Care as a Pathway to Homelessness

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Abstract

Homelessness is a complex issue. The pathways that lead to homelessness are often adverse events, rooted in childhood and early adolescence. Emerging evidence suggests that high prevalence of care histories correlate with people experiencing homelessness. The purpose of this research is to understand how care experience functions as a pathway to homelessness. A thematic analysis of six interviews formed the basis of the analysis. Through these interviews, it was revealed that each participant's childhood experiences was underpinned by trauma, which became a key trigger for participants' pathways into long-term homelessness. The results of this research hold many implications for government policy settings and service providers.

Keywords: addiction, adolescence, children in care, homelessness, homelessness pathways, trauma

Introduction

Homelessness is a complex issue affected by many risk factors. These factors may include childhood trauma, mental illness, poverty, crime, domestic violence and addiction. The risk factors have been well researched (Al-Nasrallah et al., 2005; Kim, Ford, Howard and Bradford, 2010; Curry and Abrams, 2014; Beaton, Cain, Robinson and Hearn, 2015; Woodhall-Melnik, Dunn, Svenson, Patterson and Matheson, 2018). Given this complexity, it is perhaps helpful to approach issues surrounding homelessness in a systemic manner. International evidence that links high prevalence of care histories with homeless populations (Fowler, Toro, and Miles, 2009; Curry and Abrams, 2014) underpins much of this research. To date, there has been limited research investigating pathways to homelessness in New Zealand, despite the most recent Auckland Homeless Count conducted by Housing First Auckland (2019). Of concern, 44.7 per cent of participants reported experiencing foster care or a group home as a child. However, the extant literature shows little understanding of this correlation in the New Zealand context.

The goal here is to understand how the experience of homeless individuals relates to their experience of care as children or youths. In understanding the common characteristics of the experience of homeless populations with care history, we may also better understand the pathways that first led to homelessness. This research has important implications for both government policy settings and the associated service providers. Service providers require targeted strategies to prevent homelessness for at-risk groups of young people who are leaving care. In fact, even the government announced recently that additional funding should be extended to support young people transitioning out of care up to the age of 25 years (Treasury, 2019). This research seeks to answer, ‘What trigger points in the care system lead young people to become homeless either as an adolescent or as an adult?’.

The goals of this qualitative research are to answer three questions:

1. What are the common experiences of homeless people (or people who have been homeless) with care history?
2. What is the relationship between care experience and homelessness, and specifically, care as a pathway into homelessness?

3. What are the implications of the findings for service providers, government agencies and policy settings?

Context

Homelessness is a truly complex problem involving many risk factors including trauma, poverty, crime, mental illness and addiction (Al-Nasrallah et al., 2005; Kim et al., 2010; Curry and Abrams, 2014; Beaton et al., 2015; Kim et al., 2010; Woodhall-Melnik et al., 2018). These risk factors provide a useful framework to expand the understanding of social experiences and their impact (Clapham, 2002). Housing and homelessness may be viewed within the broader context of social constructivism—the assumption that individuals construct social life through social interaction (Woodhall-Melnick et al., 2018). In other words, we might theorise that, taken together, both past and present interactions with family, peers, community health and welfare systems all play a crucial role in shaping the conditions for social life, which subsequently affect housing stability.

Within the context of 'care as a risk factor for homelessness', it is useful to consider how care relates to other risk factors for homelessness. For example, early trauma is well-evidenced in the literature as surrounding both homelessness and children in care (Mcmillen et al., 2004; Bruskas, 2008; Foster, Beadnell and Pecora, 2012). Both groups, children entering care and individuals entering homelessness, are equally as likely to have experienced early trauma.

Two common types of studies investigate the relationship between foster care and homelessness. The first underlines overrepresentation of people with a care history in the homeless population. Conversely, the second examines the overrepresentation of homelessness among people with a care history. Making this distinction aids in our understanding of the experiences of homeless people from different points in their journey. This might assist in establishing different types of intervention strategies for government policy settings.

Care as a Pathway to Homelessness

We know from the international literature that, for many young people ageing out of care, the transition to independence comes with many challenges, including access to stable housing (Curry and Abrams, 2014). In fact, care experience is a well-established risk factor for

youth later becoming homeless (Fowler, Toro and Miles, 2009; Curry and Abrams, 2014). For example, studies have shown 20–30 per cent (Pecora et al., 2006) and 31–46 per cent (Dworsky Napolitano and Courtenay, 2013) of young people who have been in the care system also experience homelessness within a relatively short time after leaving care. Fowler et al. (2009) found that in the first two years following care, rates of homelessness exceeded 12.9 per cent. Moreover, one-fifth of the population had experienced long-term homelessness, and two-fifths had endured housing issues in the two years after exiting care. While these studies link care to the potential risk for homelessness, the trajectory into homelessness is not well understood due to the complexities of this population.

Trauma

Trauma is a significant theme in the literature surrounding homelessness (Al-Nasrallah et al., 2005; Kim et al., 2010; Beaton et al., 2015; Woodhall-Melnik et al., 2018) and children in care (Mcmillen et al., 2004; Bruskas, 2008; Foster et al., 2012). Trauma is defined as 'the direct experiencing or witnessing of life-threatening events or violation of bodily integrity and a subjective reaction of extreme fear, helplessness or horror' (American Psychiatric Association, 2006, p.1016). Psychological trauma can result from adverse experiences such as childhood abuse, domestic violence or parental death. The evidence suggests that traumatic experiences in childhood, direct or indirect, can set the scene for less social and familial support, risk of psychiatric disorders and normalisation of environmental instability (Herman, Susser, Jandorf, Lavelle and Bromet, 1998). The literature also indicates that the removal of children from their biological families may unwittingly expose them to additional trauma (Foster et al., 2012). Consequently, trauma can contribute to poor mental health and substance abuse, both of which affect a person's ability to secure and sustain stable housing (Kim et al., 2010). Additionally, the lack of stable housing affects individuals' physical health (Taylor and Sharpe, 2008), resulting in a downward spiral that poses other related challenges. The literature also highlights how intergenerational trauma is an important feature for Indigenous populations (Curry and Abrams, 2014).

Complex and Psychosocial Issues

The research shows that homeless people with care histories present a number of complex issues including mental illness, trauma, addiction (Curry and Abrams, 2014), emotional problems, behavioural problems, victimisation, adolescent parenting, criminal convictions and high school completion (Fowler et al., 2009). Issues surrounding the nature of trauma feature prominently across the literature in the context of interpersonal relationships, Indigenous heritage (Curry and Abrams, 2014) and parent neglect (Fowler et al., 2009). Pecora et al. (2006), for example, studied the intermediate and long-term effects of care on adult functioning. They discovered many examples of people living in fragile economic situations, with one-third living with household incomes below the poverty level.

Youth leaving care face a unique set of barriers to independence due to their backgrounds and history with the child welfare system (Curry and Abrams, 2014). The intersection between individuals' backgrounds and child welfare systems complicates causal relationships, rendering these more challenging to ascertain. It is unclear, for example, whether underlying issues (e.g., mental illness) drive the trajectory of young people into both care and homelessness, or vice versa. Dworsky et al. (2013) found that fleeing while in care, greater placement instability, being male, a history of physical abuse, engagement in delinquent behaviours and demonstration of symptoms of mental illness were all associated with an increase in the risk of becoming homeless. Undoubtedly, there is a gap in the existing knowledge in terms of understanding the causal relationships that drive this trajectory into homelessness (Curry and Abrams, 2014). We know, for example, that lack of housing affects psychosocial systems, which makes securing housing even more difficult (Fowler et al., 2009). However, because it is difficult to determine whether these complex issues occurred before, during or after episodes of care or homelessness, a firm link between care and homelessness is difficult to ascertain.

Impact of Colonisation

Homelessness is endemic to colonised countries, as cited in literature across New Zealand, Canada and Australia (Peters and Christensen, 2016). Many complex factors lead to homelessness; however, there is clear evidence that suggests that Indigenous people are

statistically overrepresented within homeless populations. Crucially, within homeless populations with care history, this statistical overrepresentation is even more predominant among Indigenous peoples (Curry and Abrams, 2014). Moreover, individuals identifying as Indigenous were more likely to report experiences of institutionalisation during care. Curry and Abrams (2014) further reinforced the sociocultural factors of colonisation and intergenerational transmission of trauma for Indigenous people.

New Zealand has systemic inequality. Such inequity disproportionately affects Māori people, who are more likely to live in poverty and face homelessness (Groot, Hodgetts, Nikora and Leggat-Cook, 2011). For New Zealand Māori, these effects have extended to the disruption of whanau, hapu and iwi structures, poverty and displacement through loss of land, disruption of traditional child-rearing practices, intergenerational trauma and racism (Groot et al., 2011; McIntosh and Mulholland, 2011). Recent reports also show that Māori comprise 61.6 per cent of children in care (Oranga Tamariki, 2018) and 42.7 per cent of homeless people in Auckland (Auckland Homeless Count, 2019).

These statistics show the disruptive and enduring effects of colonisation on Indigenous people, which 'cannot be decontextualised from the uneven economic and community development, institutionalisation, landlessness, and cultural genocide' (Christensen, 2016, p. 3). The structural racism rooted in colonisation, is also evidenced within government homelessness policies in Australia, Canada and New Zealand, which continue to favour the values and priorities of non-Indigenous people (Peters and Christensen, 2016).

Government Policy

New Zealand is undergoing significant reform of its youth protection and justice services. The government has committed to a substantive program of legislative reform that will underpin the operation of the new system (Oranga Tamariki, 2019). This is a two-phase approach to improve the wellbeing of children in care, enhance their voice and support the operation of the Ministry's core services.

Historically, child welfare grew out of a broader social work framework that was concerned for health, education, housing and income maintenance (Hyslop, 2017). Child

protection policy has also been influenced by political, social, economic and scientific drivers that have affected how it has been applied in the New Zealand context.

More specifically, social work practice has continued to be shaped by welfare regimes and the ideological context in which it emerges (Wallace and Pease, 2011). For example, the retraction of welfare states from the 1970s was mirrored by social work, which became mandated to deliver a child protection brief. Inevitably, funding for child protection social work has continued to be drawn disproportionately from the ranks of the poor. As demand for child protection has risen, state resources have become more limited, and it has become increasingly unrealistic for social work to meet the demands of the child protection task (Hyslop, 2017).

Moreover, social work has developed in response to the needs of people who have been marginalised by market society. Specifically, over the past 30 years, the growth of social inequality that has arisen from neo-liberal ideology has detrimentally affected social workers and the people they serve (Cree, 2013). Further, economic drivers continue to play a significant role (Hyslop, 2017). Within this context, the New Zealand government has adopted a social investment approach. This approach is not without flaws, since it is founded on the premise that ill-treated children are a future liability. This creates an economic driver that brings more children into care (Hyslop, 2017). As a result, these drivers have had a detrimental effect on child protection policy; further, the compassionate practices of social work have been replaced by technocratic and punitive child protection policies (Featherstone, White and Morris, 2014).

Method

An interpretive research design (Rowlands, 2005) was used for this study, which enabled a strong focus on the perceptions, attitudes, feelings and experiences of participants. The social constructivist paradigm makes sense of participants' experiences of care and homelessness; it assumes that individuals construct social life through social interaction (Woodhall-Melnick et al., 2018). Within this approach, we can theorise that past and present interactions with family, peers, and community health and welfare systems play a crucial role in shaping the conditions for social life, which affects housing.

Selection Criteria Selection

1. The participant had experienced homelessness. Statistics New Zealand (2009) defines homelessness as living situations that provide no shelter, or makeshift shelter (considered without shelter), including situations such as living on the street and inhabiting improvised dwellings (e.g., living in a shack or a car).
2. The participant was in care as a child or youth. Oranga Tamariki, the Ministry for Children, is the mandated government department responsible for the care and protection of children under the *Oranga Tamariki Act 1989*. For this research, a child in care is defined as a child or young person who was removed from their family and placed in a foster home, family home, or another type of institution.

Recruitment

Letters were emailed to community organisations that worked within the homelessness space. These organisations included LinkPeople, the Auckland City Mission, Lifewise, VisionWest, and Kāhui Tū Kaha. The organisations were asked to help identify potential candidates who met the criteria and wished to participate.

My experience gave me a keen awareness of the importance of building trust and rapport. Therefore, when recruiting participants from community organisations who work with the group to whom I am connected, a certain level of trust and rapport was assumed.

Six participants volunteered to participate and progressed to full participation. All participants interviewed were Māori—four males, one female and one transfemale—and were aged between 38 and 55 years. Participants were given a pseudonym to ensure anonymity.

Ethics

Ethics approval for this research was granted on 24 January 2019 by the University of Waikato Ethics Committee. I relied on recruitment via support workers only and did not recruit or access prospective participants through any client records held by my organisation. Prospective participants were given time to consider participation in this research and were followed up by a support worker. I did not follow up directly with any prospective participants, unless I was assured by their support worker that the prospective participants were happy for me to contact them.

A non-judgmental and trauma-informed approach was necessary at all stages of engaging participants in this research. This approach involved giving participants maximum agency over the interview process and environment. I informed each participant that they had the option to stop the interview, take a break or withdraw entirely from the research.

Data Collection

This research primarily comprises qualitative data gathered from interviews with participants. Stories of participants were used to highlight themes and trigger points that relate to their experiences of care and homelessness. Additionally, basic demographic data were collected for all participants.

Further, I used secondary concurrent quantitative data recently collected to measure the prevalence of care experiences among people who have been homeless (Auckland Homeless Count, 2019).

Findings

Consistent themes arose from the stories of participants; these centred around trauma. The main finding from the interviews was that participants' childhood experiences were underpinned by trauma, which, consequently, was a key trigger for the pathway into long-term homelessness from care. First, the participants experienced adverse and traumatic events from a very early age, usually within the context of their family home, but not always. Second, the trauma had a predictable impact on them (they did not form healthy attachments with parents or carers, became distrustful of people, struggled at school and failed to flourish). Third, participants developed maladaptive coping mechanisms to respond to their experiences (e.g., consuming non-prescription drugs, running away or joining gangs). Fourth, as the young people were noticed for acting out, they were placed into care, which led to more trauma. The wheels spun faster as higher levels of behavioural issues were met with higher levels of control from the care system. For five of the six participants, running away from care because of trauma was a trigger point for homelessness throughout their early teens and into adulthood.

Early Trauma

The experience of trauma was a significant theme across all participants' stories. This is consistent in the literature surrounding homelessness (Al-Nasrallah et al., 2005; Kim et al.,

2010; Beaton et al., 2015; Woodhall-Melnik et al., 2018) and children in care (Mcmillen et al., 2004; Bruskas, 2008; Foster et al., 2012).

Abuse.

Consistent with the literature (Foster et al., 2012; Mcmillen et al. 2004; Bruskas 2008), all six participants described experiencing some form of abuse as children. Five participants experienced abuse at home before entering care.

Moana described being frequently beaten by her stepfather because she was not his child. She was removed by Child, Youth and Family Services (CYFS, the former name for Oranga Tamariki) when she arrived at school at the age of nine with two black eyes. Moana described her grief, as she never had the chance to say goodbye to her parents. Moana recalled being left alone at home, as a six-year-old, to care for her newborn brother. She was beaten for leaving bottles sterilising on the stove. Rangi described his father 'being funny' towards him because he suspected he was not his real son and punching him and ramming his head into walls. Mere described being sexually molested at the age of seven by her best friend's father. Two other men again molested her at ages of nine and 11.

Abuse while in care was also a consistent theme in all six interviews. Three participants experienced sexual abuse during care. Moana and Anaru experienced sexual abuse by relatives of their carers, and Mere described being 'manipulated' into sex by boys from the foster home. Anaru described his sexual abuse in care at the age of 14 when he was left alone by his foster family with an older relative. Moana was repeatedly raped by male relatives of her caregiver across two different placements. She disclosed the incidents to her caregiver, who did not believe her.

Parent(s) with mental health or addiction issues.

At least four participants reported having a parent with mental health or addiction issues. Anaru described coming from a family of 'pissheads' and a mother with addiction. Mark described, as told by a social worker, that his mother had mental health and addiction challenges and was a user of secondary mental health services. Moana

described living with her mother as ‘horrible … She was an alcoholic and liked to take pills [drugs]’.

Impact of Early Trauma

The trauma had a predictable impact on participants' lives, affecting their ability to flourish as young people. The result of trauma manifested in many ways, including on participants' abilities to form healthy attachments to parents or carers, learn and succeed at school, and trust people and service providers. Tame described the effects of his abuse in care. He engaged in violent behaviour as a young person and an adult.

Lack of healthy attachment to parents and carers.

A lack of healthy parental attachment in early childhood was relevant for all six participants. Four participants experienced a disruption to parent attachment before the age of two. Anaru was abandoned at birth and placed into care. Mark was removed by CYFS when a neighbour contacted CYFS concerned about him, a newborn, and his 18-month-old brother being left alone at home while their mother was at the pub. Mere experienced the loss of her adoptive parent at the age of two. Tame was uplifted by CYFS at age two, as his parents were allegedly not able to look after him properly. Moana experienced the loss of her grandmother, who was her primary caregiver at the age of six and had to return to her biological mother’s care, who was an alcoholic. All six participants described feeling disconnected from their biological families.

The poor parental attachment also transferred into care environments. Rangi described feeling estranged from his foster carers. Moana described her dislike for her carer. Two participants described the challenge of being Māori and being placed with white foster parents. Morehu also reflected on how he felt being in different foster families of both Māori and Pakeha backgrounds: ‘With Māori families, I felt right at home. With Pakeha, I didn’t belong. I felt like an alien with a Pākehā family’. Morehu also described being picked on at school by his peers for being different from his foster family. Tame expressed that although he liked his white foster parents, he was also picked on at school for being a different ‘skin colour’ to them. Mere felt she did not belong with her adoptive family before entering care. Consequently, the poor connection to parents and

carers left participants feeling a lack of sense of family and belonging. Anaru described feeling disconnected from his culture and iwi as a result of his poor connection with his mother and family.

Poor education.

Trauma undoubtedly took its toll on participants' learning and education. A lack of education was a theme associated with childhood, with five of the six participants identifying issues with schooling and literacy. Tame explained, 'I didn't learn to read in care. I went to school, but I went to eat my lunch. That's it. I was hopeless at school'. He learned to read as an adult in prison. Learning to read as an adult had a profound impact on his life. Rangi described feeling 'left behind' because of his learning challenges. Without basic literacy, these individuals would have struggled to enter into the labour market or sustain a living, and consequently, were locked into the cycle of poverty. In addition to the common experience of early trauma, all participants experienced multiple care placements, which would have further disrupted their education. Given the age group of the participants (38–55), it is important to note that they would have experienced the education system in the 1970s and 1980s in New Zealand. The New Zealand education system has since undergone—and is currently undergoing—significant reform. It would be useful to further understand the changes that have taken place to ensure young people with learning difficulties and trauma are supported in learning environments.

Rebellion and Maladaptive Coping

For all participants, the impact of trauma took the form of resistance and rebellion. Most participants shared experiences of rebellion against their families or caregivers, running away to the streets, engaging in crime and violent behaviour, using drugs and joining gangs. Responses to trauma were heightened by further exposure to trauma and violence as a result of engaging in these behaviours. Consequently, the children became trapped in a vicious cycle of trauma that became a trigger for homelessness. This stage was a trigger point for homelessness for at least five of the participants, who described being exposed to homelessness at an early age while engaging in maladaptive coping behaviours.

Crime and violence.

All six participants disclosed engaging in criminal behaviour as children or youth. Anaru described stealing items from people from a young age as an act of resistance. Anaru went on to rob banks and fuel stations as an adult. Tame described feeling 'angry' when his foster parent beat him. He retaliated by breaking their valued possessions. The violent behaviour escalated to Anaru killing the foster parents' farm animals. Moana remembered running away at the age of 12 from her foster family and stealing a chocolate bar. She was arrested by police. Morehu described engaging in violent behaviour throughout his teens. The behaviour became more extreme for Tame, who described something 'snapping' in him after being severely beaten with a strap by the older children in care. Tame obtained a petrol tank and burned the house down. Fortunately, everyone escaped, but the house was destroyed. Tame was charged and imprisoned for two years.

Drug use.

Use of, or exposure to, drugs at an early age was a common theme for five participants before or during care. Five participants described using drugs during their time in care; two of these participants described using drugs before care. Only one participant did not share any experience with drugs. The use of drugs is not surprising, as we know from the literature that trauma can contribute to poor mental health and drug abuse (Kim et al., 2010). Before care, Moana described having her first joint of marijuana at the age of eight, which she obtained from home (her stepfather grew it). Mere had her first joint at the age of nine; she stole it from her older sister. During care, Anaru described being forced to take drugs by a relative of his foster parents before he was molested. Morehu reported that his foster parents grew marijuana, which he regularly smoked from the age of eight. Rangi took marijuana to school and smoked it with other children.

Drug abuse, a response to trauma for this population, can affect people's ability to secure and sustain stable housing later in life (Kim et al., 2010). Conversely, the lack of stable housing can also affect a person's health and wellbeing (Taylor and Sharpe, 2008).

Running away to the streets.

Running away in response to trauma was a common experience for five of the six participants. This behaviour began at an early age, continuing well into their teens. Only one participant remained in care until he was 18. Based on my observation as a researcher, the participant's physical disabilities may have mitigated his risk of running away. Moana described running away after being sexually abused by male relatives of her foster carers across two placements. Mere, a transgender female who was placed in an all-boys home, described running away with another vulnerable young boy after a week of being coerced into sex with the boys in care.

Rangi explained that being regularly beaten by his foster dad resulted in his running away to the streets, while Morehu ran away four times from his foster family in his early teens. His longest homelessness episode lasted nearly 18 months. This theme of 'running away' ties into previous research, which indicates a link between youth runaway episodes and the likelihood of homelessness in later adolescence and early adulthood (Williams, Giano and Merten, 2019). This link is often underpinned and amplified by mental health issues and raises questions about how the care system meets the mental health needs of young people.

Gang affiliation.

All six participants described being affiliated with gangs early in life as a means of belonging to a family. However, for some participants, this came with exploitation by the gangs. Moana described the gang moving in her rental home when she was an adult and using her home as a base for selling drugs. Consequently, she was evicted from her home and ended up homeless. Anaru had an altercation after joining a gang at 17 and was severely beaten.

Escalating Levels of Care and Control

For all participants, the vicious cycle of abuse and maladaptive coping resulted in multiple placements. For some participants, this meant moving to placements with tighter control (i.e., institutions).

Further abuse and re-traumatisation.

Four participants described being physically abused by their foster parents in response to their behaviour. Rangi stated, 'I started to get angry, and they didn't know how to deal with me, so, they started to beat me up'. Morehu remembered being beaten by his foster father with a wooden baton until he passed out for not listening to his foster father's instruction.

Changing placements.

As the children's behaviour escalated, they were moved to different placements when their foster parents could no longer manage their behaviours. All participants described having at least three or more placements, with one participant being moved nine times. Most participants could not explain why they were moved so many times from their placements; however, one participant stated, 'They just told me I'm a problem child. I didn't think I was a problem child; I just thought I was a survivor'. One participant attributed some of the adversity he experienced to him not having a stable home. He described how his brother was also in care, but his life was very different because he was placed with the 'right family'.

Tighter control and institutional care.

All four male participants described being placed in environments with tighter control as they rebelled more against their foster families. All male participants started in family home placements and gradually moved to more secure, institutional placements or youth prisons. This pathway did not apply to the two female participants. The institutional environments were traumatic for the participants. Fighting as a means of survival was a common experience in institutional settings for the participants. All four male participants ended up in youth prisons in their mid-teens because of criminal behaviour.

Distrust of service providers.

Consequently, the abuse and re-traumatisation of these young people during their care resulted in the distrust of government agencies and social services. This prevented participants from seeking help from organisations as young people and later as adults. Notably, some participants also perceived Work and Income (WINZ) and the care system

to be the same entity. They felt that they could not approach WINZ for help later in life after their poor care experience. Morehu stated, 'Their job is to help people and pick them up when the system is failing people, and they don't'. Anaru described his lack of trust for services in general after care, explaining how he felt when a homeless outreach service approached him on the street to help him: 'I don't have no trust for nobody. Fuck off; I don't want to know. I don't want to answer your questions'.

From Care to Homelessness

For all participants, exposure to homelessness occurred at a very young age and gradually became a normalised way of living. Patterns of social behaviour become normative when individuals believe those behaviours are accepted by or prescriptive to themselves and others (Normative, 2017). Over time, behaviours become normalised, reinforced by the internalised belief-system surrounding those behaviours (Raghaven et al., 2006). As homelessness becomes normalised, individuals are less likely to seek help or support for their behaviour or situation because they do not consider these to be abnormal.

The normalisation of homelessness was illustrated in all participants' stories. Morehu described homelessness as 'a part of who he is'. Morehu stated he was part of a street family, in which he is known as 'street uncle'. Mere described being completed part of street life and the street being all she knew.

Homelessness was, inevitably, a courageous choice, underpinned by trauma, that participants made to escape very adverse circumstances with very limited options available to them. As Mere described:

A preliminary conceptual model (see Figure 2) was extrapolated from participants' stories to illustrate the pathway to homelessness from care. The model shows how the children's responses to trauma acted as a trigger for homelessness.

Responses to trauma were exacerbated by further exposure to trauma and violence as a result of engaging in these behaviours. Consequently, the children became trapped in a vicious cycle of trauma that became a trigger for homelessness. This model is particularly useful in the New Zealand context, where there is a clear gap in the literature surrounding care as a pathway to homelessness.

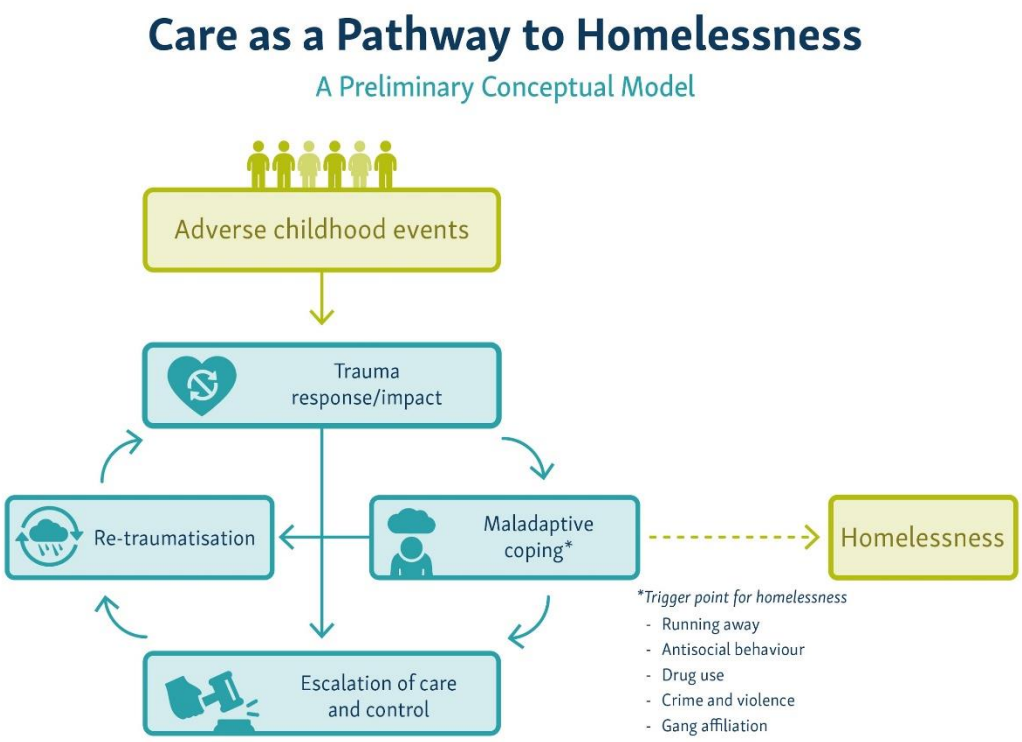

Figure 2: Preliminary conceptual model showing care as a pathway to homelessness.

Note. The pathway is underpinned by a cycle of trauma, trauma responses and maladaptive coping.

Limitations

Several limitations were identified through the course of this research that must be considered when reviewing this report. The first limitation is the risk of bias within the findings due to the lead researcher's own experience and institutional knowledge. To mitigate this risk, participants were not asked any set questions. Instead, they were invited to share their experiences. It is also important to note that the familiarity and experience of the researcher working with people who have experienced homelessness and the key providers enabled the researcher to develop a therapeutic relationship with the participants. This relationship encouraged openness and trust for the participants.

Moreover, a further limitation was the small sample size. Given that participants were connected with organisations, the sample of participants was further narrowed for this research.

Additionally, it was clear from the small number of interviews that there was a degree of saturation within the findings (defined as the point at which substantially new information is obtained). Therefore, there were no further efforts to recruit participants. Notably, all participants interviewed identified as Māori. Although we know that Māori are overrepresented in the statistics for homelessness and children in care, it would have been helpful to understand and compare the experiences for other ethnicities. Given most of the sample was male, it would have been interesting to explore further and compare the unique experiences of females and individuals who identify with the Rainbow communities (LGBTIQA+).

These sample demographics are consistent with international evidence around the disparity for Indigenous people, and while out of the scope of this research, it requires further investigation, specifically around the impact of colonisation.

Further, it is important to note that all participants were older adults who were asked to describe their childhood and care experiences in retrospect, with some having to recall their experiences as far back as three or four decades. It would have been useful to interview younger homeless individuals who have left care more recently. Also, this research did not compare the experiences of people who have been homeless but have not been in care. Finally, participants were all currently engaged with a housing service.

Conclusion

This research attempted to explore the trigger points in the care system that lead young people (using the service) to become homeless in adolescence or adulthood in the New Zealand context. The main finding from the thematic analysis was that participants' childhood experiences were underpinned by trauma, which consequently was a key trigger for their pathway into homelessness from care. All participants experienced adverse and traumatic events from a very early age, which usually occurred within the context of their family home, but not always. The trauma had a predictable impact on the young people's lives, their relationships and their ability to flourish. Participants used coping strategies to respond to their experiences, including taking drugs, running away and joining gangs. Over time, these strategies

became maladaptive, as they became learned and normalised by the individuals. As the young people were noticed for acting out, they were placed into care, which led to more trauma.

These behaviours associated with maladaptive coping exposed the participants to homelessness at a very young age, and consequently, homelessness became a normalised way of survival by the time they left care. Based on these findings, the following recommendations are suggested for service providers and government policy settings:

1. *Homelessness is a failure of government systems. There must be more conscious efforts to join systems to support the most vulnerable people*—Young people with mental health issues who run away from home as a child or teen are more likely to report homelessness than youth with better mental health and without histories of running away. Service providers and policymakers must focus their efforts on addressing the mental wellbeing of vulnerable youth.

   Notably, within this research, many participants described having a parent with mental health or addiction issues. Therefore, there needs to be increased policy to support the mental health and addiction needs of parents of children in or at risk of being removed and placed in care (Foster et al., 2012). There is also an opportunity for government to invest in alternative and evidence-based approaches to supporting children at risk of being placed into care and their families, such as Mana Whanau (2019) programs, which aim to keep families together and increase the resilience of families and young people.
2. *Services must be entrenched within a structure bound to trauma-informed practice and policy*—Given the high prevalence of trauma among homeless individuals with care histories, it is essential that services and policy promote practices that focus on engagement and building trust when working with this population. It is important to note also that *trauma drives distrust towards service providers*. Therefore, there needs to be a greater emphasis in services genuinely connecting and engaging with this group. The current government investment in Housing First programs for homeless individuals and families places people at the heart of the service provision and planning, focusing intensely on engagement and trust building. This approach of

trust building and engaging needs to be mirrored within the care system, which tends to be very punitive towards young people and their families.

The increase in Housing First initiatives over recent years has done little to address the underlying causes of housing instability, and the normative trauma unstably housed families experience (Brush, Gultekin, Downdell, Saunt Arnault and Satterfield, 2018). It is not sufficient for services working with children in care or individuals who are homeless to be 'trauma-informed'. Instead, it is critical that services recognise that the robust assessment and treatment of trauma is integral to housing instability and wellbeing. Services need to consciously equip people with adaptive coping strategies and resilience. This is consistent with empirical evidence that argues that to effectively assist individuals experiencing homelessness, efforts must include special attention to trauma. More specifically, stakeholders must understand how individual, family, community and cultural factors influence help-seeking behaviours in this vulnerable and growing population (Brush et al., 2017).

3. *There needs to be a national housing and homelessness strategy that is rooted in the Treaty of Waitangi and Human Rights*—Homelessness is a complex issue and requires a multipronged approach to address its drivers. The statistics for Māori homelessness and children entering care are alarming. There needs to be a recognition that this is a failure of government in developing culturally appropriate responses to Māori. Responses also need to genuinely engage whanau, iwi and hapū and recognise their critical role in leading and sustaining change for Māori. A national strategy and policy must also recognise the right to safe and healthy housing. The *New Zealand Bill of Rights* neglects the right to a home; it is time this was refreshed.

   There is a global driver through the United Nation’s Sustainable Development Goals (2019) to eliminate homelessness by 2030. Public and private sectors must be engaged in this conversation to ensure collective actions and efforts are aligned towards government obligations under international human rights law.

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