% of women and 98% of men had experienced an extreme trauma event (such as rape, murder, assault), the majority of people have experienced physical or sexual assault, and that multiple experiences of traumatic events are common. This research shows that a key need in the context of iterative homelessness and mental disorders is the need for the healing of cumulative trauma. Healing for each individual will mean very different things and may require varying levels of support. Broadly, however, drawing on the research data and using the concept of the healing framework developed by Coleman (2000: 20), a conceptual frame of healing for homeless people with mental disorders is included below.

6.3 Responding to iterative homelessness and mental disorders: A potential healing framework



Adapted from Coleman (2000: 20)

Similarly to the first 'wheel', this framework is not an exhaustive summary of the key mechanisms of an appropriate response to iterative homelessness and mental disorders. It does attempt, however, to draw together the key issues raised in interviews and surveys with homeless people and with the numerous professionals who also offered analyses of how best to approach the complex needs of their clients. As such, the framework represents a second major contribution of the research.

- The outer rim represents key **desirable outcomes** for homeless people with disorders. These may include maintaining positive personal relationships, establishing a place and network within the wider community, returning to education, and developing a physical, spiritual and emotional sense of home through these networks, through employment and so on.
- These desirable outcomes are in turn related to some **core aspects of stability and healing**. These key aspects of stability and healing are practical responses to issues of

structural and multiple disadvantage as well as responses to repeated emotional and spiritual hurt, betrayal and loss.

- At the core is a **point of stability** through which the process of healing might be initiated.

Embedded in the findings of this report, this framework suggests the need to work with individuals from a point of stability...

- towards a basic level of trust...
- with the longer term aim of equipping individuals with the tools and confidence to...
- develop their own level of independence at a practical and emotional level.

As noted, this framework does not include all potential elements of healing, but pivots on the theme repeated in survey and interview data – the need for a point of stability. In turn, this needed point of stability pivots on the provision of mental health, housing and support services designed with an awareness of how compounded exclusion and vulnerability translate into specific survival strategies and traumatic lifestyles. In other words, in order to use policy and practice within the arenas of health and housing to address iterative homelessness for those with mental disorders, services with the capacity to build relationships with clients are essential.

A central policy implication of this research is that, in the specific circumstances surrounding the experience of repeated and often ongoing homelessness, housing and mental health management will continue to break down as long as service provision is ‘outcome’ structured and that the answer to iterative homelessness is accommodation alone. Better partnerships between government departments will not provide better outcomes for homelessness people with mental disorders unless they are accompanied by staff, time and resources to work with individuals and their specific issues.

The central point to come out of the research is that the effect of iterative homelessness and the effect of experiencing mental disorder *grows* and becomes *much more* than the need to address housing and stabilise mental health even though these remain primary issues. Much work is needed on the range of related and accumulated issues complicating stable housing mental health such as relationship and trust building, domestic violence, abuse and drug and alcohol addiction, budgeting, cooking, and so on. The further implication of this is that people require a range of points of stability and support to address issues and prepare, emotionally, physically and financially, to make choices about their accommodation options, including independent living.

For some, points of stability may need to come through the provision of supported accommodation – for some, crisis accommodation might be needed, for others long term accommodation might be needed.

Iris:...yeah it's [accommodation support service targeting women with mental health problems] made such a difference because you have that space and you have that support when you've got to do things. You've got the support here to help link you into local GPs, for example, who have an interest in mental health, and assisting me to find a psychiatrist who could meet the needs that I had. I couldn't work with a male it had to be female... And I've taken on the...Church as a result of the childhood sexual abuse and they were there to come with me to the interviews, that sort of thing I couldn't have done. Basically if you're homeless you can't do it because no one can contact you. There's a whole lot of issues, its not just having nowhere to sleep but its, yes, you don't have a point you can be reached.

For others, the provision of accommodation based support may be inappropriate or need to be accompanied by other services:

- some may need help maintaining stability in their own housing (for example, those in public and private rental);

- some may maintain tenuous housing but rely on support groups as a point of stability (for example, those in boarding houses);
- some may require the specialised support of groups to maintain stability (for example, Alcoholics Anonymous, parenting support)
- some may be extremely chaotic and highly transient and need support and stability provided through outreach and drop-in centres (for example, those sleeping rough).

Indeed, as Bachrach (1996: 325-238) has strongly argued, the focus on stable housing alone may be seen as misguided in a context in which restlessness and high mobility are key coping mechanisms for some homeless people with mental disorders. A point of stability, then, should be seen to revolve around *diverse* elements such as ongoing relationships, basic day services, support groups and short and long term accommodation.

6.4 Research Implications

This report strongly emphasises the need to view the issue of the repeated or iterative homelessness of those people with mental disorders holistically. A holistic view of this issue requires more than working to better link and coordinate current services. This report demonstrates a need to refocus understanding and representation of the issues this group faces. This report suggests a pressing need to develop a *national discourse* about the role of repeated trauma in driving iterative homelessness and about the centrality of stability and healing in developing appropriate responses. Concepts such as stability and healing focus attention on the lived reality of homeless people with mental disorders and promote a framework for responding to this lived reality which is unified, relevant, and inclusive of all areas of government. These concepts could also act to unify policy and service and program aims. While there is still much work to do, elements of these two key issues are summarised below:

- Stability

There is a need for a point of stability – whether developed through housing, drop-in centres or support groups – to sustain and build relationships with individuals. This should be viewed as a resource saving mechanism in the context of the demonstrated ongoing cycling through accommodation, prison, hospital, support services etc.

- Healing

There is a need for support, housing, and mental health care to be set within a targeted, case worker and key worker based service sector which can provide sustained one-to-one relationship building with clients. Underpinning this sector should be an awareness of the diversity and vulnerability of individuals and therefore, of the diversity and vulnerability of the care being delivered.

The key contribution of this research is the development of a clearer understanding of the importance of a point of stability and the need for healing for those homeless people with mental disorders. As stated, a conceptual change in the way in which iterative homelessness is imagined and understood is the starting point for a national agenda more clearly focused on ‘underpinning’ rather than ‘presenting’ issues.

Also presented in this project were a range of specific findings about housing, health, support and institutional neglect. The implications of these are considered below:

6.4.1 Housing

- This study shows a critical lack of safe and stable exits from homelessness for homeless people with mental disorders and a clear need for support to make housing work. There is a need for an accommodation sector targeting homeless people with mental disorders (and their related issues). This sector must provide a *range* of accommodation for different age groups - crisis, medium term and long term – with specialised support. This in turn would address gaps opening in SAAP service provision to those with mental disorders and dual diagnosis, and free existing non-targeted accommodation for other clients, particularly in the case of crisis accommodation.

6.4.2 *Mental Health*

- This study shows alienation of clients from the mental health system. There is a need to challenge the 'medicalised' domain of health departments. There is a need for greater resources for return to the wider use of holistic health care including *ongoing and preventative* case management and the provision of free counselling.

6.4.3 *Support*

- This study shows that the experiences of iterative homelessness and mental disorder may have an effect on all parts of an individual's life. This study shows that homeless people with mental disorders may need intense support to access, utilise and maintain the housing and income support offered by government. Much more attention needs to be paid to the 'fit' of people with traumatic lifestyles with current policy foci and service delivery. Ownership of support and trauma issues needs to be taken at a policy level. This research demonstrates a strong case for the implementation of a 'key worker' model in which individuals' access of services and every day needs could be mediated on a one-to-one basis.

6.4.4 *Institutional neglect*

- This study demonstrates high incarceration and hospitalisation rates, the lack of exit planning and a significant proportion of exits from these institutions onto the street. This study reveals a critical need for a standardised and compulsory system of accommodation and support assessment at exit from hospital and prison. Further, this study reveals the need for ongoing relationship and support building within the community following exits from prison and hospital.

6.5 **Recommendations from homeless people with mental disorders**

As well as generating data critical for the analysis presented here, homeless people with mental disorders also offered their own analyses of what drives iterative homelessness and how best to respond. Included below are two statements (preceded by a summary made by the author) which capture and summarise some of the key issues discussed by participants in the research. These statements are taken from transcripts of recorded conversations and are reproduced at length here in order to retain a sense of the passion and insight of these participants. Further, these statements remind researchers, policy makers, and service providers alike, of the wealth of information and knowledge held by homeless people with mental disorders themselves.

6.5.1 *Housing*

- Supported and community integrated housing with rent adjusted to income level is needed to prevent iterative homelessness

Catherine: So what do you think is the first message that you would try and send out?

Iris: That housing is so vitally important. Housing that's integrated into the community, that is not little enclaves, not mini institutions or anything else. That prevention is better than cure, it's been around for a long time that philosophy but it seems with mental health people still can't acknowledge it... If people who are mentally ill can be more comfortable with it and that comes from more community acceptance to a degree, then they're going to be more aware of what's happening with them and not so afraid to go out and look for help

...but you, if you don't have a solid home base you don't have a safe place to go then you can't do most of the other stuff and services can't come to you if you don't have a home base. I know there was a protocol written up many years ago between Mental Health Community Services and Housing on three way support which protocol, I've got a copy of it and of course, I don't think anyone's ever implemented it. But Housing and Mental Health do need to get together, they do need to acknowledge that putting people with mental illness into ghettos like

South Coogee is a no, no cos they can't cope with it...A woman I know who's been living in South Coogee for years and she's been beaten five or six times and robbed just going from the bus stop to her front door and it's a bit terrifying. People with mental illness can't cope with that...So I would love to see more supported housing or more community type housing out there that there is a drop in support thing, like, there's a lot more housing out there for people with intellectual disabilities than there is for people with mental illness and yet the mental illness can be temporarily a lot more incapacitating. You need that security.

I mean if I go back to work and I or when I go back to work, and say I work for 12 months and something happens and I fall down in a heap again, ok I'm not going to have had time to have millions of dollars in the bank or anything, so what happens to my housing? I lose it again and I have to start work. Where if you've got some sort of community, supported community housing that ups and downs your rent as your income goes, you can stay there when you're not well but there will be something there to connect you up when you start getting ill so that you don't have to go through that cycle and the older you get the harder it gets. I mean I know I was quite suicidal when I was in a refuge and I spent a few nights sitting on the train tracks, the only thing that stopped me was that the poor bastard who hit me would have to live with it, and I couldn't do that to someone else. It was like, I'm getting too old for this, I'm 54 next month, I don't need to be doing this again...

6.5.2 *Mental Health*

- There is a need to challenge the medical model being used in mental health and to approach treatment and individuals holistically

Adrian...I think the service has sharply declined and they're using what they call the medical model which is basically medication that's it and I was saying to Natasha today, that's the nurse who looks after me, she's also one of my inner circle, and I was saying look, or we were saying, there's more to it there's more to treating the illness than just medication. Things like groups, things like familiar staff, more beds, yeah, probably too. I'd put in better pay for mental health professionals because they must need it to attract people to the job. Some will do it for dedication but you don't know for how long, if they get a better offer financially they're going to take it which means more money in training mental health professionals.

Catherine: So what other things do you think are important in treating mental health illness? You say groups – what do you mean?

Adrian: Well, there's current affairs groups for instance - discussing an article out of the newspaper. There's pottery, what else, group therapy discussion groups.

Catherine: What is it about those that you think are helpful?

Adrian: For pottery I think getting your hands dirty with clay is very healing, it has an earthy thing about it. Current affairs groups to keep people aware at least a little bit, maybe encourage them to take an interest in the world outside and get their mind off their problems. Teach them to think also...the ability to think gets very impaired after mental illness. Discussion groups where people have issues or might have problems that they want to bring out. Cooking lessons, if people can cook for themselves they can survive better in a room or whatever, if there's cooking facilities.

7 CONCLUSIONS

At state and Federal level, a range of government departments are battling to come to terms with the difficult issues surrounding iterative or repeated homelessness and mental disorders. Support and accommodation services are similarly battling with the every day lived reality of these dual contexts. This research has been able to demonstrate that there are some significant gaps between these two levels of response, gaps which in turn impact on the relevance of service delivery models for clients. Further, given many study participants' experiences of discrimination, stigma, or lack of understanding of their mental health, it is also clear that the wider community remains insulated from the stark realities of coping with mental disorders and iterative homelessness.

In this research, part of addressing these gaps at a practical and conceptual level has been to focus on, and actually illustrate, trajectories of iterative homelessness. As early indications suggested, it was found that the experience of repeated moves through accommodation in the marginal housing sector and beyond was common amongst those with mental disorders. Accommodation ranging from public and private rental through to caravan parks and literal street dwelling was found to constitute these trajectories. This finding challenges any assumptions that housing risk should be associated with the marginal housing sector alone and underlines the importance of understanding iterative homelessness as a trajectory which can include stays on the street, in institutions, in private accommodation, with family and friends and so on.

A web of factors was found to underpin the experience of iterative homelessness in the context of mental disorders; these factors affected each individual in different ways. Research data illustrated a range of connected arenas of extreme disadvantage and exclusion. Social, economic, institutional, spatial and symbolic exclusion translated for participants in this study, into difficulties maintaining social networks, extremely low income, unemployment, low education levels, high incarceration rates, poor general health, isolation, discrimination and extremely low self-esteem.

In turn, this seemingly immovable grid of disadvantage was negotiated and challenged by participants throughout the life course. Participants detailed periods of extreme chaos marked by drug use, transience, violence and poor general and mental health, as well as periods of work, education, good family relationships, stable general and mental health.

This research illustrates a backdrop to these 'good' and 'bad' periods, of extreme violence, abuse, assault, domestic violence and life trauma resulting in, and/or exacerbating, mental disorders. It is argued that little recognition or exploration of how this backdrop interacts with trajectories of illness and iterative homelessness exists in the current policy framework, though service staff deal with these issues on a daily basis, sometimes without adequate staffing or skills.

It is argued that effective responses need to be pitched with the aim of *healing* the individual by equipping him/her to better cope with accumulated trauma and by working towards practical improvements in his/her immediate situation. Underpinning such an approach is the need for a point of stability – a point which may be constituted by accommodation, a drop in centre, a key worker, a support group – and most likely, by the coincidence of all of these and more.

It is clear from this research that responses to homelessness which fail to address the core issue of trauma in particular, and its immediate mental health and other impacts, fail homeless people doubly because of the often short term intervention made. Rather than acting to break exhausting trajectories of iterative homelessness, these short term measures simply add in another experience of uprooting and underline many homeless people's sense that there are simply no avenues to be heard in full and have the incredible complexity of their issues appreciated and understood in any depth.

The key point here is that **stable accommodation alone will not 'fix' the issue of iterative homelessness in the context of mental disorders.** Many participants in this study indicated that they had had secure accommodation in the past. What is needed is a system

of accommodation, support, and mental health care with the capacity to form ongoing relationships with clients, and to respond to the destructive experiences layered under presenting disadvantage and distress.⁸

⁸ In terms of successfully housing people with a psychiatric disability, O'Brien *et al* (2002: 71) similarly note the critical formal and informal links of housing and support and the potential waste of resources when the balance of infrastructure and support is not struck.

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