

*Between the Long Grass and the
Housed: A qualitative inquiry into
the experience of homelessness in
Darwin*

Catherine Ann Holmes

Master of Science (Honours). 'Healthy Marketplaces: Insights into Policy, Practice and Potential for Health Promotion'. (University of Western Sydney, 2003).

Bachelor of Applied Science (Environmental Health). (University of Western Sydney, 2000).

Associate Diploma in Applied Science (Health and Building Surveying). (NSW TAFE, 1993).

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Certificate of Authorship

I certify that this thesis has not previously been submitted for a degree, nor has it been submitted as part of the requirements for a degree.

I also certify that this thesis is entirely my own original work and has been written by me. Any assistance that I have received throughout the duration of this research and in the preparation of the thesis itself has been acknowledged.

Catherine Ann Holmes

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Contents

LIST OF FIGURES, PHOTOGRAPHS AND TABLES	X
KEY TERMS	XI
ABSTRACT	XIII
PREFACE	XV
CHAPTER ONE: INTRODUCTION	1
THIS THESIS IN A NUTSHELL	2
THE GAP IN OUR KNOWLEDGE	6
THE RESEARCH QUESTION	7
THESIS STRUCTURE AND OVERVIEW	8
CHAPTER TWO: LITERATURE REVIEW	11
GLOBALISATION AND AUSTRALIA'S SOCIO-ECONOMIC HEALTH	12
HOME	15
<i>The holistic view of home</i>	18
<i>Conflation of house, home and family</i>	20
<i>From home to homeless</i>	22
HOMELESSNESS IN CONTEMPORARY AUSTRALIA	24

<i>Australia's homeless and the Supported Accommodation Assistance Program (SAAP)</i>	28
<i>Research into homelessness</i>	30
<i>When society's rules are broken: normal versus stigmatised</i>	35
HEALTH AND HOMELESSNESS	38
<i>Health, wellbeing and quality of life</i>	39
<i>Aboriginal health</i>	43
<i>Quality of life among homeless individuals</i>	44
<i>Quality of life, trauma, Post Traumatic Stress Disorder (PTSD) and treatment</i>	46
<i>Social exclusion, urban development, public places and poverty cultures</i>	53
SUMMARY	55
CHAPTER THREE: STUDY CONTEXT	58
HOMELESSNESS IN THE NORTHERN TERRITORY	58
DARWIN'S HOMELESS ENUMERATED	62
WHY THE LONG GRASS?	63
SOCIOECONOMIC CONSIDERATIONS IN THE NT	65
CRIMINALISATION OF POVERTY AND POLICING THE POOR IN DARWIN	66
DARWIN'S HOMELESS SERVICES	70
<i>SAAP funded services in the Darwin area</i>	70
<i>Government departments and funded programs</i>	74
SUMMARY	79
CHAPTER FOUR: METHODOLOGY	81
A POST-POSITIVIST RESEARCH PARADIGM	82
THE CATALYST FOR EXPLORING HOMELESSNESS	84
LOCATING THE STUDY AND SELECTING A STUDY SITE	85
ETHICAL ISSUES WITH VULNERABLE RESEARCH PARTICIPANTS	87
<i>Collaborating on an ethics protocol</i>	87

<i>Informed and voluntary consent where there are unequal power relations</i>	88
AN EMERGENT METHODOLOGY: A POST-POSITIVIST MULTI-METHOD INQUIRY	90
<i>Drawing from the ethnographic tradition</i>	91
SUMMARY	93
CHAPTER FIVE: DATA COLLECTION AND ANALYSIS	94
DATA COLLECTION PERIOD	94
NEGOTIATING A ROLE AND BECOMING AN INSIDER	95
<i>Rapport building</i>	95
<i>Recruitment of participants</i>	98
<i>Excluding formal interviews as a method</i>	100
DATA RECORDING	101
<i>Participant observation</i>	101
<i>Informal interview (conversation)</i>	102
<i>Individual narrative</i>	102
DATA ANALYSIS	103
DATA ACCURACY AND FEEDBACK	104
LIMITATIONS OF THE STUDY	104
WITHDRAWING FROM THE FIELD	107
SUMMARY	108
CHAPTER SIX: OZANAM HOUSE: THE STUDY SITE	110
A SOCIETY OF ST VINCENT DE PAUL SERVICE	110
<i>The ‘Vinnies’ spirit</i>	110
<i>The philosophy, goal and mission of Ozanam House</i>	112
ORGANISATIONAL STRUCTURE, FINANCE AND POLITICS	113
<i>Finance</i>	115
<i>Mounting tension at Ozanam House</i>	116
<i>Redundancy and shelter closure</i>	117

THE PLACE AND ITS SURROUNDS _____	118
<i>The premises</i> _____	120
<i>The men’s shelter</i> _____	124
<i>The meal service</i> _____	127
OZANAM’S GUESTS: WHO ARE THEY? _____	132
<i>In the shelter</i> _____	134
<i>At the meal service</i> _____	136
<i>Volunteers</i> _____	138
SOCIAL INTERACTIONS AT OZANAM _____	139
OTHER BUSINESS AT OZANAM _____	142
SUMMARY _____	143

**CHAPTER SEVEN: HOMELESS KNOWLEDGE BASE AND THE
INSTITUTIONAL LANDSCAPE _____ 145**

OZANAM HOUSE: THE END OF THE LINE _____	146
CHOOSING DARWIN AND TRAVERSING THE INSTITUTIONAL LANDSCAPE _____	147
<i>Charities, transience and travel</i> _____	148
<i>Institutional knowledge and planning</i> _____	149
<i>Knowledge accumulation</i> _____	153
SUMMARY _____	155

CHAPTER EIGHT: THE LIVED EXPERIENCE OF TRAUMA _____ 156

TRAJECTORIES OF TRAUMA _____	157
<i>Vignette #1, Steve</i> _____	159
<i>Vignette #2, Polly</i> _____	162
<i>Vignette #3, Olivia</i> _____	166
<i>Vignette #4, Edwin</i> _____	167
<i>Vignette #5, Mike</i> _____	168
<i>Vignette #6, Kim</i> _____	170

TRAUMA’S SYMPTOMS SHAPING IDENTITY _____	171
SUMMARY _____	175
CHAPTER NINE: DEVIANCE, STIGMA AND IDENTITY _____	177
MANAGING STIGMA: HOMELESS PEOPLES’ PERCEPTION OF THE SELF AND OF HOMELESSNESS _____	181
<i>Managing the person and personal belongings</i> _____	181
<i>The idea of having a job</i> _____	187
<i>Shame as stigma</i> _____	190
<i>Personal appearance and hygiene</i> _____	194
<i>The Long Grass as a dangerous place</i> _____	198
<i>Mobility as stigma management</i> _____	200
THE ‘NORMALS’ PERCEPTION OF HOMELESS PEOPLE _____	201
<i>Community perceptions</i> _____	201
<i>The institutional perception</i> _____	203
<i>Police interactions</i> _____	207
IMPLICATIONS FOR INTERACTION IN SOCIETY _____	210
<i>Becoming discreditable: relationships and interactions with the ‘normals’</i> _____	210
<i>Socialising with the ‘normals’ from Ozanam</i> _____	213
SUMMARY _____	216
CHAPTER TEN: HEALTH IN A HOMELESS CULTURE DOMINATED BY TRAUMA AND STIGMA _____	220
THE ROLE OF OZANAM HOUSE IN LONG GRASS HEALTH _____	223
<i>Accessing care with a ‘normal’</i> _____	223
<i>Generating wellbeing through creating home</i> _____	227
HEALTH CONCERNS AND BELIEFS OF GUESTS _____	229
<i>Reported health complaints</i> _____	229
<i>‘Crazy people’</i> _____	230

<i>Diet, food safety and volunteering</i> _____	232
<i>Sexual health</i> _____	238
<i>Morbidity and mortality involving sorcery</i> _____	242
<i>Children and place</i> _____	243
RESPONSIBILITY FOR HEALTH: ACCEPTING POOR HEALTH, FATALISM AND PERCEPTIONS	
OF SERVICES _____	245
<i>Compliance</i> _____	246
<i>Marijuana, alcohol, bush and other medicines</i> _____	248
<i>Sobriety, housing and social death</i> _____	251
SUMMARY _____	255
CHAPTER ELEVEN: CONCLUSION: CHALLENGES AND	
IMPLICATIONS _____	258
KEY FINDINGS, CHALLENGES AND IMPLICATIONS _____	259
<i>Trauma</i> _____	259
<i>Trauma-related behaviour and treatment</i> _____	260
<i>Stigma</i> _____	261
<i>The relationship between service availability and service need</i> _____	263
<i>Home in the Long Grass</i> _____	264
<i>A homeless knowledge base</i> _____	266
<i>Homeless people and health</i> _____	266
<i>A final comment...</i> _____	270
REFERENCES _____	271
APPENDIX 1: SAAP FUNDED SERVICES IN THE DARWIN AREA _____	298

List of Figures, Photographs and Tables

Figure 1: Homelessness in Darwin and the Northern Territory _____ Error! Bookmark not defined.

Figure 2: Letter to the Editor, Northern Territory News _____ 68

Figure 3: Local Map of Stuart Park, Darwin _____ 111

Figure 4: The St Vincent de Paul Society organisational structure _____ 113

Figure 5: Service provision at Ozanam House _____ 143

Photograph 1: Ozanam House looking from across the street _____ 121

Photograph 2: Ozanam House entry, carport and office area _____ 122

Photograph 3: The lounge, servery and kitchen _____ 123

Photograph 4: The men's shelter _____ 124

Photograph 5: Meal tables for guests at the rear of the property _____ 130

Table 1: SAAP funded services in the Darwin area for youth _____ 300

Table 2: SAAP funded services in the Darwin area for single adult males _____ 302

Table 3: SAAP funded services in the Darwin area for adult women _____ 303

Table 4: SAAP funded services in the Darwin area for families and others _____ 305

Key Terms

In this section, I have listed key terms used frequently in this thesis. The definition provided here for each relates specifically to the way in which the term has been applied in this thesis.

Chief Executive Office	St Vincent de Paul's Northern Territory central administration office
Committee	Group of Vincentian volunteers from the St Judes Conference with responsibilities for managing Ozanam House, i.e. the Management Committee.
Committee member	Individual Vincentian volunteer on the Management Committee.
Community	A group of people brought together by choice or force of circumstance, and who share a common interest in a common geographical locality, such as 'mainstream community', 'homeless community' and 'Aboriginal community'.
Conference	A group of Vincentian volunteer members who work together to respond to the needs of the poor and homeless.
Guest	Homeless person who uses the Ozanam House services but who generally does not do voluntary work during their visit.
Guest volunteer	Homeless person who uses Ozanam House services as well as doing voluntary work for the service.
Humbug	Hassle, beg.
Informant	Person who shared information for the purpose of this study.
Key informant	Person who shared detailed information for the purpose of this study.

Living rough	A way of living which usually refers to people who stay, sleep and/or live and conduct daily life where there is no conventional housing and few facilities. People camp, sleep out, squat or use some other improvised shelter.
Long Grass	A place or places where people stay, sleep and/or live and conduct daily life where there is no conventional housing and few facilities with people camping, sleeping out, living rough, squatting or using some other improvised shelter.
Long Grasser	Person who may, or may not, be homeless who lives or spends time in the Long Grass where there is no conventional housing and few facilities.
Management Committee	See 'Committee' and 'St Judes Conference'.
'Normals'	Those individuals who make up the mainstream society and who are not socially excluded and generally live in conventional housing.
Ozanam House, Ozanam or the House	St Vincent de Paul's meal and shelter service catering to the poor and homeless in Darwin.
Skid Row or Skid Road poor	Chronically homeless individuals who are the most impoverished in a society and likely to remain so.
Staff	The paid employees working at Ozanam House.
St Jude's Conference	Specially formed group of Vincentian volunteers with responsibility for the management of Ozanam House. See also 'committee' and 'conference'.
Participant	Person who shared information for the purpose of this study
Vincentian	A person who becomes a member of the St Vincent de Paul Society and who undertakes work with the poor and homeless.
Volunteer	A person, not necessarily homeless, who works voluntarily at Ozanam House.

Abstract

This study of homelessness in Australia in 2004 took place at a time when the national homeless population exceeded 100 000 people. The Northern Territory had the highest rate in the country with around 5 500 people. There were more than 2 500 homeless people in Darwin alone, with around 40% of this population ‘living rough’ or in improvised dwellings, known locally as living in the Long Grass. Aboriginal Australians were grossly over represented in these figures, and in Darwin they were a highly visible population in the urban landscape.

A review of the literature found that the poor health of homeless people was often reported. There were many agencies who responded directly and indirectly to homeless issues and there were government policies and programs dealing with homelessness. The focus of most of the literature was on the enumeration and prevention of, or early exit from, homelessness. Shifting away from this traditional focus, the present study was directed towards understanding the homeless experience and how the health and life quality of homeless people could be improved during their homelessness.

The key questions asked, ‘*What is the experience of homelessness in Darwin?*’ and ‘*What are the key dimensions of that experience that influence the health homeless people?*’ To answer these questions, a mixed methods inquiry explored the lived experience of homelessness in Darwin between June, 2004 and June, 2005. The study was undertaken through St Vincent de Paul’s Ozanam House meal and shelter service. Their clients’ life worlds and experiences were documented through participant observation, informal interviews and individual narratives.

This study found three key dimensions of the homeless experience which had a significant influence on the health of these people. These included the existence of a homeless knowledge base among the homeless; the high prevalence and the effects of pre-existing and ongoing trauma; and the stigmatisation processes homeless people were required to negotiate and manage. Findings were that homeless people constructed positive notions of home, situated within their homeless context, which contributed to their improved wellbeing. This wellbeing was negotiated within a complex framework where stigmatising and traumatising processes dominated. Wellbeing was further influenced by factors such as sexual health, food, sorcery, social connectedness and loneliness.

This study has found that there were very few treatment options available to homeless people who suffered from trauma related illness. The lack of treatment options was only one of the many barriers homeless people experienced in obtaining services from health care providers. Consequently, homeless people typically managed the symptoms associated with trauma and other problems themselves, often with the use of alcohol. Self management of wellbeing and health reinforced the negative perception of homeless people held by mainstream society, in turn reinforcing the stigmatising processes individuals spent much of their daily life managing. By addressing the key dimensions of the homeless experience which have had the greatest influence on health, the relevant agencies can begin to create living environments which reflect the experiences and the hopes of the homeless people and which are supportive of good health and a better quality of life.

Preface

The purpose of this preface is to introduce my own position as researcher in this inquiry, by outlining the assumptions I have made about the nature of reality and the nature and construction of knowledge. By locating myself, I have described the lens through which this study was approached. Importantly, this preface describes the subjectivities which I knowingly brought to this study and subsequently attempted to manage.

My own assumptions about reality and the construction of knowledge have aligned me with a post-positivist research paradigm. Such a position has been compatible with this particular inquiry in that I am concerned with understanding the complex world and lived experience of a homeless population from their own perspectives. This is the type of concern that Schwandt (1998) suggested was a key distinguisher between this paradigm from that of positivism. (The matter of research paradigms has been explored further in **Chapter Four**).

In addition to the importance that research paradigms have on the research process, the lens through which research is undertaken by the individual researcher is also important. The age, gender, ethnicity, religious and other beliefs of a researcher will affect most aspects of the inquiry, from what is to be researched, to how the research was undertaken, and the interpretation of the data. Other factors, such as the time and place of the researcher's upbringing and own life experiences, for instance, also shape the values, assumptions and biases brought to a study. Given this, it is necessary to discuss some of my own circumstances that may have consciously and unconsciously shaped this post-positive or qualitative inquiry.

I was born in 1970 in Sydney, Australia, and was one of four children raised in a conservative Sydney suburb where narrow social borders prevailed. University education was common among parents and expected among children, and incomes were relatively high. My parents, both Anglo-Australian, were both university educated, my father in engineering and my mother in education. Our family held essentially Christian values and a protestant work ethic. I acknowledge that being white, middle class, Christian and educated, in my mid 30s, and living in the Western world means I am extremely privileged.

In my middle-class environment social deviance occurred 'elsewhere', naturally so did homelessness. Most people would have agreed that homeless people were to be found in Sydney's Hyde Park, comprising older alcoholic men. Where I grew up, the odd run-away young person staying with friends or camping out was considered just that; a run-away with a home and a family. Thus, in the quiet green Sydney suburbs there was a distinct absence of people living rough (with the exception of a 'hermit' who lived in a nearby cave in the bush). But while homelessness remained 'out of sight, out of mind' it was during this time I started to wonder about house and home, and the social realities constructed by communities.

Despite being surrounded by wealth and opportunity, I discovered that poverty created stresses in life that wealthy people were unaccustomed to. I also realised that poorer people were often too busy surviving to have time to resist what appeared to be an oppressive state. From this I developed a sense of responsibility to fight against social injustices.

From an early age I had been interested in the environment, and later became curious about the relationship between the environment and human health. I completed studies in environmental health and building surveying in order to practice professionally as an environmental health officer and building surveyor. My studies provided for a sound technical knowledge base from which to practice but did not provide me with the latitude

I had hoped for in initiating sustainable community changes. I then gravitated back to formal study where I developed a keenness for doing research.

This study commenced with my desire to better understand the relationship of power and community participation in environment and health programs, as it was my belief that these links were not well understood. I contemplated the many contexts in which these issues could be explored. Concurrently, I was following a local community interest newspaper story of a homeless man occupying the grandstand overlooking a sporting field (this was widely regarded as being a problem). The journalist had implied that this man was responsible for the inappropriate disposal of needles used in shooting up illicit drugs, and also in paedophilia. After being accused and then tried by the media, he was left to be punished by the community, as his location was disclosed in the same article. There was no evidence of any of these behaviours. It was the processes engaged in by local politicians, government and media and their subsequent actions stigmatising this ‘problem’ that were the catalyst for my research.

I came to this research with a background in environmental health, which by definition is multidisciplinary. This of course, has also affected the way I have approached this study as I have not felt bound by any one school of thought. This professional and personal background has aimed to provide the reader with an insight into who I am as researcher and what I have brought to the research context.

Chapter One

Introduction

Homelessness and extreme poverty are not only associated with developing countries (Leach, 1998; Finley & Barton, 2003; Zufferey & Kerr, 2004). With industrialised nations reporting a growth in the number of people living below the poverty line, there is strong evidence to suggest worldwide growth in inequalities between the wealthy and poor, which may be in part attributable to globalisation (Kahne, 2004; Bambrick, 2005; Chopra, 2005). One indicator of the consequences of these inequalities derived from globalisation is reflected in the increased visibility of the most extreme poor; the homeless (Hasegawa, 2005), and as Finley and Barton (2003) commented, “*being without adequate shelter is a situation that thrives in the United States and in other economically wealthy nations*” (p.483). The increased visibility of poverty has, however, generated public debate that positions homelessness as an unpalatable condition, without the normal safeguards for health and security experienced by other citizens. This position was affirmed in Australia’s *Working Towards a National Homeless Strategy* in its opening lines: “*It is not acceptable for people in Australia to be homeless*” (Commonwealth Advisory Committee on Homelessness, 2001; p.8).

This thesis is about the experience of homelessness; primarily living rough in Darwin, the capital of the Northern Territory, Australia. To date, it has been difficult to find published studies in this country that explore homelessness from the perspective of the homeless individual. This study therefore asks the question: ‘*What is the experience of*

homelessness in Darwin? This led to a further question: *‘What are the key dimensions of that experience that influence the health homeless people?’* In this chapter I explain the need for this investigation and introduce some of the key areas I explored in order to respond to these research questions. The chapter concludes with an outline of topics to be addressed in subsequent chapters.

This thesis in a nutshell

This thesis provides an account of the daily lives and experiences of a homeless population while they accessed an institutional setting in Darwin. The population under study comprised both Aboriginal and non-Aboriginal people from a variety of ethnic backgrounds.

The St Vincent de Paul Society’s Ozanam House provided a meal and shelter service to some of Darwin’s most impoverished and disadvantaged homeless individuals, and became the setting through which the bulk of data was collected. Through participant observation and key informant interviews, this study documents the experiences and perspectives of homeless individuals, (euphemistically known as ‘guests’ by the service), during their participation in activities and interactions with staff and other non-homeless people at Ozanam House. Specifically, this study investigates the life trajectories of guests at the service; the nature of the relationships between guests and non-homeless people at and beyond the service; and the mechanisms by which homeless individuals define their identity both within and beyond the institutional environment.

In order to respond to my research questions, I consider the homeless experience from the perspective of the homeless individual, as well as the key dimensions of that experience which have the greatest influence on notions of health and health-related behaviours.

Over twelve months of fieldwork I pieced together a construction of everyday life for the homeless people who accessed Ozanam House. These people were often referred to as ‘Long Grassers’. I explored their world views and how these shaped, and were shaped by, daily life experiences and gained an appreciation for how life events could generate meaning and lead to particular behavioural responses. This enabled me then to consider

‘health’ for this population within a social and cultural framework, which was recognised by McDowell (2006), Sen (1993) and others as an important component that shapes the quality of life of individuals, and can not be understood in isolation from the meanings and values individuals ascribe to the many events that make up their life stories. Through gaining an understanding of this social and cultural context, this inquiry investigates the pathways and barriers effecting individuals in sustaining improved health and therefore life quality.

Homelessness in Darwin is widely regarded as an ‘Aboriginal’ problem. It is commonly understood in terms of Aboriginal people being ‘itinerants’ who have chosen to leave their home communities to congregate in town to binge drink and live the ‘Long Grasser’ lifestyle. This has led to the assumption that the person is always free to choose to return home at will. This perception is reinforced daily among the Darwin non-Aboriginal community¹ through various forms including such government funded programs such the former ‘Itinerant Program’, now the ‘Community Harmony Strategy’, which aims to return itinerants to their home country. It is also reinforced by proposed election policies advocating zero tolerance of ‘habitual drunks’; local Council by-laws prohibiting camping; in local news media including talk-back radio; and in other public interviews and discussions. This inquiry investigates the foundations for these perceptions and the impacts these have had on the homeless population. I will conclude by reviewing how this perception has worked to obscure the complexities of life faced by all homeless Long Grassers in Darwin, both Indigenous and non-Indigenous.

Zufferey and Kerr (2004) found it was important to challenge the construction of homeless Australians as ‘deficient’, arguing in favour of recognition of their resistance and strengths. They argued that understanding the constructions of homelessness and how this influences solutions, along with acknowledgement of the contribution that

¹ Extracting from the definition of ‘community’ offered by Brown and Pitcher (2005), in this thesis the term community, as in ‘mainstream community’, ‘homeless community’ or ‘Aboriginal community’ etc, refers to a group of people brought together by choice or force of circumstance, and who share a common interest in a common geographical locality.

service-users' perspectives can make, remains important for the development of strength-based models in policy development and service delivery. The negative or deficient perception of homelessness which pervades the Darwin population, and has been demonstrated through media coverage and discourse, masks the causes and consequences of being homeless and acts to prevent appropriate action in the creation of environments that are supportive of health and improved life quality.

There is mounting evidence that welfare and government agencies will only assist those people whom they have concluded 'deserve' to be helped and demonstrate a willingness to be helped, such as those individuals who receive unemployment benefits on the condition they actively seek employment and provide evidence of their attempts. This welfare discourse around 'deserving' or 'undeserving' is underpinned by whether an individual's poverty is regarded as a choice or whether it be by chance (La Gory *et al*, 2001). This is problematic, and as Blunden (2004) commented, "*Every opportunity for a claimant to qualify as 'deserving' adds stigma to another person thereby deemed 'undeserving'...separating out the deserving poor only accentuates the stigma for those deemed 'undeserving'*" (p.73). In addition to the stigma caused by dividing welfare recipients into deserving and undeserving, those on welfare may be regarded as 'dependant'.

According to Blunden (2004), dependency is now synonymous with poverty, and moral and psychological dependency widely regarded as a personality disorder, curiously understood as a choice rather than a situation of chance. Consequently, there is a strong likelihood that society will regard homeless individuals in receipt of welfare as undeserving and responsible for their own poverty, resulting from a profound personality disorder. Blunden (2004) argued that to be welfare dependant is to be subordinate to others, and it is this subordination that reinforces stigma. This thesis explores the processes of stigmatisation experienced by homeless marginalised individuals that stems from their poverty and homelessness.

Debate over the matter of ‘dependency’ through receiving welfare is not new in Australian society. It has led to the establishment of mutual obligations between recipients and the government or government funded agencies. The idea is to combat the potential for the development of what is widely understood as a psychological disorder (Blunden, 2004). The homeless, for example, agree to sign over future government pensions in exchange for emergency accommodation and food and enter into ‘case management’ arrangements in order to continue to receive agency support and welfare pensions. There is an emergent ideology that theorises the user-pay approach to accessing crisis services maintains the dignity of the person in crisis. This is evident in policy documents and agreements. One example of this approach is the agreement between St Vincent de Paul and the Supported Assistance Accommodation Program (SAAP) with funds disseminated through the Commonwealth and Territory Family and Community Service departments. Blunden (2004) rejects this position, referring to it as an ‘outrageous lie!’.

This thesis draws on the life stories and experiences of homeless people to discuss the effect of such attitudes on them. After documenting this evidence, I briefly discuss the political, social and economic circumstances that give rise to an ideological position that has seen service providers, such as St Vincent de Paul, having to re-interpret their own philosophical foundations to fulfil the terms of funding agreements, and the subsequent impact of this on chronically homeless individuals.

Ozanam House was one of the few services in Darwin that continued to provide for the chronically homeless and poor at no, or minimal, cost to the individual concerned. Unlike many other services, they also accepted men with ‘problems’ such as mental illness and alcohol addiction. During the fieldwork phase of this research, Ozanam House ceased to offer the only men’s crisis accommodation available in Darwin that would accept men who had no money. Consequently, this study was undertaken during a time of policy and staff change, which was often perceived to be a crisis by many homeless individuals. As a researcher I was able to document the perceptions homeless people had about Ozanam House and the staff, and also the impact of these changes to

daily life patterns. Amongst other things, this enabled me to gain an insight into the relationship between mutual obligation policies and the realities of life for homeless people.

In exploring these aspects of homelessness in Darwin, this research aims to contribute to the small body of knowledge that seeks to explore how healthful environments can be created for a homeless population that reflect the hopes and experiences of these people.

The gap in our knowledge

I will now turn to a brief précis of the research on homelessness that has been conducted in Australia. (The research on homelessness is described in greater detail in **Chapter Two**). As early as the late 1960s, the stories told by 1000 homeless men in Victoria, Australia, were collected and analysed. Commenting on the findings of this work, Stubbs (1966) concluded:

Many of these men [the chronic homeless] are beyond rehabilitation by the time they have reached Skid Row – certainly none of our present services succeed in rehabilitating them. But improvement and extension of our present preventative, *supportive* and rehabilitative services is possible – and urgently needed (Stubbs, 1966, p. 88, emphasis added).

In 1992, Neil and Fopp (1992) authored the first detailed study in Australia on the causes and consequences of homelessness. This study did not generate any new empirical or statistical data but reviewed published reports on specific aspects of homelessness and policies and services designed to alleviate homelessness and housing stress, adding to our knowledge in this area. The aim of their work was to alleviate homelessness through the provision of a house or home and employment. With an emphasis on preventative policies, Neil and Fopp (1992) stated:

...homelessness is not just a function of the housing system, but the interaction of the housing and labour markets within a *particular social context* (p.217, emphasis added).

My qualitative inquiry explores the lived experience of a homeless population, in a particular social context, with an emphasis on understanding health. To date, the nature of research about homelessness in Australia has been limited and has typically focussed

on enumeration and early prevention and exit strategies. Inquiries that consider links between the lived experience of homelessness to life quality and health appear not to have been undertaken or are unpublished. There also appeared to be a lack of published studies in an Australian context which considers any dimension of their quality of life, whether subjective or objective. Wolf *et al* (2001), in the context of the U.S.A, claimed that “*Despite the focus of homelessness research in recent years on the prevention and dynamics of homelessness, and effective strategies for intervention, relatively few studies have been conducted on the quality of life of the homeless population*” (p.396). There are also very few published studies on homeless people in institutional settings in Australia, and I have been unable to locate any such studies in Darwin. This research aims to fill this void and thereby arrive at a more complete understanding of the health needs of a homeless population.

The research question

The changing face of homelessness has served to generate greater interest, debate and concern for homeless people. As stated, the central questions directing this research sought to understand the experience of homelessness in Darwin and the key dimensions of that experience that influence the health homeless people. In consideration of an answer to these questions, it was critical to learn about the daily life or culture of these people, especially if ‘health’ is to be understood within the social and cultural context in which it is constructed. Through learning about the experience of homelessness in Darwin and identifying the key dimensions of that experience which have a significant influence on the health of homeless people, this study aimed to explore future possibilities for the development of:

- (i) healthful environments for a homeless population that reflect the experiences and hopes of the homeless themselves; and
- (ii) how such environments can be constructed so that they are supportive of health and a better quality of life.

This study applied a range of methods in order to:

- (i) observe, participate in, and document the daily interactions between guests, staff and other non-homeless individuals at Ozanam House;
- (ii) record individual narratives or life stories and experiences of guests;
- (iii) construct a cultural interpretation of the Ozanam homelessness community;
- (iv) explore their health seeking behaviours within and beyond the study site;
and
- (v) generate theoretically grounded suggestions for creating environments that are more supportive of health and a better life quality in a particular social, cultural, political, economic and geographical context.

The research questions were premised on the assumption that homeless people are marginalised, form a distinguishable cultural group, and have defined behaviours, beliefs and survival strategies. Davis (1996) observed:

All cultures, regardless of their social or ethnic nature, are prone to certain health problems. The homeless suffer from a variety of serious health conditions that significantly affect the quality as well as the length of their lives (p.179).

With health and life quality influenced by social and cultural practices and beliefs, the context in which a homeless person attains health is likely to differ from the mainstream or housed community. In turn, one would expect the way in which the dimensions of health are manifested, for example, wellbeing, security and social fulfilment, will be shaped according to the context in which the person exists.

Thesis structure and overview

In the preface to this thesis I introduced the reader to where I position this research; that is within the post-positivist paradigm (Schwandt, 1998). I described my motivations for this study along with my perspective as researcher; the lens through which this research was conceived of and then undertaken, and identified my own subjectivities. In this first chapter, I raise the need for knowledge generated by a study of the lived experience of being homeless in Australia. The guiding questions for that study have been stated. The next step is to provide an overview of the way in which this thesis will unfold.

In **Chapter Two** a critique of the pertinent literature is presented, providing the theoretical framework for this study. I concentrate on the broader socio-cultural, economic and political contexts relevant to this study and identify the dimensions of the homeless experience discussed in the literature.

Chapter Three is an extension of the literature review, wherein the homeless situation in the Northern Territory and Darwin is the central focus. The social and political contexts which directly affect the homeless experience in Darwin are explored. The chapter concludes with an overview of the key local services available which aim to respond to homelessness.

An account of the reasons a multi-method research methodology was adopted for this study is provided in **Chapter Four**. The methods used in data collection and analysis are then detailed in **Chapter Five**, along with the limitations of the study.

Chapter Six presents material generated through field investigations. The emphasis of this section is on the study site, Ozanam House. The place, services, people, processes and the St Vincent de Paul ethos and organisational environment are described.

In **Chapter Seven** I explore the planned use of services through the accumulation of a homeless knowledge base. I describe how individuals gathered information and acquired current knowledge of the services available to them through their own experiences, shared experiences and service providers.

Since one of the most consistent dimensions of the homelessness experience identified in this study was the incidence of multiple traumas, **Chapter Eight** focuses on the lived experience of trauma. Trauma played a pivotal role in daily life and decision making for nearly all the informants in this study, and had a profound affect on health and life quality.

Chapter Nine unpacks the complex process of becoming and living as homeless, drawing on the theoretical works of Erving Goffman (1963) to explain the issues around identity and individual interactions with the larger social system. **Chapters Seven, Eight** and **Nine** together provide a discussion on the significant dimensions of the homeless experience that affect the daily life and health of Ozanam's homeless population.

Based on these findings, **Chapter Ten** discusses the ways in which health is understood and managed by the population under study. In this chapter I interpret the role of a social institution involved with health care (in this case Ozanam House) and detail the health concerns and beliefs of guests. The concluding chapter, **Chapter 11**, returns to my research questions and provides a summary of the key findings in this study. From this summary, I draw out the challenges for government and non-government agencies involved in policy formulation and service delivery for homeless populations.

Chapter Two

Literature review

Living homeless is shaped by a range of social, political and economic factors that together provide the context in which daily life is negotiated and experienced by more than 100 thousand Australians every day (Chamberlain & MacKenzie, 2003). In this Chapter, I concentrate on the broad context that affects living homeless in Australia, raising the key dimensions to the homeless experience that dominate academic discourse. In doing so, I discuss some informative theoretical perspectives on ‘home’, ‘homelessness’ and ‘health’. Understanding ‘home’ represents a valuable first layer to our understanding of the loss experienced by homeless people. Its limitation, however, is that homelessness is not synonymous with loss of home or loss of house. Loss of home alone does not account for, or effectively capture, the lived experience of homelessness. To assist in navigating the terms in this thesis, I have drawn on the analytical work of such writers as Mallett (2004), Annison (2000) and Despres (1991).

The discussion then focuses on ‘homelessness’ and contemporary Australian policy, locating homeless populations as distinct cultural groups. I then concentrate on the health literature, with particular emphasis on the understandings and determinants of health, wellbeing and quality of life, and include the Aboriginal Australian perspective of health. The chapter considers what is known about the health of homeless Australian populations and concludes with a discussion on the social processes which give rise to a homeless culture.

Globalisation and Australia's socio-economic health

Wealthy nations, such as Japan, the USA and Great Britain, have invested energy and resources into understanding the complex condition of homelessness. Research, laws, strategies and programs have been developed specifically to provide insight and responses to various aspects of homelessness. Yet the effectiveness of these attempts to combat poverty and homelessness in a climate of growing socioeconomic inequalities can be questioned.

Socioeconomic inequalities do not occur in a vacuum. According to Chopra (2005), there is strong evidence to suggest worldwide growth in inequalities and poverty may be significantly influenced by globalisation. In her paper presented at an Australian home economics conference, Hilary Bambrick (2005) stated:

...Paradoxically, globalisation implies inclusiveness – yet promotes divisiveness. The dark side of globalisation pits rich against poor, north against south, power against the powerless, black against white. And good against evil (p21).

In an address to the United Nations Commission on Human Rights, Miloon Kothari, echoing Bambrick's views, pointed specifically to globalisation as exacerbating the gap between rich and poor. He argued that inadequate living conditions and housing are now present in global proportions. Kothari's concerns have been recognised through many studies (see Kahne, 2004; Morrow *et al*, 2004; Hasegawa, 2005) exploring the link between this era of globalisation to poverty and homelessness (Finley & Barton, 2003). With globalisation a significant factor in increased poverty in developed countries, Australia, like the rest of the industrialised world, is not immune to the adverse effects of this dominant economic and political system.

The Commonwealth Government of Australia has disputed the notion that domestic and international social and economic policies have disadvantaged the nation's poor. Despite this, the impact of globalisation on the health and welfare of Australians is now becoming clear. Structural changes such as urban redevelopment and gentrification observed by Hasegawa (2005) in Japan; a changed welfare system such as Canada's which sees

private solutions to social issues as well as financially driven social policies (Morrow *et al*, 2004); and increased income distribution inequalities in the USA despite overall economic growth, as documented by Kahne (2004), are all impacts of globalisation that are mirrored in Australia.

'*Australia's Social Trends*', an annual series by the Australian Bureau of Statistics, reported in their 1994 publication that the inequality in income distribution of earnings of fulltime adult employees had increased over the previous decade. In the 2000 publication the report revealed that this trend had continued throughout the 90s, showing further growth in income distribution inequality (ABS, 1994; ABS, 2000).

The 1998 Social Trends publication reported 3.4 million people living in poverty in Australia between 1995 and 1996, using the Henderson Poverty Line as a measure² (ABS 1998). Poverty in Australia is measured in terms of relative poverty; being income compared with the income of other families. According to Kelly (2001, as cited in Serr, 2004), the top half of Australian families shared 93% of the wealth, with only 7% shared by the bottom half.

While there is strong evidence to suggest globalisation is increasing poverty in Australia, the resultant social and ecological changes of this international system, as Bambrick (2005) pointed out, have had a profound affect on 'patterns' of health and disease. For most Australians these affects have been positive as confirmed in the Australian Institute of Health and Welfare's (AIHW) report, '*Australia's Welfare 2003*', which maintained that the overall health and wealth of the nation was strong. Yet Indigenous Australians have: much poorer health; suffer higher rates of injury related deaths; are less likely to own their own home; are more likely to be homeless; have a significantly lower life expectancy; and experience a rate of infant mortality nearly three times that of the non-Indigenous population. The report commented, "*similar constellations of disadvantage are experienced by Australians of low socioeconomic status*" (AIHW, 2003a; p.15). In

² The Henderson Poverty Line was developed in 1975 and refers to an approach used to measure the relative poverty of Australians. It works by estimating the income needed for different sized families for very basic or essential living needs (The Brotherhood of St Laurence, 2002).

support of this, Bambrick (2005) stated “*extreme socioeconomic inequalities are evident*” (p.21) in Australia.

This finding is echoed in the ‘*Social Health Atlas of Australia*’ (Glover, Harris and Tennant, 1999) wherein the authors described the:

...striking disparities in health that exist between groups in the population. People of low socioeconomic status (those who are relatively socially or economically deprived) experience worse health than those of higher socioeconomic status for almost every cause of mortality and morbidity (p.v).

Argy (2004) acknowledged that while Australia currently enjoys economic prosperity, its policy norms and values have shifted resulting in ‘government insensitivity’ to social conditions. He cited policy development including those that related to: the long-term unemployed; the underemployed; the growth of low paid and casual employment markets; the “*meaner and more demeaning treatment of welfare recipients and the steady reorientation of welfare spending towards ‘middle class’ benefits*” and the declining progressiveness of the tax system, as central in redefining the social fabric of Australia (p.1). Not dissimilar to the findings in both Morrow *et al* (2004) and Hasegawa’s (2005) research, Argy (2004) concluded that, “*the old welfare worker state is changing beyond recognition*” (p1).

Globalisation is identified as an important dimension in the literature which affects the experience of homelessness. Globalisation has resulted in greater inequalities between the rich and poor people of Western societies, and has been linked to the dismantling of welfare systems. In turn, this impacted on those people in the lower socio-economic groups, exacerbating reduced life quality and poorer health. Homeless people are positioned on the bottom rung of that socio-economic ladder.

Before turning to a discussion which examines the principal consequences of concern to this research, i.e. homelessness, it is important to firstly consider the various constructions of home that exist. These constructions provide some insight into the multiple experiences of loss endured by individuals who become homeless.

Home

...the concept of home cannot exist without the concept of homelessness. Home and homelessness exist in a dynamic, dialectical relationship. They are not, as some suggest, fixed oppositional terms. Rather they refer to 'complex and shifting experiences and identities' (Wardaugh, 1999: 93) that emerge and unfold in and through time (Mallett, 2004; p.80).

A house or shelter, in the physical sense, refers to a structure that people dwell in. Houses may be luxurious, modest or even basic, according to a community's standards, expectations or cultural norms. A house may be positioned on a continuum in terms of its suitability for human habitation. At one end, they are deemed habitable, and at the other they become sub-standard or inadequate. Sen (1993) argued that adequate shelter is fundamental to quality of life and is the basis for the development of all other quality of life issues. Inadequate housing is therefore not only detrimental to quality of life, but contravenes many international human rights declarations and treaties that espouse adequate housing as a fundamental human right (Leach, 1998; Sen, 1993). Therefore, to be without a house, that is to be roofless, is a readily discernable condition. Although the loss of adequate or inadequate shelter is only one aspect of, or pathway to, becoming homeless, it forms the basis of working definitions of 'homelessness' in Australian and many other societies. The loss of 'home', which may or may not have been imbedded in or intrinsically linked to the house, is another matter altogether.

Researchers have explored the meaning of home in specific contexts, such as for migrant women (Thompson, 1996; Pulvirenti, 2000), older women (Gattuso, 1996; Swenson, 1998; Sixsmith and Sixsmith, 1991), the intellectually disabled (Annison, 2000) and families of divorce (Anthony, 1997). This interest has contributed to a growing body of knowledge available to academia, governments, planners and service providers and the like, of the challenges faced when individuals are confronted with a move away from, or loss of, home. This knowledge has developed our understanding of how we create, recreate, retain or discard elements of home. It has also helped us to understand that home is not always construed in a positive vein. Emerging from this body of work is the existence of multiple interpretations and meanings ascribed to 'home' by researchers and

individuals, influenced by experience, perspective and methodological approaches to inquiry. As Veness (1993) observed, “*selected, arbitrary versions of home are being used by researchers, advocates and policy-makers to define what homelessness is*” (p.321). Consequently, the constitution of *home* has been explored from a variety of theoretical and disciplinary backgrounds (Annison, 2000).

In her paper “*Understanding Home: a Critical Review of the Literature*”, Mallett (2004) provided a thorough critique of popular notions of home presented in contemporary literature. She noted that the English origins of the word ‘home’ was derived from ‘ham’ meaning village, estate or town, and by the nineteenth century a man’s house was, almost literally, his castle. This conception, which identified home as a ‘haven’ and incorporated a house and the surrounding land, has continued to dominate contemporary white Western ideas of home. Favouring a physical structure, the white Western home is where space and time are “*controlled and ‘structured functionally, economically, aesthetically and morally’ and where domestic ‘communitarian practices’ are realized*” (Mallett, 2004; p.66). This popular notion of home as house and haven makes distinctions between public and private or inside and outside worlds. Home, as private and inside, is safe, secure and comfortable and in theory is free from surveillance and public scrutiny. Home allows for intimacy for close and caring relationships as well as regeneration. In contrast, the outside or public worlds are imposing and potentially dangerous, and have connections to work, politics and non-kin socialisation.

A criticism of home as haven is premised on the fact that home for many people is not a haven at all, and is a site for sexual, physical and emotional abuse, bringing the outside and dangerous world to the inside and private world. Individuals can feel homeless at home (Veness, 1993; Smith, 1994), and as Tuan (1974) so aptly commented, “*Familiarity breeds affection when it does not breed contempt*” (p.99).

Mallett (2004) also identified the popular conceptions of home which place an emphasis on the interaction between place and social relations, such as those suggested by Saunders and Williams (1988), Pahl (1984) and Massey (1992). This idea presents home

as a socio-spatial system where social relations occur and are reproduced in the house. Social relations in these spaces tended to be described as positive. While home carries a social dimension for many people, constructing home in these terms is problematic for those that live alone, where social interactions in the house may be limited or non-existent or where social relations lead to negative social effects beyond the home setting.

In addition to the notions of home that link house and social relations, are those that are linked to memories. Tucker (1994) identified the natural and the ideal home: the natural being the place understood as conducive to existence; the ideal or imagined home where an individual would reach fulfilment. In this conception, people search for home, which is provisional, unstable and permeable, and is constructed and negotiated.

Home has been described as the 'experience' of being at home, and focuses on the practice and diverse ways people 'do' or 'feel' home. These phenomenological interpretations tend to identify home as a physical space to live and a space for expression of social meanings and identities. Similarly, there is the notion of home as an ideological and sociological construct with people making sense of, and creating, home through lived experiences (Mallet, 2004).

The linking of identity and the concept of self to home has been advanced by authors such as Jung (1961) and more recently Cooper Marcus (1995). In these conceptions, home has been described as a symbol or mirror of the self, with the house embodying the occupant's sense of self. Home can also be a space for self expression. According to Tucker (1994), home may be an emotional environment, a culture, a house or an historical time or place, or any combination of these. Bachelard (1969) went as far to say that home is fundamental to being, as the human identity can be defined by the home as a series of existential experiences of house, town, family, social and professional settings and so on. In this sense, Bachelard (1969) argued that to be deprived of the aspects of home is to deprive man of himself and his humanity. Along this same vein, Wu (1993) contended that home is being with others and that this being with others constitutes the person. Likewise, Heidegger (1971) and Relph (1976) suggested home to be the

foundation of an individual's identity, which orients and directs us. "*Home is the foundation of our identity as individuals and as members of a community, the dwelling-place of being*" (Relph, 1976; p.39).

This discussion leads to an important question in this study, namely, do any of these understandings of home have resonance with homeless people? And what then, are the implications of these understandings for the homeless experience and for the health of homeless individuals?

The holistic view of home

A litany of conceptions of home in the extant literature reflect the multiple, and sometimes conflicting, notions and experiences people have of home, along with the frameworks we choose to make meaning of these conceptions. Home, as a socially constructed and spatially constituted idea (Veness, 1994), is affected by both time and context. Yet few authors have explored a holistic understanding of home. Annison (2000) observed that those who aim to do so tend to develop an 'antithesis model' which reflects the non-home characteristics of the setting under study, such as home being a place where an individual has control over the number and choice of co-residents. She maintained that the common dimensions of home found in the literature see it as a place, with psychological resonance and social meaning, affected by time and with a spiritual element. Annison (2000) suggested that Sixsmith (1986), Despres (1991) and Smith (1994) provided holistic approaches to understanding the concept of home.

Sixsmith (1986) concluded from the literature that home could be concrete, less concrete or totally abstract, enduring or transitory and may differ from person to person, whereas Despres (1991) found four differentiated categories of home discussed by researchers. These included: the territorial; the psychological; the socio-psychological; and the phenomenological and developmental categories of home. The territorial interpretation placed emphasis on the security and control dwellers can exert over the space and behaviours that take place within it and are the primary outcomes of territorial satisfaction. Inherent in homelessness is the occupation of public and semi-public spaces,

in which a reduced level of control can be expected. This has implications to the extent by which homeless people can conceptualise and then experience home in a territorially-based construct.

Despres (1991) found the psychological category had two models, the first being the psycho-analytical which sees home as a symbol of one's self. "*After the body itself, the home is seen as the most powerful extension of the psyche*" (Despres, 1991; p.100). This model builds on Jung's (1981) theory of the collective unconscious and allowed "*for definition and maintenance of three levels of the self: the Ego; the Id; and the Superego*" (Despres, 1991; p.100). The second psychological model was built on Maslow's hierarchy of human needs, where the most basic function of home was to provide shelter which responded to the human need for physical security and health. From this, psychological wellbeing can be attained through comfort and social interaction. Each model, therefore, may be problematic for the homeless existence and the attainment of psychological wellbeing, physical security and health. The first tends to conflate home with house and the second model of home is affected by the extent to which physical security and health can be attained with crude shelter or improvised dwellings. In each model, homeless people are largely excluded from the possibility of experiencing home.

Then there is the socio-psychological interpretation of home. Despres (1991) described self identity as understood in relation to broader social entities, with home acting as a dialogue between individuals and the larger community. The home is a "*container for the material possessions that are meaningful to each household member, the home provides the information necessary to the development of their self-identity, these objects being concrete embodiments of different aspects of their personality*" (Despres, 1991; p.101). The fourth model of home identified by Despres (1991), the phenomenological and developmental interpretation, suggested that home is experienced over time, influenced by individuals' life events. This home is a dynamic process which transforms a dwelling unit into a home in the context of everyday life, and connects a person with their past, present and future. Again, the socio-psychological category of home has limited relevance to homeless people who do not have objects which embody their

personality. The phenomenological interpretation, however, may have some meaning, although the experience of home may well be one that has adverse consequences to the health and wellbeing of homeless people.

The third holistic approach to understanding home was described by Smith (1994) and identified attributes and non-attributes of home. For Smith, positive dimensions of home included identifiable essential contributors, such as: positive social relations; a positive atmosphere with warmth, care and cosiness; individual privacy and freedom; the opportunity for self expression and development; a sense of security; and a sense of continuity. Lack of freedom; dissatisfaction with personal relationships; a poor physical environment; a negative atmosphere; and lack of personalisation, permanence, security and ownership were negatively associated with home environments. Smith (1994, as cited in Annison, 2000) maintained “*home is a complex multidimensional concept, which is experienced simultaneously as a physical and social environment, and as a place for satisfying personal needs*” (p.258). For homeless people, it may well be that the negative associations of home are more commonly experienced.

Conflation of house, home and family

In Australia, mainstream notions of ‘house’ and ‘home’, and even ‘family’, have perhaps been too often conflated, maybe as a result of our Anglo origins where home became associated with man and his castle. Wakely’s (2003) “*Dream Home*” provided a useful example of this notion. According to Mallett (2004), this fusion has been deliberate and has had benefits which have extended beyond industries such as real-estate, to governments with particular social agendas. The Commonwealth Government of Australia (2004) joint initiative with the building and design industries, ‘*Your Home. Your Future, Your Lifestyle. Your Step By Step Guide to Comfortable, Stylish and Healthy Living*’, is one such example where house and home merged as one concept. Further, it is a prime example of what Mallett (2004) might have described as a clear gain for the building and design industries and government, resulting from a community’s valorisation of home ownership.

This particular costly initiative, comprising video, magazine with CD ROM and web-based informational and promotional material, aimed to assist the public in developing housing that were energy efficient, designed in an environmentally sustainable fashion and which secured the important services of professionals at different stages. The contents of the material largely aimed to explore the size of the building, solar passive design, orientation, site planning, insulation and the like, right through to your choice of appliances, wherein the ‘perfect marriage’ between a stylish house and good appliances can be achieved. While the advocacy of sustainable housing was not under scrutiny, the strategy of linking house design with a preferred government social ideology was rather more contentious. Of particular relevance to this research were the opening lines of the video production; sentiments expressed throughout the material of this initiative. The Commonwealth Government of Australia (2004) proudly told us that houses were once just shelter from the elements, but now:

...we want them to be stylish, comfortable, healthy, safe, and above all, we want them to enhance our lifestyle. Your home is more than just bricks and mortar, it communicates your values. Your home is an expression of you (2004, transcribed from video production).

This form of blending of house, home and family is what Mallett (2004) regarded to be part of a broader government driven ideological agenda “*at increasing economic efficiency and growth*” (p.66).

While this may well be the case, the question remains that if the governments (or part of) see the ‘house’ as synonymous with ‘home’, when a person becomes homeless do they no longer retain the fundamental means to communicate their values or the mechanism for self expression? Or is it that homeless people lose their values and ability for self expression when they no longer dwell in a house? Through multiple subtle and subliminal messages, such as those prescribed in ‘*Your home. Your Future...*’, the socioeconomic imperative to sustain occupation of a house is profound. In achieving this broader ideological agenda, part of government may take on a pivotal role in the stigmatisation, social exclusion and sustained marginalisation of homeless persons.

This role is in direct opposition to the Australian Government's position in responding to the provision of support and accommodation assistance to those that "*form one of the most powerless and marginalised groups of society*" (Commonwealth Government of Australia, 1994, p.1). The Supported Accommodation Assistance Program (SAAP) is the primary strategy in Australia that seeks to respond to the needs of people who are homeless, at risk, and/or are escaping domestic violence (Carusi, 2003). The preamble of the *SAAP Act 1994* stated:

...the Parliament recognises the need to redress social inequalities, and to achieve a reduction in poverty and the amelioration of the consequences of poverty for individuals (Commonwealth Government of Australia, 1994, p.1).

The Act identified the need for responses to empower homeless people and maximise their independence in ways that: respect dignity; enhance self esteem; are sensitive to social and economic circumstances; and are respectful of cultural backgrounds and beliefs. The confusion lies in the fact that part of the same government's rhetoric advocated an ideology that stripped these homeless people of their values and basic human rights, destroyed dignity and self esteem and disregarded social and economic circumstances and cultural backgrounds and beliefs. Consequently, the conflation of house and family with home has had adverse consequences for those without a home.

From home to homeless

Home, according to Annison (2000), is a multi-faceted concept. As discussed, home can be a haven or conversely, a place of oppression and fear. Alternatively, home can be a site for political action or radical activity for people who feel marginalised from public spaces. Home may be constituted by a family, a place for social relations and connectivity or refer to a house, place, space, town or country of birth, work or memories. It may also be a state of being in the world, a reflection of the self or the foundations of one's identity.

Home can also be a homeland, town, city, community, outstation³, where a person's family is or where a person usually lives. It can be a network of relationships in which people stay, arrive and leave. It can be many places with many states of being. Home can be about where you are going rather than where you are from, which is consistent with Tucker's (1994) belief that home-searching is a basic human trait necessary for survival of the species. As Mallett (2004) argued, it can be possible then to be homeless *"in one, some or all of these categories at the same time"* (p.79). Home, therefore, has no singular meaning and as Mallett (2004) concluded:

the term home functions as a repository for complex, inter-related and at times contradictory socio-cultural ideas about people's relationship with one another, especially family, and with places, spaces and things (p.84).

The loss of home is therefore contingent on an individual's conception of home in the first place. Whatever that particular loss may be, it has a profound affect on individuals, families and whole communities. Anthony (1997) observed that the loss of home may generate severe grief in individuals which resembles the loss of a family member. She found that the process of loss ranged from denial to acceptance, and paralleled the stages associated with death and dying. Similar experiences of grief over the loss of home have been documented by Relph (1976), citing examples from the USA, the Czech Republic and Japan.

While understanding home provides an insight into the potential types of losses and associated grief individuals experience, these many conceptions of home point to the possibility of multi-dimensional aspects of home being experienced during 'homelessness'. However, to reiterate a previous point, the loss of home and house only explains part of the homeless experience.

³ An outstation refers to an Aboriginal settlement whereby Aboriginal people reconnect with more traditional living practices on home country. Known as the outstation or 'homelands movement', from the early 1970s some smaller groups of Aboriginal people moved (sometimes forcibly) away from the larger communities or settlements (Royal Commission into Aboriginal Deaths in Custody, Commissioner Elliott Johnston 1991).

Homelessness in contemporary Australia

Veness (1993) commented:

...the majority of the literature on homelessness is strangely silent about how present definitions of homelessness are based on a particular ideology, and how these ideological constructs are being written into public policy...when researchers and policy-makers use a definition of homelessness that implicitly supports an already biased definition of home they may be hurting marginalized people and reinforcing the status quo (p.320).

Layered over this ideological influence, homelessness is culturally and socially defined, with meaning attained through a particular community at a given point in time (Tipple & Speak, 2005). Consequently, definitions of homelessness vary and government policies and/or legislation that distinguish 'homeless' from 'housed' differ from place to place. Despite loss of house and home not being synonymous with homelessness, the loss of a house or shelter and important elements of home are a common experience among many homeless people. In Australia, many have argued that house, home and homelessness are all culturally defined, multilayered and multidimensional (Keys Young, 1998; Chamberlain & MacKenzie 2003; MacKenzie & Chamberlain, 2004; and Memmott *et al*, 2003), yet rarely do homeless definitions and policies reflect this complexity.

Veness (1993) contended that the most common interpretation of homelessness found in policy documents and research literature typically include three dimensions; the habitation of structures that do not meet society's standards; the inadequate economic relationship to housing; and the illegal or unconventional access to private spaces. Rarely do definitions of homelessness engage with the many ways people experience home, with most definitions gravitating to more tangible and less ambiguous working definitions, such as those based on shelter type. Veness (1993) argued that by narrowing the definition of homelessness around structures, economic position and legal rights, we fail to address quality of life issues.

Australia is no exception to this common interpretation. In Neil and Fopp's (1992) study, one of the first to explore the causes and consequences of homelessness in Australia,

homelessness was observed as an interaction of structural factors, such as housing and labour markets, within a particular social context. Neil and Fopp (1992) maintained that for successful policy, recognition must be given to the fact that homeless populations are not homogeneous and that any general assumptions made about their needs must be questioned.

It is debatable as to whether contemporary policy has taken Neil and Fopp's (1992) findings into consideration at all. Homeless policy has been founded on methodologies and definitions developed by Chamberlain and MacKenzie (1992). They described their definition as a cultural one wherein homelessness and adequate housing are understood as social constructs and cultural concepts, with meaning attained through a particular community at a given point in time (Chamberlain & MacKenzie, 2003). This approach was employed by the Australian Bureau of Statistic (ABS) in the 1996 and 2001 census reports and identified three categories among the homeless population for enumeration purposes; the primary, secondary and tertiary homeless (ABS, 1996 & 2001). The primary homeless consisted of people without conventional accommodation, such as those sleeping rough, in improvised dwellings or squatting in derelict buildings, cars and railway carriages. The secondary homeless category included those that regularly move from one form of temporary shelter to another, such as people in hostels and night shelters, and the tertiary group referred to those in boarding houses on a medium to long term basis (Chamberlain & MacKenzie, 2004; Memmott *et al*, 2003).

Despite the claims of a 'cultural' definition of homelessness, the three categories used to enumerate homelessness made distinctions based on shelter type (Flatau *et al*, 2006), and did little to explain the socio-cultural variations in meaning. This was illustrated by Keys Young (1998) who conducted one of the first studies to examine the meaning of homelessness from the perspective of Aboriginal and Torres Strait Islander Australians. Five distinct types were identified:

- (i) Spiritual forms of homelessness linked to separation from traditional land or family;

- (ii) Overcrowding as a hidden form of homelessness leading to stressful and distressing circumstances;
- (iii) Relocation and transient homelessness due to transient and mobile lifestyles and the necessity of travel for access to services;
- (iv) Homelessness as a result of escaping an unsafe or unstable home for safety or survival reasons; and
- (v) Homelessness due to a lack of access to a stable shelter, accommodation or housing, with nowhere to go.

Participants in their study regarded homelessness as a significant problem due to the disproportionate numbers affected. They believed it was experienced differently to non-Indigenous people due to underlying causes and factors combined with poor health, financial and social status. To be branded homeless can bring major stigma and shame to communities (Keys Young, 1998).

Building on the work of Keys Young (1998), Memmott *et al* (2003) also raised concern over the ‘cultural’ definition of homelessness proposed by Chamberlain and MacKenzie (1992). They noted the many cultural groups existing in Australia who ascribe their own meanings to housing and home and draw on the Aboriginal people living outside of conventional structures to make this point. They argued that Aboriginal Australians living without walls or a roof may see themselves as both ‘placed’ and ‘homed’ (Australian Institute of Health and Welfare (AIHW), 2003a). Memmott *et al* (2003) suggested the term ‘public place dwellers’ was more appropriate than ‘homeless’ in this context and characterised this segment of Aboriginal Australians as:

...those who do not pay for accommodation, have a visible profile (socialising, sheltering, drinking, arguing and fighting in public), have low incomes of which a substantial part is often spent on alcohol, have generally few possessions (minimal clothes and bedding), and usually conform to a “beat” of places where they camp and socialise in particular public or semi-public areas (Memmott *et al*, 2003; p.i).

Like Keys Young (1998), Memmott *et al* (2003) advocated for categories of public place dwellers which also included: spiritual homelessness; crowding which causes stress; and

those escaping unsafe or unstable family lives. Memmott *et al* (2003) departed from Keys Young's (1998) categories in that they identified those living and occasionally spending time in public place as two additional categories of public place dwellers, and suggested a further subdivision of these based on those who intended to return home and those who intended to live permanently in public places. Memmott *et al* (2003) did not specifically acknowledge transient homelessness due to transient and mobile lifestyles and the necessity of travel for access to services, however this may be incorporated in the category of spending time in public places with the intention to return home eventually. Again, the lack of access to stable shelter, accommodation or housing category identified by Keys Young (1998) may be encompassed by Memmott's *et al* (2003) public place dweller category. Without specific recognition of homelessness stemming from lack of access to shelter, there remains the potential to obscure the cause or type of homelessness experienced, leading to an answer of 'it depends' to the question of an individual's intention to return home. Despite an increased understanding of Aboriginal homelessness, the AIHW (2003a) contended that this topic is still not well understood.

A further definition of homelessness in Australia has been developed in relation to the Commonwealth government's primary response to homelessness, affected through the *SAAP Act 1994*. The Act uses a formulation of homelessness that concentrates on eligibility for services (Chamberlain & MacKenzie, 2003). A person is deemed homeless if they live in a SAAP agency or other emergency accommodation, and they do "*not have access to safe, secure and adequate housing*" (AIHW, 2003b, p.xv). Further, a person is also deemed homeless if the housing they have access to: damages or is likely to damage their health and safety; marginalises a person; places a person in a position that adversely affects the adequacy, safety, security and affordability of housing; or if they have no security of tenure (AIHW, 2003b). Housing that is affected by any one or more of these conditions renders it unsafe, insecure or inadequate.

Australia's homeless and the Supported Accommodation Assistance Program (SAAP)

In John Stubbs' 1966 book, *The Hidden People. Poverty in Australia*, he referred to the vagrants and homeless men as the 'homeless army' because their numbers exceeded that of the army. Drawing from the data collected by Jordan (the manager of a Victorian homeless service), Stubbs (1966) observed that the places serving homeless men at the time reduced the visibility of the plight of the homeless from the public eye. Following more than 1000 interviews with homeless men over a 2 year period, Stubbs (1966) concluded that:

...because our homeless men are in frequent contact with each other and tend to become acculturated to common distinctive values, customs and myths, the group has developed characteristics of a sub-culture similar to that of the American "Skid Row" communities (p. 80).

Forty years on, the homeless army continues to grow, and includes more than 100 000 people across Australia (ABS, 2004). This population, however, is now five times larger than the Australian army (Roy Morgan and the Australian Department of Defence, 2003) with many people well hidden. Social dysfunction, lack of personal resources with few belongings, hunger, unstable employment, crime and incarceration, physical and mental illness, substance use and abuse, neglect or rejection, violence, death, socio-economic related stress and general deprivation were all characteristics of homelessness that emerged through Jordan's homeless study and remain relevant today (Stubbs, 1966).

Homelessness rates are one important indicator of poverty. Increased rates of homelessness also reflect the growing inequalities between low and high socioeconomic groups in Australia. Chamberlain and MacKenzie's (2003) *Counting the Homeless 2001* report, drawing on the 2001 census data and supplemented by the National Data Collection Agency, estimated the national homeless population to be more than 100 000. This is an approximation only, accounting for fluctuations associated with people moving in and out of homelessness. Of this population, 78% (58 116) were identified as individuals and there were a growing number of younger homeless people, with 46% of this population being under 25 years of age.

While only 2% of the total Australian population identified as being Indigenous, Indigenous peoples were over-represented in all sections of homeless populations. In 2001 they accounted for 9% of the total number of this population nationally, and between 2000 to 2001, they accounted for 16% of SAAP clients (Chamberlain & Mackenzie, 2003).

The Commonwealth government's primary response to homelessness is affected through the SAAP. As noted, it is a bilateral agreement between the Commonwealth and States and Territories and uses a formulation to define homelessness that determines eligibility to SAAP services (Chamberlain & MacKenzie, 2003). The national goal of SAAP is to provide transitional accommodation and related support services to people who are at risk of homelessness, or who are homeless. Resolving crises, re-establishing family links where relevant, and re-developing the capacity of clients to live independently are key dimensions of this goal. SAAP, at a national level, aims to: reduce homelessness; promote self-reliance, choice and independence; respond to the dynamic nature of crisis; and strengthen partnerships with service providers (NT Department of Health & Community Services (NTDH&CS), 2005). There were four strategic themes that were identified as priority areas. These included:

- (i) A client focus orientation to service delivery;
- (ii) Integration and collaboration between SAAP and other service systems;
- (iii) Increasing performance, knowledge and skills; and
- (iv) All levels of government working with community in partnership (NTDH&CS, 2005).

One important matter arising from enumeration of homelessness and SAAP service provision is that funding has been distributed on the assumption that homeless populations are distributed in the same way as the general population. Echoing this concern, Chamberlain and MacKenzie (2003) argued "*the geographical distribution of the homeless population across the states and territories should inform how resources are distributed*" (p. 67).

Research into homelessness

While definitions of homelessness have continued to place an emphasis on its structural causes, a review of the recent literature dealing with homelessness in the Australian context and more globally suggested that research and policies (both government and non-government) have concentrated their energies on: early prevention programs that attempt to prevent people from entering into a state of homelessness; early exit programs that return people to acceptable accommodation; and of course, enumeration. Research under these banners has tended also to be fragmented, as illustrated by studies on the links between housing and homelessness, such as Judd's *et al* (2004) exploration into housing options for older homeless Australians, or understandings of homelessness among Indigenous Australians (Keys Young, 1998; Memmott *et al*, 2003). Other research fragments have considered specific illnesses, mortality and access to health care among homeless people (see Darnton-Hill *et al*, 1990; Rosenthal *et al* 1994; Buhrich *et al*, 2000; Kang *et al*, 2000; Kamieniecki, 2001; Buhrich *et al*, 2003; Judd *et al*, 2004; Robinson, 2003; Teesson *et al*, 2003 & 2004; and Graham-Jones *et al*, 2004; Rice *et al*, 2005). Some researchers have concentrated on the enumeration of various homeless populations (see Strategic Partners Pty Ltd, 2001; Chamberlain & MacKenzie, 2003; MacKenzie & Chamberlain 2004).

Consequently, much of the research on homelessness in Australia has had the propensity to tell us about parts of the phenomena and has aimed to solve the homeless 'problem' (see Darnton-Hill *et al*, 1990; Chamberlain, 1999). While this body of knowledge is critically important, rarely does it advance our understanding of the lived experience of homeless people while they are experiencing homelessness, nor the context in which decisions are made and where meaning is attained. Without this knowledge it is difficult to determine what dimensions, if any, of the homeless experience have an influence on health and life quality of homeless people.

The dominance of research undertaken from a positivist perspective in the public health discourse has been well documented (McIntyre, 1996; Ritchie, 2001). The majority of knowledge generated about homelessness has also been through traditional scientific

methodologies such as census data and structured survey instruments. As such, qualitative inquiries have the potential to complement this knowledge by generating additional, perhaps alternative, understandings of the issue through obtaining a greater depth of insight into aspects of homelessness. In Australia there have been few such investigations, but the few that have emerged, have been critical in unpacking the multiple layers and dimensions associated with homelessness (see Keys Young, 1998; Coleman, 2000 & 2001; Robinson 2004 & 2005; Parker & Fopp, 2004; Zuffrey & Kerr, 2004; Danby *et al*, 2006). Yet much remains to be learned about the lived experience of homelessness from the perspective of the individuals concerned; the emic view point.

Echoing this view, Parker and Fopp (2004) contended: “*much of the Australian literature regarding homelessness to date omits the perspective of people who are homeless...particularly in the academic literature, qualitative analysis remains relatively undeveloped...*” (p.145). Zuffrey and Kerr (2004) also found that the “*..study of the lived- experiences of homelessness remains an area that is largely under-researched*”(p.343), while Robinson (2004) argued for a shift from solving the homeless problem as it relates to causes, to understanding what homelessness actually is through the experience of compounded social exclusion lived as compounded displacement, vulnerability and trauma. She commented, “*...we continue to match our ‘solutions’ to homelessness with ‘causes’, rather than looking at what lived trajectories of homelessness actually become*” (p.5). Of particular importance to this present study, Waters (2001), in an exploration into the links between housing conditions and health of Australians, emphasised the need for research on the effect of homelessness on health, and the relationship between housing and health among Indigenous Australians. Needless to say, my own investigation of the literature found a scarcity of research that explored the lived experience of homelessness in Australia.

The ‘*Working Towards a National Homeless Strategy*’ (Commonwealth Advisory Committee on Homelessness, 2001), maintained that the only way to reduce homelessness is by tackling the structural factors that produced it. These factors related to employment, income security, housing, strengthening families, community support,

health, disability, drugs and alcohol, and criminal justice and correctional services. Like previous approaches to the 'homeless problem', the Strategy placed emphasis on reducing homelessness through prevention, and highlighted a range of research needs commonly directed at 'at risk' homeless populations. Although the Strategy identified a number of health related initiatives and necessary actions which cut across multiple sectors, there is only one area specifically identified under the heading of 'Health' for further research, that being the "*need to know more about the experience of people at risk of homelessness... in exercising their entitlements under the Medical and Pharmaceutical Benefits Schemes and using practitioner services*" (2001, p.35).

Under the Strategy's heading 'Indigenous People', there is greater scope to explore health within a cultural context. It identified the need to "*improve the health status and longevity of indigenous people experiencing homelessness*" (Commonwealth Advisory Committee on Homelessness, 2001; p.46), to which this thesis is a response. Further, the strategy highlights its aim to:

To increase and improve awareness and understanding of how the legacy of history continues to affect the emotional and social wellbeing of indigenous people (p.46).

In recent decades the voice of Aboriginal people has increasingly challenged the dominant historical narratives. Despite this, today there still remains a reluctance to listen and really acknowledge and understand the legacy of this history by the dominant institutions. One prime example of this is the Australian Prime Minister's, Mr Howard's, willingness to accept a version of Aboriginal history and the injustices of the past, yet at the same time, refuse to make an apology for this past. This refusal illustrates a dominant discourse which sees the history of Aboriginal people as being disjointed from the contemporary socio-economic challenges that exist in many Aboriginal communities today.

The limitations derived from the inconsistencies between the identified goals and research areas detailed in the '*Working Towards a National Homeless Strategy*', and the emphasis Australian researchers have placed on enumeration, early prevention of and

early exit from homelessness, the evidence confirms that support services remain a critical area for investigation when people exist without a house and/or a home. Further, the fragmentary approach to knowledge generation and the omission of the perspective of homeless voices in research is considered a limiting factor in gaining any comprehensive or meaningful understanding of the complexity of homelessness. Zufferey and Kerr (2004) commented:

The lack – or apparent lack – of recognition of the complex interplay of factors that make unique each person experiencing homelessness, is evident in policy and practice, which can be overwhelmingly generic, inflexible and disempowering (p.249).

This process, according to Zufferey and Kerr (2004) has blamed the victim, and they have questioned to what extent policy makers, funding bodies and service providers “*contribute to exploitative systems of power, constructing processes of victimisation*” (p.350).

It is perplexing that researchers and policy makers seem reluctant to place any emphasis on the quality of life of a person while homeless and also reluctant to explore the situation beyond the realms of securing accommodation for the individual. Jordan (1996) contended that the lack of research on the everyday lives of poor people in any dimension other than material resources is due to a literary construction of the poor as threatening, burdensome and a source of social contagion. He maintained that many researchers did not want to add fuel to this view and therefore avoided such investigations. Jordan (1996) suggested that when qualitative studies were undertaken, they addressed a claim from a conservative camp, such as ‘dependency culture’, and attempted to show that aspirations and attitudes did not differ between the poor and other citizens. Ife (1997) however, argued that social, political and economic order lie deeply embedded in the dominant economic rationalist, market and managerial discourses. He sees this order as fundamentally unsupportive of goals that relate to social justice, including legitimising the voices of marginalised people. Both Ife (1997) and Jordan’s (1996) arguments may account for the limitations in the depth, scope and the nature of inquiry in areas of social justice, such as homelessness, in Australia.

Despite the misconceptions and multiple interpretations of homelessness, the academic knowledge generated so far and subsequent dialogue have ensured it is generally touted to be more than a housing deficit and is widely regarded as a multilayered and multidimensional problem (Leach, 1998; Morrell-Belai *et al*, 2000; Robinson, 2004, 2005 & 2006; Flatau *et al*, 2006). This work has given homelessness legitimacy in government policy and expenditure. Too often, however, this recognition is sucked away in a vacuum of rhetoric, as our policies, programs and mainstream understandings of homelessness gravitate back to the more tangible working definition based on shelter type essential to the generation of traditional scientific knowledge. This approach points to a fundamental imperative to unpack the many layers and dimensions of homelessness until they are reflected in social planning, policy and action. As such, definitions of homelessness require conceptual development if they are to respond to the disjuncture between the multiplicity of forms of loss of home together with the lived experience of being homeless. As Springer (2000) has argued, “*Reliable data about the homeless is a basic need of policy makers to find positive solutions...*” (p.476).

Like ‘home’, homelessness has many meanings to different individuals and cultural groups. How these meanings are understood is also influenced by the theory and approach informing the inquiry. As with the term ‘home’, what homeless is really depends on a number of factors. The need to understand the multiple ways in which home is understood by individuals provides an important first step to understanding what is lost when a person becomes homeless. Despite this, regardless of an individual’s understanding of home, it is important to reiterate that the loss of this home does not effectively capture the experience of homelessness. The loss of home is only part of becoming and being homeless, with homelessness itself providing additional experiential layers, or what Robinson (2004) has referred to as the lived trajectory of homelessness. As such, to be homeless may be best understood as the process and experience of loss of house and home, which becomes inextricably linked to the experience of being homeless. In homelessness, individuals may retain, reconstruct or develop new understandings of home, but do not appear to have all the necessary elements to experience a positive sense

of home that many authors allude to. This is supported by Veness (1993) who found that some individuals who were labelled homeless contested the term as they considered that the environments and experiences that constituted their worlds constituted their notion of home.

Veness (1993) asserted that the domain between what is home and homeless is a contested one:

Homeless is not a temporally and spatially circumscribed category that puts those people who fall into it in a time and space limbo until the boundary conditions of home have been met. Rather the environments and experiences of home are negotiated...By upholding the idea that home should be reserved for people whose habitats and habits conform to minimum standards, and then insisting that all people be guaranteed access to society's definition of home, the homeless cannot be 'neutralized' – ignored (p.324-5).

Perhaps at the heart of the homeless debate is the propensity of mainstream society and policy makers to construct homelessness only as a negative condition or problem or as Veness (1993) contended, a place reserved for those who fail to conform to minimum standards. Homelessness, after all, is not entirely devoid of the positive dimensions ascribed to home. In Australia Serr (2004) maintained, "*unless the real poverty experts, namely the poor themselves, have a significant voice in the definition of the problem, no adequate solutions can be found, nor meaningful strategies formulated*" (p.148).

From this standpoint, the scope to learn about environments that are conducive to better health and life quality for this population and which reflect the experiences and hopes of homeless people themselves, is somewhat expanded. We must, however, explore the social processes which give rise to, or support, the thinking on homelessness which reigns over mainstream society.

When society's rules are broken: normal versus stigmatised

In the developed world there has been a growing tendency for society to blame the poor and their shortcomings for their poverty (Phelan *et al*, 1997). If we are to subscribe to the notion that social justice and action are essential if we are to reduce the growing inequities between the wealthy and poor, it is both timely and critical we explore the

underlying causes of this blame. Phelan *et al* (1997) have suggested that dominant groups disseminate systems of beliefs, values and attitudes which are internalised by most of society; a process which defends the social order. In this context, Phelan *et al* (1997) argued that it is inevitable that homeless people will be stigmatised for their poverty.

...identifying a person as being homeless, rather than eliciting compassion or reducing blame, engenders a degree of stigma over and above that attached to poverty...a label of homelessness significantly increased social distance (Phelan *et al* 1997 p.332).

Goffman (1963) identified three types of stigma: physical deformities of the body; blemishes of individual character (such as those affected by mental disorders, imprisonment, addiction, alcoholism, homosexuality, unemployment, suicidal attempts and radical political behaviour); and tribal stigma of race, nation and religion. At the core of each of the three stigmas lay social exclusion or rejection from full social acceptance.

According to Goffman (1963), a stigma referred to an attribute of an individual that is deeply discrediting, making the person different from the social group, “*of a less desirable kind...reduced in our minds from a whole and usual person to a tainted, discounted one*” (p.3). He held that while individual attributes were central to stigma, it was their relationship to the expectations of the social group that defined and determined whether an individual was credible or not.

Individuals at risk of deviant stigma, according to Goffman (1963), are either the ‘discredited’ or the ‘discreditable’. When the stigma was known to others it constituted an individual being a ‘discredited’ person. In this case, the stigma was either not able to be hidden and/or the individual had revealed it. Goffman (1963) argued:

...we are likely to give no open recognition to what is discrediting of him, and while this work of careful disattention is being done, the situation can become tense, uncertain, and ambiguous for all participants, especially the stigmatized one (p.42).

Conversely, the 'discreditable' worked to conceal their stigma. Goffman (1963) explained that while the 'discredited' focussed on managing tensions during social interactions, the 'discreditable' emphasis was on managing information about their differences. Goffman (1963) argued that through effective management, this latter group could be regarded by others as non-deviant due to their avoidance of stigma symbols and by their use of dis-identifiers. Stigma symbols, he suggested, included those things which linked individuals to their deviance, whereas dis-identifiers referred to props or actions used to reinforce a non-deviant status among others.

While the literature has identified homelessness itself as a highly stigmatised condition, the associated conditions also break the rules established by the dominant groups of society. Living rough with no fixed address; not having employment and/or receiving welfare pensions without 'good' reason; being perceived as dangerous (Hopper, 1988); and failing to participate in 'normal' social processes are all conditions that challenge the social order of things and attract a deviant stigma. As Hopper (1988) observed, "*homelessness remains locked with the conceptual brace of 'deviancy'*" (p.164).

Becker (1963) highlighted the significant effects of being branded. He commented, "*the most important consequence is a drastic change in the individual's public identity*" (p.32). He explained that one deviant act was likely to lead to the individual being regarded as deviant in other respects. Becker (1963) argued, "*social groups create deviance by making the rules whose infraction constitutes deviance and by applying those rules to particular people and labelling them as outsiders*" (p.9). Through this process, what is 'normal' became defined. In short, normality was a construct, ascertained by the level of danger perceived by people cohabitating in a common physical setting (Misztal, 2001), and the 'normals' were those that do not break the rules and who were not regarded dangerous by the social group.

The processes of normalisation and stigmatisation in society have an important bearing on how homelessness is understood and the lived experience of homeless individuals. These processes have implications for structural responses to homelessness which aim to

educate, employ and house people, for instance, yet at the same time work to exclude, stigmatise and punish those who have broken, or continue to break, the 'rules'. It can be concluded from this review that exclusion from participation in normal society has consequences for the health, wellbeing and life quality of individuals. But we must ask, however, *how* do these processes of stigmatisation and normalisation affect the homeless experience, and *to what extent* do they influence the health of homeless individuals.

Health and homelessness

As already discussed, Australia's poor continue to be flagged as experiencing reduced health outcomes when compared to wealthier Australians (see Glover, Harris & Tennant, 1999; AIHW, 2003a; Bambrick, 2005). Despite the decades of dialogue and effort aimed at reducing the inequalities among Australia's rich and poor, poor Australians continue to be worse off, and their health compromised. In fact, Waters (2001) found that while the 'health gap' grew over a 20 year period from the early 80s to the late 90s, of greater concern was the finding that aggregate incomes over the same period remained unchanged. It stands to reason that the homeless, the most impoverished in Australian society, are most adversely affected in terms of health outcomes; a view supported by the Commonwealth Advisory Committee on Homelessness (2001), who maintained that the homeless "*have significantly poorer health than the general community — mental health problems are particularly prevalent*" (p.34). This position was echoed by the Human Rights and Equal Opportunity Commission in a national inquiry who confirmed that "*homeless people suffer a high rate of physical and mental health problems. Many of them are regarded unemployable and are generally isolated from the rest of the community*" (Sidoti, 1996, p.6).

The '*National Inquiry into the Human Rights of People with Mental Illness*', often referred to as the '*Burdekin Inquiry*', reported the changes to homelessness resulting from deinstitutionalisation of mental illness in Australia (Human Rights and Equal Opportunity Commission, 1993). This report, and many since, identified that homeless people suffer from chronic ill health (Geber, 1997). This report was pivotal in raising awareness about the mental and general health of all homeless populations, highlighting the broad range of

health problems as they relate to associated high risk behaviours. Further, it has been demonstrated that at least one significant mental disorder affects at least 75% of homeless populations accessing inner city hostels (Robinson, 2003).

Like the ideological imperative to maintain a house as a fundamental mechanism to express your values and good citizenship, staying healthy or in good health are now often associated with self-development and the potential of individuals and are both a civic duty and a duty to oneself (Peterson & Lupton, 1996). Peterson and Lupton (1996) contended that advertisements, such as the South Australian Health Foundation's which stated that 'to enjoy life you must be healthy first, and to realise your dreams the first step is to enjoy being healthy', imply that individuals are free to adopt health promoting strategies. In fact, a strong characteristic of the new public health philosophy, they argue, is to enforce such strategies. For homeless individuals, the prerequisite of attaining good 'health' in order to enjoy life may well place an 'enjoyable life' out of the reach of many. This thinking also has implications for the matter of freedom of choice in relation to health seeking behaviours and also the real accessibility of health promoting strategies to fringe dwellers or marginalised citizens.

Health, wellbeing and quality of life

'Health' remains a contested term. The World Health Organization's 1946 constitutional definition of health has been the most universal. It described health as:

... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security (WHO, 1946).

Although praised for its holistic and positive sentiments and generation of global interest in health, this definition has received wide criticism for failing to translate into practice (see Seedhouse, 1997; Raeburn & Rootman, 1998; Wass, 2000). Others have suggested that the definition of health includes an equally vague word, 'well-being' (Engelhardt, 1981; Seedhouse, 1997; Van Spijk, 2002). Engelhardt (1981) commented, "*such a*

definition of health packs the ambiguity of the concept of health into the ambiguity of the concept of well-being” (p. 32). Describing human well-being as value laden in character, Engelhardt (1981) stated that it “*is contextual and has numerous contexts in which human well-being can be defined*” (p. 147).

Despite the ongoing debate about the limitations, meaning and practical implications of the WHO’s ‘holistic’ health, it is the most commonly cited definition in Australia, reflecting more so an ideal rather than anything attainable. In reality however, the biomedical view of health has dominated health policy and practice, and as Senior (2002) has argued, this approach has a “*focus on the individual and their disease with little concern for an individual’s place in society*” (p.62). This view sees health and disease objectively according to our understanding of the disease and based on its structure and function in humans (Lavados, 2002). While this approach to health has failed to recognise the multiple social influences affecting the health of individuals and communities, it has also created tensions between doctors and patients. According to Senior (2002), these tensions can be attributed to different understandings of the body and disease by the patient and doctor and are exacerbated by the disempowerment of individuals throughout their life by the medical profession.

Baum (1998) identified three key perspectives on health found in the literature: health within a biomedical model; health as an expression of political economy; and health as understood by ordinary people (the lay perspective). Ordinary people, (in theory, including those who are homeless), tended to incorporate three domains in their construction of health: not being ill; a prerequisite for life’s functions; and wellbeing expressed in physical and mental terms. Other lay interpretations of health also included health as a reserve for recovery from illness; as social relations; as psycho-social wellbeing; and as encompassing a spiritual dimension (Baum, 1998; Raeburn & Rootman, 1998). With diverse understandings of health and illness among ordinary people and the medical profession, Senior (2002) maintained the derived tensions result in barriers to communication and may be the cause of: different opinions on appropriate

treatment; non-compliance with medical instruction and treatment; dissatisfaction with quality of care; and different ideas about quality care.

Illich (1976) argued that health and daily life have been appropriated and controlled by biomedical notions of health and modern medical practices. Sontag (1979, as cited in Baum, 1998), in advancing this argument, found that being unhealthy or ill were undesirable states which suggested “*adverse moral and psychological judgements about the ill person. Being healthy is viewed as so important that it affects both the way people experience illness and the way they regard those who are ill*” (Baum, 1998; p.4). Lupton (1994) went as far as to say that in contemporary Western societies, medicine and public health have “*replaced religion as the central institutions governing the conduct of human societies*” (p. 156). According to Senior (2002), in this context the biomedical model of health has been favoured at the expense of holistic views of health. Holistic views, Lavados (2002) asserted, have two key features: feelings of well-being and suffering; and the ability to perform actions that people need or want to on a daily basis.

It is evident from the health discourse that the disjuncture between ordinary and biomedical notions of health generates challenges for individuals to take control of their own health. For homeless individuals, these challenges are perhaps even greater as their visible illnesses attract the adverse moral judgements referred to by Sontag (1979), fuelling society’s stigmatising processes. In this way, illness engenders increased levels of social exclusion.

Kahn and Juster (2003) suggested that “*wellbeing and quality of life are elusive concepts*” too (p.628). While ambiguity around ‘health’ remains, ordinary people continue to make links between their quality of life, wellbeing and health status. Concepts of health are nearly always embedded with notions of wellbeing (and vice versa). Douglas and Mathers (1988) noted that people engage in practices which may adversely affect health, but which are conducive to feelings of wellbeing, for example smoking or unprotected sex. This, they argued, enhances some of the determinants of quality of life, at the expense of others. Cummins (2006) commented, “*It is often*

assumed that medical health equates to high life quality, this is not necessarily so in all situations. Provided that people have other resources, financial or relational, some people in ill-health can experience high life quality” (p.13).

Classical theorist, Max Weber, hypothesised that one’s lifestyle and quality of life was a function of both life choices and life chances. He maintained that lifestyles were social processes that occurred mainly by choice within a social context which was provided by chance (La Gory *et al*, 2001). As discussed earlier, it is this notion of quality of life which has provided a cornerstone for Western contemporary ideology around welfare and those who are deserved or not.

Raeburn and Rootman (1998) maintained that quality of life is the subjective or experiential account of an individual’s perception of their life. They noted, *“In particular, it relates to the degree to which the person is able to enjoy the possibilities that life presents”* (p.36), although maintaining that Quality of Life (QoL) is determined by both environmental and personal factors. They argued that when the determinants have a positive effect, the experienced positivity is wellbeing. On the contrary, a negative experience is ill-being. This understanding is useful when considering wellbeing among homeless populations as it permits a continuum of experiences that determines an individual’s quality of life, irrespective of the type and number of possibilities available for enjoyment. For instance, a homeless individual may well be presented with only a few limited possibilities when compared to an individual who is both housed and homed and with the financial resources to create greater possibilities. The capacity to enjoy the possibilities available to each individual, however, may well be the same.

One limitation, however, with definitions of quality of life for homeless individuals, such as that proposed by Raeburn and Rootman (1998), is that they have not explicitly recognised that as wealth increases (or poverty decreases) the number of potential possibilities an individual can create in order to enjoy is expanded. Using a large scale Australian household survey data, HILDA, Headley and Wooden (2004) have

demonstrated that improved economic circumstances relieved ill-being. Further, Cummins (2006) contended that “*the relationship between income and wellbeing is exponential*” (p.9), with wealth a powerful influence on wellbeing. Cummins (2006) argued that the power of money lies with its quality as a flexible resource against threats to wellbeing, rather than in the purchase of luxury goods. Homeless people then, as extremely financially disadvantaged and socially disconnected, are vulnerable to attacks on wellbeing, and may well lack the resources necessary to defend against them.

Wellbeing is an important dimension of holistic and the lay person’s views of health. Without wellbeing, in theory homeless people can not achieve any form of health at all. This situation raises the question as to the extent to which wellbeing is valued by homeless people. If it is valued, how is it valued, achieved and maintained where poor socio-economic conditions prevail?

Aboriginal health

Indigenous views on health differ from Western biomedical models of health and are based on the WHO’s holistic definition. A definition of Aboriginal health was developed by the National Aboriginal Health Strategy Working Party and later adopted by Australian and Torres Strait Islander Commission. The Working Party explained that in Aboriginal society there is no word, term or expression for ‘health’ as in Western society, with the nearest translation probably ‘life is health is life’, reflecting a cyclical concept of life-death-life. They described health as:

...Not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community (National Aboriginal Health Strategy Working Party, 1989, p.x).

Despite the above definition, following the 1994 National Aboriginal and Torres Strait Islander Survey, researchers found that Aboriginal peoples use diverse criteria to define their health status (Senior, 2002). According to Senior (2002) and Scarlett, White and Reid (1982), these differing perceptions around health mean that western health services delivered to Aboriginal people are often inappropriate and intimidating. Gray and Boughton (2001) called for an understanding of health in Aboriginal Australians that

goes beyond the statistical realms of knowing, advocating for “*more qualitative surveys and ethnographic study at regional and community level...*” (p.v). They contended that the most sophisticated studies identify health as best understood in terms of the society in which people live, as well as individual health behaviours.

Echoing this sentiment, Senior (2002) argued that studying health in the context of a community’s everyday life will develop our understanding of: why people value health in a particular way; how their historical, social or cultural circumstances affect health; and how these circumstances influence their beliefs about appropriate health care and health actions (p.5). While research has tended to focus on understanding notions of health among specific cultural groups based on their ethnicity, our knowledge about health as it is understood among Aboriginal peoples remains limited. Even less is known about the meaning of health among homeless sub-cultural groups which consist of those from a diversity of ethnic backgrounds and include Aboriginal and Torres Strait Islander peoples. As health is socially and culturally constructed, the evidence presented in the literature points to the need to examine the ‘everyday’ of homeless populations if we are to have an understanding of what constitutes health and life quality, before we can contemplate what types of environments may be conducive to good health and better life quality.

Quality of life among homeless individuals

Qualitative or post-positivist investigations on the quality of life of homeless populations in the Australian context were unable to be located. Despite this, knowledge generated through Quality of Life (QoL) instruments has provided a useful perspective on the QoL among homeless populations (although few such studies of this kind appear to be published in an Australian context too). In a Canadian study, Russell *et al* (2005) found that QoL for homeless and hard to house individuals was affected by basic needs (including shelter, food, clothes, personal hygiene, identification, money and transportation) and poor health, with physical fitness and mental health regarded as being important. Health problems, lack of money, feeling trapped and living in a shelter system

all contributed to stress and poor mental health, adversely affecting QoL. Access to alcohol, tobacco and drugs was important to the quality of life of a number of individuals.

Russell *et al* (2005) identified less tangible influences on QoL which included access to clean and single shelter (i.e. non-share) which was linked to stability, privacy and a sense of pride. Sufficient nutritious and aesthetically pleasing food was important, along with money, which facilitated choice, freedom and recognition from society. Employment was important to a personal sense of feeling good about oneself, although both choice and availability of work were influential determinants. Relationships with friends and family also had an impact on QoL, and so too did self respect, self care and having the respect of others.

Studies by Schutt *et al* (1997, as cited in Wolf *et al*, 2001) and Wolf *et al* (2001) inquired into the relationship, in an American context, between quality of life of homeless individuals and becoming housed. Schutt *et al* (1997) found that among the shelter users participating in the study, securing housing improved satisfaction with this aspect only, and not overall QoL. Similarly Wolf *et al* (2001), found that for some of Los Angeles' homeless people, becoming independently housed improved some aspects of QoL, for instance, satisfaction with housing, leisure and money, whereas housing did not necessarily improve satisfaction with clothing, food and social life. They suggested that although independent housing was a preference of participants, it did not necessarily improve other aspects of their lives. Wolf *et al* (2001) concluded:

This study shows that becoming housed may solve the problem of lack of shelter among homeless people, but does not necessarily address all of the other quality of life issues. Others have suggested the need for providing material as well as non-material support to homeless people, in order to meet their various needs and to prevent recurrent homelessness (p.397).

Bearsley and Cummins (1999) conducted one of the few published QoL studies in Australia with homeless youths in Melbourne. They found that the 'homeostatic mechanisms' which maintained Subjective Quality of Life (SQoL) were functionally inadequate to cope with the objective hardships they experienced. They suggested that SQoL for these youths was eroded prior to homelessness and as a result of negative

developmental experiences. In a further study, Cummins (2006) reported that low levels of support were worse for personal wellbeing than no support at all. *“This may be because low levels of support drain personal resources in relation to reciprocal interaction with the support source, whereas the situation of no support relieves people of this burden”* (Cummins, 2006, p.17).

The findings of these studies have provided a useful starting point to explore the wellbeing of Ozanam’s homeless population. They also point to the potential implications for services such as Ozanam that support homeless individuals, particularly when these people volunteer in order to meet social and other needs and to achieve or maintain wellbeing. Yet the role of volunteerism in wellbeing and ill-being of homeless individuals in such services is not well understood. In a review of the volunteerism and wellbeing literature, Lake (2004) identified volunteerism as an important mechanism for social connectedness and in obtaining a sense of community belonging. Volunteers obtained control over their life by choosing to volunteer, and believed that what they did made a difference. She described these choices as empowering individuals and improving their capacity to cope. In her own research, Lake (2004) found that those who volunteered had higher levels of life satisfaction and wellbeing and suggests this may be due to the stress from other demanding life roles being buffered through the activity. Lake’s (2004) study, however, did not include volunteers who were experiencing homelessness.

With Ozanam House encouraging and even expecting homeless people to volunteer, this discussion raises the question of whether volunteering is ultimately good or bad for the health, wellbeing and QoL of homeless people.

Quality of life, trauma, Post Traumatic Stress Disorder (PTSD) and treatment

A lower SQoL has often been found among individuals experiencing mental illness, and according to Lam and Rosenheck (2000), it is even lower for those who experience homelessness. In a London based study, d’Ardenne *et al* (2005) found individuals

diagnosed with Post Traumatic Stress Disorder (PTSD), had a lower SQoL. They noted that patients who experienced a traumatic event as life threatening or who experienced multiple traumatic events had particularly poor QoL. Social inclusion and material support were considered to be as important to QoL as specific psychological or medical interventions, although treatment for depression was raised as a possible method in improving SQoL for PTSD patients. They found those individuals with PTSD from an ethnic minority experienced increased social exclusion.

In the USA the experience of trauma among homeless women, and to a lesser extent men, has been explored and has revealed a lifetime prevalence of trauma associated with physical and sexual abuse among homeless populations that far exceed the general population (Buhrich *et al*, 2000). In Australia, however, Buhrich *et al* (2000) claimed to be the first to publish data on lifetime trauma among a homeless population through their exploration of the prevalence of trauma among a Sydney based population. Data was collected from 157 participants from diverse ethnic backgrounds using a comprehensive interview which included the nine item trauma section in the Composite International Diagnostic Interview (lifetime). The authors reported that a lifetime event of trauma was almost universal, with all the women and more than 90% of men having experienced a trauma event - a finding replicated in my own study. They noted that while their study did not assess the prevalence of PTSD, the predisposing factors were present, including the experience of multiple traumas.

In a qualitative inquiry, Coleman (2000) reported the experiences of Indigenous women who had utilised public spaces to live in Brisbane, Australia. She found that many women were attempting to escape domestic violence, yet were reluctant to access related services due to multiple factors. She commented:

...some women are traumatised by past and recent violence, and it is difficult for them to muster the personal resources required to act assertively or protectively for themselves. This past trauma may be associated with apparently high rates of sexual abuse, as a number of women seem to share this experience...(p.11)

Trauma, however, among Indigenous Australians has been a cumulative and on-going process which has been generated through colonial and post-colonial policies (Cunneen & Libesman, 2000). Advancing this argument, Zubrick *et al* (2005) argued that colonisation continues to have a profound impact on the physical health of Aboriginals and also on their wellbeing, stemming from “*multiple losses and traumas experienced as a result of separation from land, family and cultural identity*” (p.xvi).

Within this Western Australian historical context, the authors reported that one in five children were living in families where more than seven ‘major life stress events’ (such as illness, family breakdown and arrest) had occurred with the preceding year. They contended that these children are five and a half times more likely to be at high risk of clinically significant emotional or behavioural difficulties than for children who experienced two or less life stress events. These results are significant for two reasons; they are an indicator of continued homelessness among Aboriginal people; and secondly, they highlight the compounded effects of trauma and the legacy of colonial processes in contemporary homelessness. For Indigenous Australians, trauma surrounding homelessness is layered over colonial and post-colonial traumas.

More recently, Robinson (2005) reported on the ‘powerful impact’ of grief and trauma in the everyday lives of homeless youth from diverse ethnic backgrounds in Sydney. Trauma was identified as a key cause and feature of homelessness among this population, with grief regarded a core effect resulting from the loss of home. With increased awareness surrounding the role of traumatic home experiences in young peoples’ decision to leave home prematurely, Robinson (2005) contended that “*grief and trauma are never examined seriously as key structuring principles of homelessness*” (p.48). In addition to the distress associated with leaving home, either by choice or under duress, the participants in Robinson’s (2005) study were described as:

...severely traumatized by physical, sexual and emotional abuse, which perhaps had taken place over a period of several years or more. Worse, having exited these dangerous situations, while very vulnerable, they were often victimized further while trying to find somewhere safe to stay. Further still, having secured safe accommodation, some young people discussed simply being unable to live there because of feelings of isolation, fear and discomfort, often attached to painful and traumatic memories (p.51-2).

The National Centre for Post Traumatic Stress Disorder (NCPTSD), a leading authority on trauma, has described a traumatic experience as being overwhelmed with feelings of fear, helplessness or horror (Carlson & Ruzek, 2006). The NCPTSD (2006a) contended that the seriousness of the symptoms and problems an individual will experience following a traumatic event will vary depending on:

...a person's life experiences before the trauma, a person's own natural ability to cope with stress, how serious the trauma was, and what kind of help and support a person gets from family, friends, and professionals immediately following the trauma (p.1).

Individuals can re-experience the traumatic event both mentally and physically, leading to the development of PTSD, considered a psychiatric condition. Individuals feel like they are in danger, are fearful, have panic attacks, a desire to escape, and feel angry and contemplate harming other people as a self-defence mechanism. This state of anxiety and physical agitation affects both their ability to sleep and concentrate, with individuals having little or no control over the symptoms of trauma. Other trauma symptoms include flashbacks, feeling upset with reminders of the trauma, being defensive and aggressive, uncontrolled emotions stemming from sudden onset of fear, anxiety, anger etc, lack of clarity, constant monitoring for potential danger, easily startled, shaky and sweaty, pounding heart and difficulty with breathing (Carlson & Ruzek, 2006).

The NCPTSD identified 'avoidance' as a common approach to managing or surviving trauma. Staying away and disconnecting with places, activities and people which act as reminders, and avoidance of situations which invoke an emotional reaction are all common avoidance strategies (Carlson & Ruzek, 2006).

In addition to the primary effects of trauma, the NCPTSD (2006a) have documented a range of associated problems that can emerge as a result of post-traumatic re-experiencing and avoidance strategies employed by individuals. These problems may include:

- depression through loss (such as loved ones) or through isolation (as an avoidance strategy);
- self-harm and harm of others⁴;
- self-blame, guilt and shame through an inability to meet responsibilities and through questioning their role in the traumatic event;
- relationship problems due to difficulty in feeling close or trusting others, particularly when the trauma was linked to people (rather than a natural disaster);
- feeling detached or disconnected due to difficulties with feeling or expressing positive feelings and avoidance;
- social isolation and the resultant loss of support creating fear and worry;
- physical health problems due to long-term anxiety, avoidance of medical care, and coping mechanisms such as alcohol and drug use; and
- alcohol and drug misuse as a coping strategy of avoidance of feelings, images, memories common with PTSD (Carlson & Ruzek, 2006).

The NCPTSD (2006a) also argued that some people are more likely to develop PTSD, including those who experience:

...greater stressor magnitude and intensity, unpredictability, uncontrollability, sexual victimization, real or perceived responsibility, and betrayal...those with prior vulnerability factors such as genetics, early age of onset and longer-lasting childhood trauma, lack of functional social support, and concurrent stressful life events...those with a social environment that produces shame, guilt, stigmatization, or self hatred (p.2).

The most common approaches used in the treatment of PTSD include cognitive-behavioural therapy, pharmacotherapy, group treatment and psychodynamic treatment (NCPTSD, 2006b). In these treatments, education, exposure, exploration of feelings and beliefs, and coping-skills training are common strategies.

⁴ The NCPTSD (2006a) suggested this can stem from frustration over the inability to control PTSD symptoms; a learned response to coping with anger; and limited positive connections with others. While self-harm and aggression towards others was observed among the homeless people in this study, the cause was not always clear, but alcohol abuse was often one factor. However, it was noted that anger affected job security and relationships with partners, family and friends.

The NCPTSD (2006b) maintained that:

...treatment is begun only after the survivor has been safely removed from a crisis situation. If a survivor is still being exposed to trauma (such as ongoing domestic or community violence, abuse, or homelessness), is severely depressed or suicidal, is experiencing extreme panic or disorganized thinking, or is in need of drug or alcohol detoxification, it is important to address these crisis problems as a part of the first phase of treatment (p.1).

They further contended that effective treatment is contingent on the individual (and their family) recognising that PTSD is a ‘medically recognized anxiety disorder’. In the first phase of treatment, survivors resolve feelings such as anger, shame and guilt and learn coping strategies to deal with memories.

Cognitive-behavioural therapy (CBT) has been a commonly used therapeutic approach in the treatment of PTSD and entails the change of emotions, thoughts and behaviours. Medication, or pharmacotherapy, aims to manage the symptoms associated with anxiety, depression and insomnia, and has often been used together with CBT. Group treatment has been a favoured approach due to the sharing and empathy generated in such settings, whereas psychodynamic psychotherapy has explored the emotional conflicts caused by the traumatic event. Current life situations which trigger traumatic memories are identified (NCPTSD, 2006b).

PTSD often occurs in tandem with other psychiatric disorders. According to the NCPTSD (2006b), these include depression, alcohol and or substance abuse and anxiety disorders. They stated that, “*although crises that threaten the safety of the survivor or others must be addressed first, the best treatment results are achieved when both PTSD and the other disorder(s) are treated together rather than one after the other. This is especially true for PTSD and alcohol/substance abuse*” (p.1).

In addition to trauma (or even stemming from trauma), loneliness has been flagged by some authors as an important indicator of wellbeing among homeless people (LenMack Consulting Pty Ltd, 2005; Rokach, 2004). In an analysis of longitudinal research studies in the UK, LenMack Consulting Pty Ltd (2005) reported, “*At its extreme, single*

homelessness was not merely an exclusion from housing, but an exclusion from normal human relationships and society itself” (p.52). This finding is supported by Rokach (2004) in a study on the causes and consequences of loneliness for homeless people in North America. The researcher found personal inadequacy; developmental deficits; unfulfilling intimate relationships; loss of relationships through relocation or significant separation; and social marginality were the key causes of loneliness. Rokach (2004) highlighted that loneliness can have an adverse effect on the physical, mental and spiritual wellbeing of individuals. Her analysis of the literature found loneliness had been linked to pessimism, a high negative correlation with happiness and life satisfaction, depression and anxiety, hostility, alcoholism, poor self-concept, psychosomatic illness and an increased vulnerability to health problems. The perception by homeless people that the cause of their loneliness differed from the general population was an observation shared by Rokach (2004).

The human response to trauma, trauma avoidance strategies and the affects of loneliness in homelessness have been frequently described in accounts of poverty cultures (see Agar 1973; Spradley, 1970; Sansom, 1980; Glaser and Bridgman, 1999). Although the extent and form of trauma in Australian homelessness is only beginning to be understood (see Buhrich *et al*, 2000; Coleman, 2000; Robinson, 2005) from the evidence presented in this section, it can be concluded that the quality of life, health and wellbeing of homeless people will be adversely affected if they have: (i) endured trauma which leads to mental illness; and/or (ii) experienced profound loneliness. It can further be concluded that the historical influences and living conditions of homeless people, particularly Aboriginal homeless people, place them in a position whereby they are more likely to develop PTSD. For homeless individuals, contemporary treatment options discussed in the literature for trauma related illnesses are extremely difficult to implement. As the NCPTSD (2006b) have stated, the homeless person must have their homelessness addressed before treatment can commence – a catch 22 situation. This evidence suggests trauma and loneliness may be important dimensions of the homeless experience which influence health.

Social exclusion, urban development, public places and poverty cultures

To gain a greater insight into the role of loneliness among homeless people, I have reviewed literature on social and urban exclusion. Jordan (1996), discussing a theory of poverty and social exclusion, argued that societies have attempted to provide inclusive systems for the protection of the poor. This social obligation has been largely motivated by the costs associated with crime, disease, disorder and dislocation that emerge from what Jordan (1996) describes, as “*otherwise advantageous exclusion*” (p. 34). With inclusion and exclusion both features of social formations, Jordan (1996) concluded that what has been missing is a “*more comprehensive view of how groups form, organize and act collectively in pursuit of their interests, and how vulnerable individuals come to be excluded and marginalized in such interactions*” (p. 4). To inform the latter part of this missing knowledge, Jordan (1996) contended that poor people are excluded because they can not make economic contributions and therefore lose the benefits of membership of society.

Social exclusion of undesirable people is a fundamental component of the way we build and develop local areas. Housing developments have become increasingly ‘insider friendly’, and do not encourage homeless people to seek refuge in the designated created public spaces. Hillier and McManus (1994) commented, “*the erection of new, walled elite suburban developments as enclaves that penetrate or gentrify areas...represents a violation of those areas. These developments force existing residents into a condition of otherness, excluded, outside of the macho bastions of capitalist power*” (p. 91). The marketing of these houses with slogans such as ‘not just a house, it is a home’ or ‘this is more than a house, it is a community’, combined with financial unattainability to many people, serves to exclude those that do not belong, especially homeless people.

Modelled on European practices, local planning designs in Australia have reinforced this sense of not-belonging through mechanisms such as singular and signed grand entry points; no-need-to-stop road layouts; access to public amenities typically through private property; and the provision of ample off street parking for housing owners and their

guests. Morgan (1994) described these mechanisms as features of ‘panoptic’⁵ architecture which maximises the field of vision for the housed observer. If you do not belong in this locality it is patently obvious, and as Morgan (1994) says, “*the only respectable thing to do in much public space in our cities today, particularly in residential areas, is to walk, to move on*” (p. 85).

Spatial exclusion through planning and construction has not been limited to suburban housing developments. Voyce (2003) demonstrated that the developer-owners of shopping malls use spatial practices to govern the semi-public spaces in malls. Drawing on Foucault’s ideas on governance, Voyce (2003) contended that the creation of a certain ambiance conveys a message of safety in an attractive location. This spatial control welcomes some people and excludes others, and although shoppers are morally free they are shaped by mall practices. Voyce (2003) concluded that in addition to those considered disruptive, other unwelcome people included the homeless and groups of teenagers.

Homeless people occupy spaces – typically public and semi-public spaces – and generate meaning and negotiate their lives from these spaces. Goheen (1998) wrote that “*citizens create meaningful public space by expressing their attitudes, asserting their claims and using it for their own purpose*” (p.479). He saw the creation of meaningful public space as a process that is both dynamic and contentious, and subject to continual renegotiation. According to Goheen (1998), two contrasting views on the significance of public space applied to the conduct of public life in modern cities. The first, he argued, was that public space is the arena of choice for all groups to achieve public visibility, seek recognition and make demands. The second, he contended, was that the public sphere

⁵ The idea of panoptic architecture stems from a prison system proposed by Jeremy Bentham (1748-1832). The panopticon provided ongoing surveillance of prisoners with an inspector located in a central position. The inspector can see everything without being seen, and the prisoner never knows when he is being seen. This created mental uncertainty for the prisoner and as Foucault (1977) explained: “...*the major effect of the Panopticon: to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power...Bentham laid down the principle that power should be visible and unverifiable. Visible: the inmate will constantly have before his eyes the tall outline of the central tower from which he is spied upon. Unverifiable: the inmate must never know whether he is being looked at at any one moment; but he must be sure that he may always be so*” (p.201).

has been severely devalued as a powerful social and political ideal, rendering the participation of citizens in public issues inactive. For homeless people, the occupation of public space conforms to both of these contrasting views, often at the same time.

Boyer (1993, as cited in Goheen, 1998) described the 'public' as a negative concept in modern cities. She sees cities as increasingly inhospitable places where private interests compete successfully against public interests. From this perspective of modern cities, there has been an emphasis on "*the difficulty of marginalized groups in expressing or enforcing their interest in the public sphere*" (Goheen, 1998, p.481). As cities often provide the public spaces and places homeless people live and sleep, the ways in which meaningful spaces are created in this exclusionary context remain important considerations to matters of health and life quality. Homeless people often traverse common pathways in cities and congregate at given times in specific locations. There are many reasons for this group formation and shared living, for instance, food, security, shelter and law enforcement avoidance, as well as the desire to temporarily escape the requirement to manage their stigma (Goffman, 1963). These social processes support emergent sub-cultures, such as homeless cultures, which may have established practices and behaviours that adversely affect some dimensions of quality of life, while enhancing others. Researchers, such as Barry *et al* (2002), have begun to realise the profound affect a homeless culture has on how homeless people use and view health care. The evidence presented in the literature suggesting stigmatisation and marginalisation which has been expressed through persistent social exclusion, may have negative consequences for the health of homeless individuals during their homelessness.

Summary

Homelessness is defined by a large and complex socio-cultural, spiritual, environmental, political and economic system. The evidence presented in the literature has indicated that income and health inequities exist between Australia's rich and growing numbers of poor. Poor Australians experience higher rates of morbidity and mortality than richer Australians, with Aboriginal people and homeless people, in theory, the most severely affected (Glover *et al*, 1999; AIHW, 2003a). According to the literature, it can also be

expected that a continued dismantling of the welfare system will exacerbate the life conditions and health of poorer Australians.

Through an exploration into the literature on 'home', the evidence supports the notion that the loss of house and home are important dimensions to becoming and remaining homeless, although do not account for the lived experience of homelessness. Both home and homeless were found to have diverse meanings to individuals. This review has raised the question as to whether or not homeless people experience forms of 'home' during their homelessness. It has also raised questions over the appropriateness of existing homeless definitions.

Any definition of homelessness must be underpinned by what is known about the experience of home and its loss, and also by what is known about the experience of homelessness, rather than shelter type alone. Grief and pain; the desire to 'feel' positive dimensions of home and construct these; the occupation of public places; and the lack of resources are examples of what could be recognised in contemporary interpretations of homelessness. It stands to reason that if we continue to draw on shelter-oriented definitions, we run the risk of addressing a 'problem' that is poorly defined and which has implications for policy and resource allocations. Shelter-based definitions also make the assumption that lack of shelter forms key dimensions of the homeless experience for homeless individuals. As such, it is important to explore the significance of shelter to the homeless experience. A definition of homelessness which reflects the experience of homeless people will be important if improvements to the health and life quality are to eventuate for homeless populations.

The conclusions from this review of the literature are that when individuals became homeless, they were likely to negotiate social exclusion, stigmatisation, trauma and loneliness, as well as poor physical and mental health. However, the extent and ways in which these dimensions dominate the homeless experience, and the homeless experience *per se*, are not accounted for in the literature, and nor is there knowledge regarding their influence on health. The views and experiences of homeless people are rarely reflected

in research and policy concerned with homelessness. The question remains as to which dimensions of that experience have the greatest influence on the health of homeless people.

This review has also pointed to the importance of wellbeing, in some form, to the health and quality of life of homeless people. Without wellbeing, it is unlikely homeless people will be able to achieve health at all. Wellbeing and quality of life studies among homeless Australians are limited to a few quantitative inquiries which utilised subjective quality of life instruments (Bearsley & Cummins, 1999; Cummins, 2006). Such studies make useful suggestions on aspects of homelessness worth exploring and cement the idea of wellbeing within constructs of health. However, they do not capture the depth or richness of the overall homeless experience.

The trauma related behaviours discussed in the literature provide critical information and context to this study and helped to provide insight or explanation as to why homeless individuals behave in a particular way. This chapter has found that while trauma related illness may be an important dimension of the homeless experience, it is very difficult to treat with any effect while individuals remain homeless or exposed to trauma.

In the following chapter, I look more closely at the context in which this study has been undertaken. The social and political factors which directly influence how homeless people experience life are important considerations for this study.

Chapter Three

Study context

This chapter investigates the local context affecting the lived experience of being homeless in Darwin. Darwin, the capital city of the Northern Territory (NT or the Territory), has a tropical climate with a monsoon season between December and May and a dry season between June and November. Darwin is a coastal, relatively compact and small city, geographically isolated from the rest of Australia (Explore Australia, 2004). Homelessness, particularly Aboriginal homelessness, is highly visible.

Recent media reports boasted the Territory's population had exceeded the 200 000 mark. The Australian Bureau of Statistics (ABS) reported that more than one quarter of Territorians had identified their Indigenous origin and one fifth of the population had an overseas birthplace (ABS, 2004). It is the least densely populated state or territory in the country, with approximately half of all Territorians living in Darwin.

Homelessness in the Northern Territory

Third (2000) highlighted the importance of not developing a "*preoccupation with quantifying the [homeless] problem, which obscures the need to understand and resolve it*" (p.7). It is in the spirit of these comments that the statistics on homeless rates have been presented in this thesis.

Accurate statistics on homeless populations have been difficult to obtain due to the high mobility of homeless individuals, the constant movement of people in and out of this

situation and the inherent challenges associated with locating and collecting reliable data on individuals on census night. In the Territory, figures have been further affected by census recording procedures and what constitutes a culturally appropriate question and response. For example, it may not be appropriate for Indigenous people who are staying with family and are escaping domestic violence or other problems to record they have 'no usual address'. Such situations have led to an undercounting of the homeless (MacKenzie & Chamberlain, 2004). The primary⁶ homeless population is also likely to be undercounted due to the fact that homeless people often hide at night for safety, and in the cooler months, for warmth. In Darwin, for instance, homeless people and other public place dwellers hide due to fear of authorities and the likelihood of being moved on, and often do not like, are afraid to, or are unable to fill out official forms or respond to census collectors (Long Grass Association, 2004). Yet there is a groundswell of evidence to suggest that homelessness (in the structural sense) is increasing in Australia, particularly among Indigenous peoples (Goldie, 2004).

The Territory is faced with considerable challenges surrounding the socioeconomic status and living conditions of a significant portion of its population. In 1996 the Territory's homeless rate was 523 per 10 000 people (9 906 people or about 1 in 20 people). In 2001 the rate of homelessness still remained the highest in the country, but dropped to 288 persons per 10 000 persons, or 5 423 people. According to Chamberlain and MacKenzie (2003), this reduction can be explained by the change in counting procedures in remote communities where the rate of Indigenous people in improvised dwellings dropped from 6000 people in 1996 to just 1300 people in 2001.

This change in counting had the greatest affect on reducing the Territory's homeless population, reducing the total homeless population across all other states and the Australian Capital Territory by only 1700 (Chamberlain & MacKenzie, 2003). While the matter of defining all Aboriginal people living in public places without 'appropriate' shelter as homeless remains a contentious one, whether homeless or not, many public place dwellers (a term borrowed from Memmott *et al*, 2003) do not have the resources

⁶ Primary homelessness refers to those people who are living rough, or in improvised dwellings.

necessary to meet their basic daily needs. Langton (2003) wrote that the term 'homeless' in Darwin has become "*a catch-all for a range of situations which imply a failure to reside in acceptable ways in the post-industrial urban conglomerations*" (p.1). She argued that there are many Aboriginal people who resided in Darwin, who were 'mistakenly' called homeless, living with few or no services. At the same time, Langton (2003) acknowledged "*many of the "long grass" people have no communities to go back to and they are often the outcasts of their own societies*" (p.1). According to both Keys Young (1998) and Memmott *et al* (2003), these "Long Grass" people were indeed homeless in terms of Aboriginal understandings of homelessness. Keys Young (1998) reminded us of the following: there are different types of homelessness; that homelessness is characterised by varying temporal trends and patterns; and that the experience or meaning of homelessness is affected by cultural grounding.

In the NT on census night 2001, 17% (or 929 people) of the homeless population were in boarding houses. Within this population, people can be classified in both the secondary⁷ and tertiary⁸ homeless categories based on the operational definitions described earlier. For example, if an individual stays in a boarding house for more than 13 weeks they are defined as experiencing tertiary homelessness, and under 12 weeks, secondary homeless. On the same night there were a further 4% (229) in SAAP accommodation and 39% (2114) staying with friends or relatives. This population makes up the majority of those experiencing secondary homelessness. A significant portion were recorded as staying in improvised dwellings and sleepers out, defined as those in the primary homeless category, which amounted to 40% (2151) of the NT's homeless population (Chamberlain & MacKenzie, 2003; MacKenzie & Chamberlain, 2004).

In addition to these figures, in 2001 the Territory enumerated a further 775 people described as marginal residents in caravan parks. Their occupancy can be likened to that of boarding houses as the living, bedroom and cooking area are in the one room, with communal access to bathroom facilities. In this group those people who identified as

⁷ Secondary homelessness refers to those people who move from one form of temporary shelter to another.

⁸ Tertiary homelessness refer to those people in boarding houses on a medium or long term with no right of ongoing tenure and share facilities.

renting, dwelling at their usual address and with no person in the dwelling in employment were counted as marginal residents of caravan parks (Chamberlain & MacKenzie, 2003).

While the age and sex distribution of the homeless population in the Territory is similar to the national profile, Indigenous people were grossly over represented in this demographic. Those staying with friends or relatives were also likely to be undercounted. Indigenous people made up 49% of those in boarding houses and 46% in SAAP (keeping in mind only 4% of the total Territory homeless population was in SAAP accommodation on census night 2001). Indigenous people accounted for 60% of those living in improvised dwellings (the primary homeless), amounting to 1864 people in total (MacKenzie & Chamberlain, 2004). Those in this category included Aboriginal Long Grass people, many of whom were homeless, and others who had a home to return to or were homed in the Long Grass, but did not have adequate resources or services to meet basic daily needs.

The Northern Territory Department of Health and Community Services (NTDH&CS) administers the SAAP through the Family and Children's Services Program. In the most recent five year agreement, known as SAAP IV, \$7.1 million was allocated to services across the Territory annually (NTDH&CS, 2005). The first of two identified priority areas for the Territory included the development of models for service delivery to Indigenous Australians in remote and rural areas. The second priority area targeted children with accompanying adults who were in SAAP services.

Given the distribution of homeless people in Darwin and the high numbers of people categorised as primary homeless who were not living or accessing SAAP services, it is possible that these priority areas identified for the Territory will not ameliorate the living conditions for a significant number of the most impoverished homeless citizens resident in the urban centre of Darwin.

Darwin's homeless enumerated

Three local authority jurisdictions make up the Darwin area; Darwin City, Palmerston and Litchfield Shire. The 2001 census counted 2 008 homeless people in Darwin, 201 in Palmerston, and 449 in Litchfield, with a total Darwin area homeless population of 2 658. A further 314 marginal residents in caravan parks were enumerated. Excluding the marginal residents, there were 802 people in this total of 2 658 who were Indigenous Australians - a rate four times higher than that of non-Indigenous Australians. Of the 802 Indigenous peoples, 40% were in boarding houses, 1% in SAAP, 4% staying with friends/relatives and 55% in improvised dwellings (Mackenzie & Chamberlain, 2004). While more than one quarter of all Territorians were Indigenous Australians, they represented only 11% of the total Darwin area population (ABS, 2005).

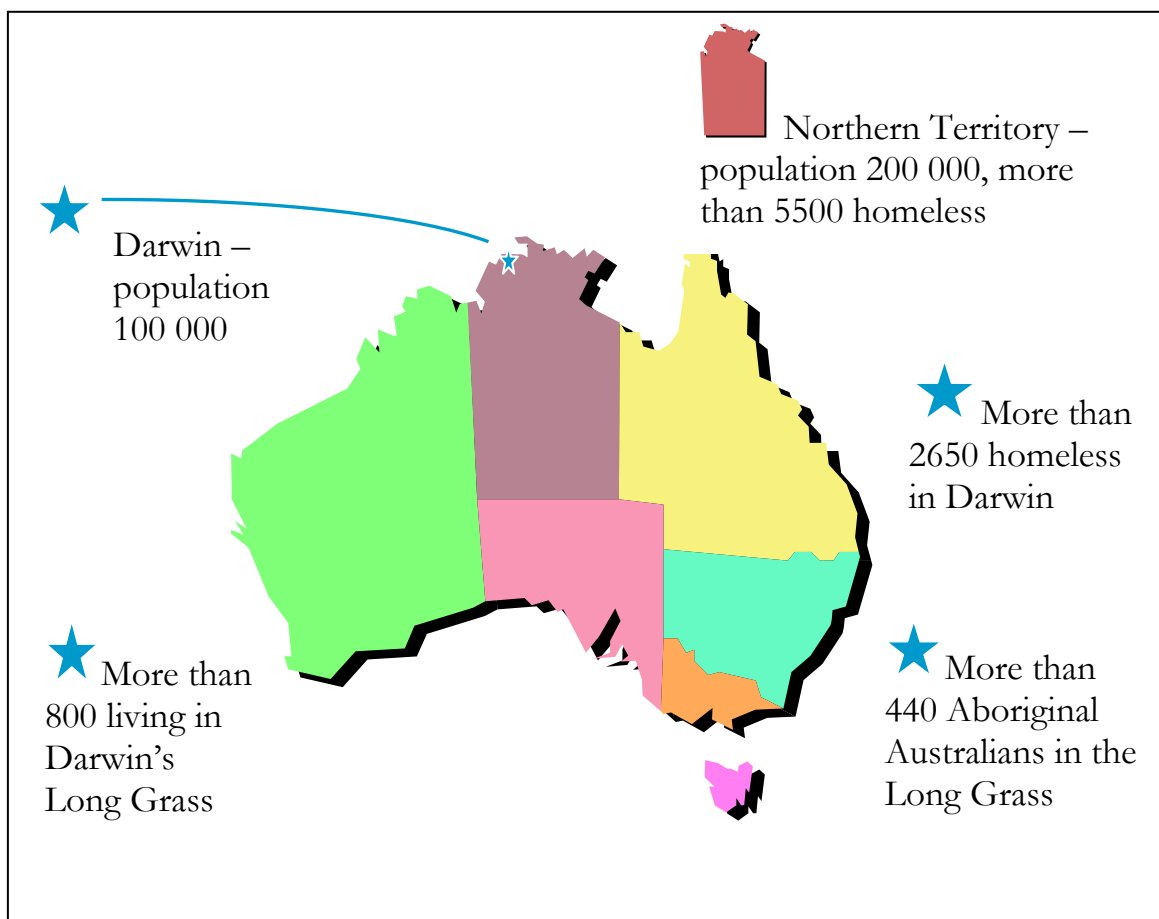


Figure 1: Homelessness in Darwin and the Northern Territory following the 2001 National Census collection.

Of the 2 008 homeless people in Darwin City, 604 (30%) were in boarding houses, 129 (6%) were in SAAP, 717 (36%) staying with friends/relatives and 558 (28%) were in improvised dwellings. Of significance, 95 (47%) of Palmerston's and 160 (36%) of Litchfield's homeless were in improvised dwellings. In these two areas there were also significantly higher rates of those staying with friends/relatives. MacKenzie and Chamberlain (2004) pointed to the general absence of SAAP services and boarding houses in these local jurisdictions to explain the higher rates. The Territory's homeless rates are illustrated in **Figure 1**.

Why the Long Grass?

In order to understand contemporary homelessness for Aboriginal people, it is important to acknowledge the historical context that has affected Aboriginal peoples' lives. While Aboriginal people have had diverse experiences through colonisation processes, in general it can be said that this process started as Aboriginal people being understood by white settlers as uncivilised savages with no claim to their land and no civil rights (Harris, 1990; Markus, 1990). At this time in the Northern Territory, it was not uncommon for Aboriginal people to be chased off their land and hunted and killed by frontier settlers (Cole, 1985). This is the first example of Aboriginal people being displaced from their homelands.

As the colonisation process progressed, pastoral stations were established and a shift in attitude occurred towards Aboriginal people as they were seen as a potential labour force, receiving meagre rations for their work, yet still regarded as savage and an inferior race (Berndt & Berndt, 1987). The situation on pastoral stations has been described as slave-like (McGrath, 1995). Around the same time as the pastoral enterprises were the emergence of the missions and government ration stations, also establishing labour pools (Curthoys & Moore, 1995). This history of being displaced and the control over the movement of Aboriginal people have led to degrees of suffering since the start of colonisation.

According to Langton (2003), today many Aboriginal Long Grass people in Darwin, both the Larrakia (traditional owners) and those from other northern locations, were there because of the “*radical displacement of indigenous people in the northern frontier society*” (p.1), from their land (sometimes forcibly). A lack of services and accommodation for Aboriginal visitors to Darwin also accounted for why people stayed in the Long Grass.⁹

In one published study in this area, Maypilama *et al* (2004) conducted research with the Yolnu¹⁰ (or Yolngu) of East Arnhem Land who lived in Darwin’s Long Grass and found that, contrary to popular belief, the main reason for living there was not to consume alcohol. Rather, Yolnu Long Grass people had deeper unresolved problems. They commented, “*the main reason for coming to Darwin was fear – fear of violence, including suicide, mental illness, aggressive behaviour and galka’ (sorcery)*” (p.3). Other reasons included: grief resulting from a family member’s death; being witness to disrespect directed at elders (cultural abuse); escaping disputes and community conflict; feelings of alienation and rejection; unemployment (no future at home); lack of access to resources including housing; and accessing services such as medical treatment. According to Maypilama *et al* (2004), staying in the Long Grass was often a necessity due to lack of available accommodation options. Often people became trapped as they could not afford to return home, although the freedom experienced in the Long Grass was often valued.

Memmott and Fantin (2001) found Aboriginal ‘itinerants’ came to Darwin and stayed in the Long Grass for much the same reasons identified by Maypilama *et al* (2004). Based on accommodation and transport needs, Memmott and Fantin (2001) suggested the

⁹ See Coulehan’s (1995) and Day’s (2001) doctoral theses on Aboriginal people in the Long Grass in Darwin. Day (2001) documented life in a fringe camp for people who made their home on ‘contested’ land. His study was undertaken in the context of political activism during their forcible removal. Coulehan (1995) explored life for Yolngu women while they were away from home and staying in Darwin.

¹⁰ Yolnu (or Yolngu), meaning person or human being, refer to the Aboriginal people of northeast Arnhem Land, formerly known as the ‘Murngin’. The Yolnu have a distinct culture and group of languages, with their relative isolation having protected them to some extent from what Keen (2004) described as the “*worst onslaughts of colonisation*” (p.14).

‘itinerants’ in the Long Grass could be categorised into three groups: those in Darwin for the short term who needed assistance returning home; those wanting to stay for a short term and in need of suitable accommodation; and those with no intention of returning home who needed long term accommodation with special support due to “*their chronic itinerant lifestyle*” (p.6).

Socioeconomic considerations in the NT

The cost of living in the Territory is high when compared with the rest of the country, and affordable housing has been identified by the Australian Housing and Urban Research Institute (AHURI) in several of their research papers as just one of the factors leading to the high homeless rates. Construction costs contributed to this situation, being higher in the Territory than anywhere else in the country. In 2000, the average weekly rent for public housing was \$114, and \$193 for private rentals, whereas the national average of \$71 for public housing and \$166 for private rentals (ABS, 2005).

In 2001, there were 6 000 public houses in stock with 1 800 applicants on waiting lists. The ratio of public houses to applicants on lists was less than the rest of the country with the exception of Tasmania (ABS, 2005). While housing stock statistics appeared comparably good, there remained a large portion of homeless people in the Territory who are not on waiting lists. The ABS (2005) indicated that of the tenants who were allocated public housing between 2003 and 2004, 52% had waited six months or under, 18% had waited seven to twelve months and 30% had waited more than one year for housing. The waiting period in some areas of the Territory, however, was greater. As an example, 75% of applicants in East Arnhem Land had been waiting for more than twelve months.

Employment in the Territory appears strong. In part this has been due to the Community Development Employment Projects (CDEP) Program which provides for the most significant proportion of Indigenous employment. CDEP is a ‘work for the dole’ program whereby Aboriginal and Torres Strait Islanders may choose to forego government benefits from Centrelink and work on community development projects for

the equivalent benefits in wages. There were 7968 Indigenous Territorians in June 2004 working for CDEP, of which 451 were from the Darwin area (ABS, 2005).

Criminalisation of poverty and policing the poor in

Darwin

Jordan (1996) observed that in both the USA and the UK there was a perception of a deviant underclass, living off crime, practicing various forms of social deviancy and exploiting the labour and property of the rest of the community. This deviant underclass comprised the poorer members of the community. Jordan (1996) argued that the deviant underclass has pervaded the socio-political realm and pressure from organised groups of mainstream citizens has resulted in political shifts in policy orientation from social justice, in the form of welfare and services, to the enforcement of work obligations and criminal justice sanctions.

Parallels with Jordan's observations can be found in the Australian context, and in particular, the experience of being homeless in Darwin. While the Commonwealth government has introduced work for unemployment benefit schemes, the shift in policy in Darwin from a welfare orientation is most marked in the efficacy of criminal sanctions delivered to houseless people for camping or sleeping in public places in contravention to Council By-law 103.

Sixty two homeless people in Darwin received criminal sanctions and were jailed between January, 1999 and June, 1999, for non-payment of fines imposed under Council by-laws which prohibited camping and sleeping in public places. In 2001, under the same by-laws, 92 people were fined (Griffith, 1999; Goldie, 2002). Goldie (2002) suggested the laws were racially discriminatory, as 70% of the people fined and jailed were Indigenous, yet only 9% of the total Darwin population and around 50% of the primary homeless population were Indigenous. Griffith (1999) contended:

The creation and utilisation of by-law 103 against itinerants, and the resultant inevitable incarceration of the homeless, particularly Aboriginal homeless, is a

frightening example of the use of by-law powers to control behaviour of the public and an apparent re-invoking of the criminalisation of poverty (p. 246).

In response to this situation, Langton (2003) observed that Darwin has become home for white Australians. She maintained that this new world had little tolerance of the traditional land owners and no concern for their future. She commented:

What is happening to the "homeless" of Darwin is what happened to the Aboriginal nations in the nineteenth century, without the unfettered murder. Instead, the laws and regulations pertaining to "illegal camping" and "trespass" are used by the Northern Territory police to achieve the same result (p.1).

Memmott and Fantin (2001) reported that Aboriginal Long Grasser people themselves believed they were unfairly or excessively treated by Night Patrol, Police or Council Officers. This discriminatory dimension of the homeless experience in Darwin has been reported in other Australian settings. For example, St Mary's House of Welcome in Victoria maintained that homeless people experienced discrimination due to their social status, appearance and lack of access to amenities and services. They argued that the effects were detrimental to the health and well-being of service users, resulting in further financial hardship and capacity to cope in extraordinarily difficult circumstances (Lynch & Stagoll, 2002). Discriminatory treatment, according to Lynch & Stagoll (2002) "*exacerbates underlying causes of marginalisation and disadvantage*" (p. 321).

The evidence suggests that racial discrimination may form an integral part of the homeless experience in Darwin, having an adverse affect on health and wellbeing. It is unclear, however, whether this form of discrimination is experienced by homeless people from other ethnic groups, or whether the discrimination is poverty related.

Community tensions in the Territory, and particularly Darwin, over 'Long Grassers' and 'itinerants', was a dominant issue in the most recent election held in 2005. The perception held by a vocal number of the housed community that this population was a homogeneous group characterised by laziness, criminal behaviour, and preference for the 'Long Grasser' lifestyle and alcoholism was, and continues to be, a strong theme emerging through TV, radio and other local media. The community rarely used the

words ‘poverty’ and ‘homeless’ to describe any part of this population, suggesting they were not conceptualised as impoverished or homeless. Using the term ‘itinerant’ implied that most people were Aboriginal and had a home to return to¹¹. An example of this perception is well illustrated in the Northern Territory News, 11 November, 2005, in the Editor’s Pick of letters sent to the paper (reproduced in **Figure 2**).

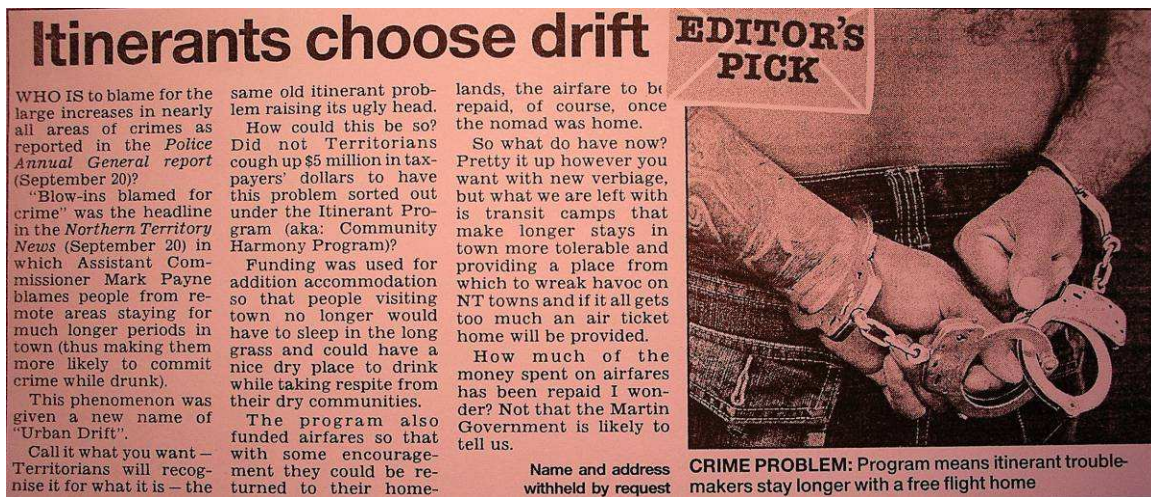


Figure 2: Letter to the Editor, Northern Territory News, 11 November, 2005. Editor's Pick.

The ground swell of dissatisfaction over the management of ‘itinerants’ and ‘habitual drunks’ common across the Territory was reflected in both the Labor and Country Liberal parties’ campaigns, as evidenced by newspaper, television, radio and other media reports. The Labor party’s new social policy advocated ‘tough new laws to tackle anti-social behaviour’ and highlighted six key areas for action. These included:

- A new Anti-Social Behaviour Act;
- Police powers to issue prohibition orders on habitual drunks;
- Habitual drunks to get treatment or face jail;
- The creation of ‘dry areas’ to protect public spaces and living areas;
- Tough new eviction laws with a zero tolerance policy for problem tenants; and

¹¹ The language in policy of the dominant political parties has since shifted again from ‘itinerant’ to ‘habitual drunk’.

- 120 extra police (Northern Territory Branch, Australian Labor Party, 2005).

While it is too early to tell what the ramifications of this policy will be, it has raised questions over the appropriateness and effectiveness of addressing homelessness within an ‘anti-social’ framework. The ‘anti-social’ policy has strong implications for Darwin’s most chronically homeless, particularly for those Aboriginal Australians who are alcoholics and drink in public places. Darwin has few treatment options either accessible or available and the anti-social policy appears to place emphasis on punitive measures. The potential for Indigenous Australians to be further disadvantaged by their alcoholism, without regard for the underlying causes of the ‘anti-social behaviour’, is problematic, and as Memmott *et al* (2003) have pointed out, “*It is also not appropriate to view the entire issue of Indigenous 'homelessness' through the lens of anti-social behaviour*” (p.ii).

This Labor party shift in policy ideology was consistent with the Darwin City Council by-laws that criminalise the poor, as discussed earlier. This situation suggests that such policies and by-laws increase the numbers of homeless people cycling through corrective service facilities, reinforcing their homelessness and placing additional stress on the day to day life of individuals. This situation has contradicted the Labor Party’s Community Safety and Justice Platform Criminal Law Reform which stated their opposition to:

...‘victimless crimes’ such as vagrancy and unseemly words or conduct unless it can be shown that the activity has offended and could reasonably be, expected to offend a member of the public (NT Branch, ALP, 2004).

Although there is ambiguity around the subjective nature of what is offensive to one person and not necessarily to another, this statement paradoxically followed another which advocated the continual review of NT laws to eliminate ‘vague, meaningless and archaic offences and procedures’.

The extent to which the social and political contexts of Darwin, a high level of policing and the mechanisms by which negative public perception have influenced homeless peoples’ lived experiences and their health was flagged for further investigation.

Darwin's homeless services

Homeless people have a diverse set of needs. Obviously housing may be one of these. However, physical and mental illness, injury, drug and alcohol addictions, spiritual and social engagement, employment, education and training are all examples of services provided to this population. The most basic services included food, clothing and shelter. In Darwin services have tended to target the specific needs of this population. There were also programs directed at the health, wellbeing and antisocial behaviour of 'itinerant' groups, such as the NT Department of Community Development, Sport and Cultural Affairs' Community Harmony Strategy (2005). In the Darwin area, various organisations provided goods and services to the poor and homeless. These may be categorised as:

- SAAP funded non-government not-for-profit organisations, for example, St Vincent de Paul, Anglicare, Salvation Army and A New Start Towards Independence (ANSTI);
- Government departments and funded programs, e.g. Centrelink, Territory Housing and NT Department of Community Development Sport and Cultural Affairs (Community Harmony Project); and
- Unfunded non-government organisations, e.g. the Sisters of Charity.

Background research was undertaken in order to gain a broad overview of the type and nature of each service provided to homeless people and also to understand where Ozanam House was situated among these services. I obtained this contextual information by telephone contact with each provider, in most cases the manager of the service, and a brief summary of their services and a description of what usually occurred were documented.

SAAP funded services in the Darwin area

The SAAP funded services made up the majority of services responding specifically to people who were at risk of, or who were, homeless in Darwin. At the time of this study there were 21 SAAP services (or projects within services) in the area including a SAAP Mental Health Resource Worker program that purportedly provided education and

training to SAAP organisations (NTDH&CS, 2002). A summary of these services, loosely categorised according to client group, has been provided in **Appendix 1**.

These services provided accommodation and support to people who were at risk of homelessness or who were already homeless and experiencing varying degrees of crisis. Each service received varying amounts of funding and typically focussed on specific problems and/or populations, such as women and violence, rehabilitation for Aboriginal clients, youth accommodation and war veterans. Several services attempted to cater for people with high levels of need but who are self supporting during day to day living, therefore can cook, clean and maintain their accommodation. The majority of services required some form of rent, with the service generally arranging with clients for deductions for this and other fees out of Centrelink payments (government welfare payments).

Until December, 2004, there were in theory, typically less than 80 beds available each night to single adult males (see **Appendix 1**, Table 2). After December, this number dropped to around 70 beds with the closure of the St Vincent de Paul's Ozanam House shelter. The actual number of available beds, however, was influenced by whether or not an individual drank alcohol or took drugs, reducing the available beds to this population quite considerably. For example, one service, accounting for 18 of these beds, prohibited the consumption of alcohol and drugs both on and off the premises at any time, and regulated this through routine and random breath and urine testing. Consequently, there were only 52 SAAP funded beds available per night for those individuals who consumed alcohol and/or drugs and who also maintained some level of control acceptable to the service provider. With alcohol use among Darwin's homeless and/or Long Grass people being well documented and highly visible (Mommott & Fantin , 2001; Mommott *et al*, 2003; Maypilama *et al*, 2004), the SAAP funded accommodation for single adult males was often inaccessible.

According to the SAAP service providers, on any one night in Darwin, they accommodated a total of no more than 15 Indigenous adult men. With more than 800

Aboriginal or Torres Straight Islander peoples categorised as experiencing homelessness in the Darwin area on census night in 2001, and more than 400 categorised as experiencing primary homelessness (Chamberlain & MacKenzie, 2003), there was a significant shortfall of appropriate shelter necessary to accommodate this portion of the homeless population.

Some SAAP services provided limited support to the needs of single adult males with alcohol and other addictions, mental illness and other special needs. However, when a clients needs: (1) exceeded the available resources (staff, funding and facilities); (2) impinged on duty of care obligations; or (3) resulted in unacceptable behaviour and complaints, service providers refused the client access to the service. For example, clients staying at one shelter were permitted access while intoxicated, however, if they exceeded a blood alcohol reading of 0.2 they were referred to the Darwin Sobering Up Shelter, colloquially known as 'Spin Dry'.

The majority of SAAP providers reported that as clients' needs increased in complexity, they were less able to respond to them. Several providers maintained that the current service delivery climate inevitably exacerbated this problem, being a litigious climate marred by inadequate funding and staff. While 'crisis' services in Darwin funded by SAAP varied substantially, inadequate funding was commonly cited as a key reason for the inability of services to meet the needs of 'high needs' clients. Lack of funding usually had its greatest effect on staff numbers and the employment of suitably qualified personnel (such as nurses and counsellors) and particularly for overnight staffing. As such, most services were not staffed during the night and therefore could not provide services to people who required a higher level of support. Service providers were cognizant of their duty of care obligations and the potential threat of litigation. The lack of delineation between each type and level of crisis invariably had the greatest impact on the neediest of individuals and families. In Darwin, it is this group who were increasingly excluded from accessing homeless services.

Based on the census data enumerating Darwin's homeless and the available SAAP services to this population, there was a clear shortage of crisis accommodation and services for all groups and at all degrees of crisis and need. In the NT, only 4% of the homeless population was in SAAP, the lowest rate in the country (Chamberlain & MacKenzie, 2003), yet the rate of homelessness was significantly higher than any other State or Territory. A key contributing factor to the poor level of services in Darwin related to funding distribution methods. As mentioned earlier, funding allocations were distributed as if homeless populations were distributed in the same way as the general population. In addition to this, in the NT homeless people were geographically dispersed over a large area, and not concentrated in the same manner as in, for example, Melbourne or Sydney.

This situation has highlighted the logistical and complex challenges to the delivery of culturally sensitive and appropriate services over a large geographical area, particularly to Indigenous Territorians. Without access to homeless services in remote locations, those people who were 'counted' as homeless at the time may have eventually relocated to urban centres in pursuit of these services. This relocation may lead to further displacement and potentially adverse consequences to the health and wellbeing of Indigenous individuals and whole communities. This may exacerbate the tensions which already exist in urban centres between residents who live in houses and those residents who do not, such as those tensions already described in Darwin.

Memmott and Fantin (2001) found in a survey with Darwin 'itinerants' or public place dwellers, that out of 52 interviewed, 26 had lived in the Long Grass for 5 years or less, with 22 living out for between 5 and 20 years. They suggested that this "*indicates chronic or lifetime itinerancy/homelessness is a reality and a norm*" (p.5). MacKenzie and Chamberlain (2004) have observed that the majority of SAAP clients in the NT are likely to be 'long-term' or 'chronically' homeless. They recognised the time consuming and resource intensive support that these most disadvantaged clients required and noted that without additional increases to overall funding, resources could only be redirected from early intervention approaches to this group.

Government departments and funded programs

At the time of my study, several government departments had their own responsibilities and programs to deliver services to homeless people in Darwin, or funded non-government organisations to provide them. For example, the government's Territory Housing espoused a "*commitment to providing safe, secure, affordable housing to those Territorians most in need*" (Territory Housing, 2006; p.1). While government offered a range of services to all community members, in this section key programs and services which potentially influenced the homeless experience and health of homeless people have been highlighted and included the 'crisis' services in Darwin.

Territory Housing

While Territory Housing did not have crisis accommodation, they had a system of priority placement under certain circumstances, such as health conditions and people with accompanying children. People who sought access to public housing were required to satisfy Territory Housing with various references and other information. Prior to being considered suitable for public housing, it was not unusual for clients to be required to produce evidence of living independently in private rental arrangements for a period of time without generating any complaints, regardless of the validity of the complaint. The process of applying and waiting for public housing was often a lengthy one. During the waiting period, additional or changed information was often required and when this occurred, it affected the length of waiting time, the eligibility and ultimately, their access to public housing for applicants.

Centrelink

The Commonwealth's Centrelink welfare payment provided homeless people with a regular income and distributed Health Care Cards to those who qualified. Health Care Cards gave access to health services and treatment from those medical practitioners who agreed to 'bulk bill'¹². Heavily subsidised prescription drugs (under the Commonwealth's Pharmaceutical Benefits Scheme and Centrelink) were also available to Card holders.

¹² Centrelink currently accepted 'The Long Grass' or a service provider for an address. Previously people who did not have an address were not able to claim pensions or other government welfare entitlements and had difficulty accessing medical services.

In addition to delivering services from designated locations, Centrelink used an outreach model to service homeless people and visited select services frequented by this population on a regular basis. Through this outreach model, clients were better able to meet Centrelink's requirements and provide any (changed) information they needed.

Mission Australia

The NT Department of Community Development, Sport and Cultural Affairs, through its Community Harmony Strategy and the Department of Health and Community Services together funded Mission Australia's Day and Night Patrol and Sobering Up Shelter. Mission Australia described themselves as a non-denominational Christian organisation with more than 280 services across Australia (Mission Australia, 2004).

According to Mission Australia, the staff of the above mentioned services have developed trusting and strong links with Darwin's homeless community through their provision of a range of services including road safety education and promotion, outreach referral services and health care. The Patrols aim to maintain social order by targeting people who misused alcohol, were in public places, and who may have been at risk to themselves and the community. The Patrol and Police were able to relocate people to alternative locations, often the Darwin Sobering Up Shelter – a shelter for intoxicated people who have no other safe accommodation available to them (Mission Australia, 2005).

At the time of writing this thesis the government had announced its intention to withdraw funding to the Day and Night Patrol service, with the Police Service proposed to take on aspects of this role. Mission Australia indicated they were strongly opposed to this and would challenge the decision. It was their view that a groundswell of support existed in the community for their patrol work which would assist in mounting an argument to retain the services. This matter was a contentious and a political one in Darwin, with a newly re-elected government that campaigned on a platform of zero tolerance for anti-social behaviour. While it was clear the Day and Night Patrol service had a core aim to

prevent anti-social behaviour, the abolition of this service in favour of policing was further evidence of a shift towards the criminalisation of people who were intoxicated in public places.

Community Harmony Strategy

The Community Harmony Strategy was administered through the NT Department of Community Development, Sport and Cultural Affairs'. A key feature of the Strategy in 2003 was the allocation of \$5.25 million towards returning 'itinerants' home, or to itinerants living more productive lifestyles in town. The strategy had two aims. The first being to reduce the incidence of anti-social behaviour by itinerants and the second to respond to the identified health, infrastructure and intervention program needs of this population (NTDCDS&CA, 2005).

An amount of \$2.5 million of this total budget was earmarked for capital outlay and the strategy comprised three approaches to the 'itinerant' problem. The first approach aimed to prevent and reduce antisocial behaviour. The second approach was concerned with infrastructure provision including shelters, facilities and accommodation and the third approach aimed to provide "*health and treatment services including expansion of Sobering Up Shelters and outreach and withdrawal services*" (NTDCDS&CA, 2005; p.1).

One Community Harmony Strategy program funded to address the first approach was Mission Australia's Day and Night Patrol service, a service noted earlier as having been under threat. Projects that related to the second aim of infrastructure included the construction of an ablutions block at Ozanam House and the construction of crisis accommodation at the Christian Outreach Centre, the Council for Aboriginal Alcohol Programs (CAAPS) and at Knuckey's Lagoon.

St Vincent de Paul and Community Harmony Strategy

St Vincent de Paul's Ozanam House, in conjunction with the Community Harmony Strategy, constructed an ablutions block consisting of two separate bathrooms with shower and toilet facilities in each. The ablutions block, however, was a source of

community tension as neighbouring property owners and businesses had long campaigned to remove the St Vincent de Paul service. The construction of the block was indicative of St Vincent de Paul's intention to remain at their current site, which generated much hostility towards the homeless community. The housed and business community members maintained that homeless people were attracted to the area due to the availability of services provided at Ozanam House and that these people behaved in an antisocial manner by urinating, defecating and having sexual intercourse in the adjoining park. Other complaints related to the humbugging (locally understood as begging, hassling and/or deceiving) of local business customers, and of drunkenness and abusive behaviour. While also meeting a critical need of the homeless population, it had been anticipated by the service that the construction of the ablutions block would mollify community tensions relating to behaviour considered antisocial. To the contrary, however, the ablutions block served to fuel a contentious local issue making the intended permanence of the Ozanam House service more apparent to the housed and business members of the community. These pressures, combined with organisational management issues, restricted access to this facility to the daytime hours only.

Christian Outreach Centre

The newly constructed crisis and acute care accommodation at the Christian Outreach Centre in Berrimah, approximately 15 – 20 minutes drive to both Darwin City and the nearest shopping precinct. The Community Harmony Strategy funded half the costs associated with the construction of two new buildings. The accommodation was intended to provide operational support for Aboriginal 'itinerants', to relocate them from the Long Grass in the wet season, and return them home. In reality, the service generally prevented people from ending up in the Long Grass and not the other way around.

The crisis service generally accommodated 25-30 people when it was in operation. Initially the cost per person was \$70 per week, deducted from Centrelink payments, and included a room, bedding, toiletries, laundry facilities and breakfast and dinner daily. Unlike other services, clients were not expected to volunteer in any way. Following the opening of the crisis accommodation, there was a lack of clarity around responsibility for

the ongoing operational costs. As such, the service was no longer able to subsidise fees for clients in crisis, and these increased to \$140 per week for a single person, \$200 for a couple and an additional \$20 per week for each child, consistent with their non-subsidised fee structure for accommodation.

Aboriginal people made up 99% of the clients at this service and it was believed they favoured it due to: the opportunity to stay with family; the ability to avoid humbugging; the provision of meals; the open bush setting; and because *everything* was done for them. Clients stayed a couple of weeks, several months or for life.

Knuckey's Lagoon Acute and Crisis Accommodation

Knuckey's Lagoon was a crisis accommodation service for Aboriginal clients. It was around 15km from Darwin city, just off the Stuart Highway, and about 10km from Palmerston. Taxis were the main form of public transport available to clients for travel between the site and other places, such as shopping precincts.

Like the Christian Outreach Centre's crisis accommodation, the building works at Knuckey's Lagoon were financially supported by the Community Harmony Strategy. The fees were \$55 per week, with children free. Knuckey's Lagoon had four very basic buildings at the site, along with toilet and shower facilities and two BBQ cook tops. There were no refrigerators, cooking equipment, crockery or utensils, beds or bedding, food, toiletries or laundry facilities.

A lack of clarity around the operational costs at the site often meant the grounds were not well kept. For one of the buildings where the wall sheeting did not extend fully to the ground, clients reported snakes and other pests entering the building in times when the grass had grown knee high. Grass fires were also problematic although had been contained until the time of this study, with no serious injuries or damage to property resulting.

As a crisis service, the absence of basic facilities and the costs associated with travelling rendered this site unfavourable to many Aboriginal people. Diet was also affected by these factors. The service, however, provided an important stopping place for remote Indigenous families who were travelling to Darwin for short term periods to keep medical and other appointments. Some clients considered this site as a secondary option and stayed only as long as it took to secure accommodation at the Christian Outreach Centre or elsewhere. The service did not relieve 'itinerants' in the Long Grass of their primary homelessness status.

Summary

Evidence of a substantial homeless population resident in the Northern Territory and specifically in Darwin has emerged and Aboriginal people among this population are over-represented. With funding in this area severely diminished by the distribution methods, geographical dispersal and cultural diversity among the homeless population, effective service delivery has shown to be both challenging and complex. It is possible that many of the current approaches to service delivery have done little to ameliorate the conditions commonly associated with homelessness, but rather have reduced the risk of, or delayed, individuals moving from secondary to primary homelessness, such as at the Christian Outreach Centre.

A number of government and non-government agencies have provided services to segments of the homeless population in Darwin. This chapter has pointed to the gaps in service provision and examined a situation which sees that the chronically homeless with the most complex issues as the least likely to have their needs met. From the available data, it was patently clear that the number of chronically homeless people in need of crisis accommodation beds and services far exceeded the available and accessible beds and services. This was most marked for single Aboriginal men with alcohol dependency. One of the important contributing factors exacerbating this situation in Darwin was under-funding. It was apparent that without the necessary critical services, the circumstances in which homeless people found themselves living in Darwin were likely to adversely affect health, wellbeing and ultimately, quality of life.

From the literature I have concluded that although not all those in Darwin's Long Grass were homeless according to their own understanding of the term, all Long Grassers experienced inadequate shelter and resources to meet the most basic of daily needs. Long Grass people, both Indigenous and non-Indigenous, did not have access to the normal safeguards for health afforded to other members of society. Nor did they participate in societal processes in the same ways as other members. Evidence emerged to suggest they were sought out and pursued by the police, Night Patrol and Council officers. There are policies and laws in place which targeted homeless people and other Long Grassers. Certain behaviours and practices, which may not have attracted such attention if they were conducted in private places, were criminalised and punished. This occurred in tandem with an inhospitable urban environment in which homeless people experienced their lives – one where they were systematically being built out and physically and socially excluded. The extent and mechanisms by which the experience of homelessness is shaped by these economic, social and political dimensions and the influence these have on the health and wellbeing of homeless people in Darwin, have remained important areas for investigation.

In the following chapter, I describe the methodological approach to my study.

Chapter Four

Methodology

This chapter describes the methodological approach used in this qualitative inquiry. It takes a multi-method approach, including participant observation, interview and individual narrative, and draws on the ethnographic tradition. It follows the lead of William Foote Whyte (1993), wherein his landmark study of Italian American slums in Boston, USA, he argued the need for a personal account of how the researcher lived during the period of the study, in order to explain the methodology. This study, *Street Corner Society, The Social Structure of an Italian Slum*, was based on fieldwork undertaken between 1936 and 1940 and explored the organisational culture of an Italian slum.

Whyte (1993) observed the behaviour of slum dwellers while making a conscious effort to divorce himself from making moral judgments and was among the first scholars to reject the notion that poor communities lacked social order. His methodological account recognised the inextricable link between the community under study and the personal life of the researcher, particularly as the researcher lived the experience and became more immersed in community life. This insight also helped to explain the process of data analysis and the themes that emerged throughout the investigation. Whyte (1993) suggested that research ideas grow continually through immersion in the data, with much of the analytical process occurring at an unconscious level. I have integrated Whyte's

approach with the expectations of contemporary academic requirements in Australia in the field of social and health sciences.

This chapter will start with a discussion which locates this research in a post-positivist paradigm. The catalyst for undertaking research in the area of homelessness follows, with an explanation for the selected study site. The ethical issues which informed the methodology are then highlighted. The chapter concludes with a discussion on the multi-method approach used in this homeless study which aimed to respond to the research questions.

A post-positivist research paradigm

My worldview or paradigm, like all researchers', is constructed and evolves as I interact with the world. It is not an absolute truth or fact, and it is not right or wrong (Guba & Lincoln, 1998). It is the assumptions I make about the nature of reality and the nature and construction of knowledge, that is my ontology and epistemology respectively, and the methodological approaches I then use that are pivotal in distinguishing this inquiry paradigm. In the following paragraphs I will discuss the two broad research paradigms: positivism; and post-positivism or naturalistic inquiry.

Positivism refers to the traditional scientific approach that has dominated research for 400 years. O'Leary (2004) commented that positivists see the world as a fixed entity and as one that is *knowable*. By this, she is referring to a belief that what is not known will be discovered as technology advances. Positivists also believe that the world is governed by a series of laws and theories and is therefore predictable, accepting only one truth and reality. Positivism exacts social research as a scientific endeavour that is empirical and reductionist, and which considers discrete parts of systems. Positivists require research to be undertaken by qualified scientists who are objective and whose biases, beliefs and desires do not affect the research. The methods employed by positivists are universally accepted, have defined procedures and are hypothesis driven. Methods are reliable, namely, producing the same results under repeated trials and reproducible by other

researchers repeating the methods and producing the same results. Lastly, research findings are largely quantitative in nature (O'Leary, 2004).

Post-positivism or naturalistic inquiry as a research paradigm includes all those researchers, according to O'Leary (2004) and Schwandt (1998), who question the assumptions of the scientific endeavour, such as the predictability of the world or the basis for only one truth. Higgs and Cant (1998) identified five major assumptions concerning the construction and nature of knowledge in post-positivist research. They were:

- (i) *Multiple constructed realities:* - Reality is dynamic and constructed, shaped by social, political, cultural, economic, gender and ethnicity issues etc (Schwandt, 1998).
- (ii) *The inquiry process affects the researcher and research participant:* - The interaction between a researcher and the researched profoundly affects the findings.
- (iii) *Knowledge is dependant on time and context/place*
- (iv) *In establishing a cause and effect relationship, the description and interpretation of events are more meaningful:* - Knowledge is generated from the research participants themselves with cause and effect relationships emerging through the data (Higgs and Cant, 1998).
- (v) *The research is accepted as value-laden:* - The researcher's particular values and biases are accepted and articulated in the research, shaping the research outcome (Higgs & Cant, 1998; Guba and Lincoln, 1998).

Post-positivist researchers therefore construct knowledge while accepting the world may not be knowable; is ambiguous; variable, with no fixed truth; and is with multiple and sometimes conflicting realities. In this research paradigm, the research/er is reflexive, intuitive and holistic. The research is inductive and deductive, may be participatory and collaborative and acknowledges that any research will be affected by the biases, beliefs and desires of the researcher. And finally, research findings are generally qualitative in nature (Creswell, 1998; O'Leary, 2004; Schwandt, 1998; Wallerstein & Duran, 2003).

In exploring the experiences of homeless people, these characteristics of post-positivist research were compatible with the research questions and aims of my study. I therefore followed a methodology that: was inductive and deductive; was participatory; acknowledged that all research is affected by the researcher; and that accepted there could be multiple constructions of reality at the one time. This latter factor was particularly compatible with the findings discussed in the literature review around the diverse understandings of home and homelessness. Post-positive methodologies have the scope to explore the context in which homeless people experience their lives, by gathering data from an uncontrolled and natural setting to construct a rich picture or thick description of that experience (Geertz, 1973; Denzin, 1989; Stake, 1995). Given that political and social environments are constantly changing, a post-positivist methodology was also considered practical for this inquiry as such approaches are able to be responsive to dynamic environments, supporting a study design which is iterative and developmental.

The catalyst for exploring homelessness

The story of the man in the grandstand first came to my attention when I was reading a local newspaper. Local Councillors were describing how they asked the man if there was anything that they could do for him and his reply was only that he wanted some cigarettes. The story then went on to discuss the inappropriate disposal of needles by injecting drug users in this park and the ‘other’ potential threats to our children. While no statements categorically held this man responsible for such ‘social evils’ as illegal drug use or paedophilia, they certainly asserted that he was associated with, if not engaged in, these activities.

So while the greater details of the story were not known by the wider community, the community was led to believe, through apparently acceptable standards of journalism for this particular paper, that such a vulnerable and marginalised man was indeed a threat to our most loved ones - our children. I wondered what sort of community considered it acceptable to advertise in a local paper the location of a vulnerable man and without

evidence and based only on assertions, allowed the same community to believe that he was a danger to their children.

This unfolding of local events caused me to reflect on the numerous reports of assaults on marginalised individuals, such as homosexual men, prostitutes and homeless people, which fill our news. The greater detail of one of these events, however, has remained vivid in my memory, providing a harsh reminder of the cruelty that lurks in the shadows of society. A man, considered homeless by the media, local council and general public, once lived near Sydney's landmark Mrs Macquarie's Chair. After much local debate, it was determined that the man could no longer continue to occupy this prime real estate, and was required to move on and his home was subsequently dismantled. Displaced, the man found shelter one night near Martin Place and became the victim of a fatal assault.

To what extent did local authorities contribute to this man's death through their policies and decisions? These were the same authorities charged with the responsibility to protect him. What social reforms could or should result? These challenging and complex questions served to spur on my interest.

While I began to question the processes and conditions that led a society to construct some people as worthy and others as worthy of discarding, I also started to wonder what daily life was like for a homeless person. What did they do and why? How did they meet their needs? How did they see themselves? Did they find enjoyment in life? And how did other peoples' perception of them shape their own identity, behaviour and existence?

Locating the study and selecting a study site

At the time my study commenced I lived in the Hawkesbury District, in a Macquarie Town, located to the north west of Sydney, Australia, one of the worlds' great megalopolises – the setting for the grandstand story presented above. With the urban sprawl of Sydney, the small townships of this area gradually became the city's urban fringe, rather than the rural townships they once had been. Popular belief held that

homeless individuals relocated from rural and marginal locations in preference for city life. Yet over time, I had come to observe a group of homeless men congregating in select locations in the Hawkesbury with regularity, including the man in the grandstand. In this instance, while some homeless people may have migrated to the city, others did not.

In a move to the much smaller city of Darwin, I explored the idea of conducting my research in this new place. Darwin, as previously highlighted, had the highest homeless population per capita in the country and among this population there was great ethnic diversity. Yet still very little was known about being homeless from the perspective of the homeless person. A number of potential organisations working with homeless people in which to conduct field investigations were identified.

A community kitchen, frequented by homeless people, provided an opportunity to learn about the experience of being homeless within a natural socio-cultural context. This setting permitted homeless people to occupy common places and spaces that would not normally be available to me without my presence being understood as inappropriate, obtrusive or unnatural. A well utilised community-based kitchen also addressed the challenge of locating a transient homeless population in a central place. No other settings in Darwin allowed for homeless people to congregate, with regularity, and in larger numbers.

In recognition of the logistical and research design considerations, Ozanam House, a St Vincent de Paul meal and shelter service for homeless and poor people, was selected as a long term study site for the following reasons:

- it was the only free meal service in Darwin providing breakfast and lunch every day of the year;
- the service was well attended by homeless people;
- attendance patterns by many guests were reportedly consistent;
- guests were from a diversity of backgrounds;
- the service was in an accessible location;

- the staff were very encouraging, inviting and supportive of the research;
- staff welcomed my participation as a volunteer student; and
- my participation as a volunteer was not likely be understood as obtrusive, unnatural or cause discomfort to homeless guests.

Ethical issues with vulnerable research participants

Third (2000) maintained that the only valid justification for undertaking research into homelessness was that it could make a real contribution to understanding and alleviating it. Despite the inherent ethical challenges of such inquiries, Widom and Czaja (2005) contended that researchers should not be deterred from conducting research on sensitive topics with vulnerable groups. They conducted a lengthy and intrusive in-person interview with 896 participants (which concluded with the taking of a blood sample), and at the end asked a series of questions about their reaction to the experience. They found that while vulnerable people had a greater emotional reaction to the process, they were not less willing to continue to participate. They also found that psychologically vulnerable individuals were more determined to continue their participation, and agreed strongly they had been treated with respect and dignity, finding their participation meaningful. This inquiry into homelessness satisfied Third's (2000) justification, and I make the point that no such intrusive participation of vulnerable people in this Darwin study formed part of the research approach. In fact, the key foundation stones in the development of the research methodology were to ensure that the methods of data collection were safe and non-intrusive and did not lead to the participants being exposed to psycho-social harm.

Collaborating on an ethics protocol

In addition to participant safety, the approach to this study aimed to integrate issues around my own safety as a researcher; an issue Booth (1999) contended few researchers address as a methodological one. Consequently, there were additional reasons which were related to logistical and ethical concerns in selecting Ozanam House as a study site. As a relatively small framed woman, working in an environment with some degree of low-level surveillance was advantageous for my own personal safety. The institutional

environment also addressed ethical concerns arising from conducting research with vulnerable people. I was able to collaborate to some extent with the organisation on the research. After gaining their support for the study conceptually, the staff and Management Committee contributed to the development of an application for consideration by the University's Human Research Ethics Committee (HREC). This process worked to improve clarity around the aims of the study and my role as a researcher, explaining within an ethical framework what I would be doing, why, and how I would be conducting the research. The organisation was also able to gain an understanding of the implications of the study to them and in a way, formalised my research activities and generated a quasi research agreement. The organisation's key responsibilities relating to the ethical dimensions of my study included:

- advice upon the ability of an individual to make informed consent;
- introductions to meal guests;
- the selection of individuals for invitation to participate in interviews; and
- the referral and co-ordination of counselling services, where appropriate.

The latter responsibility was particularly important. The application to the HREC for ethics approval identified potential harmful effects on the research participants as a result of participating in my study and described the strategies developed to minimise and address those effects should they arise. The role of the organisation in providing or coordinating counselling services was pivotal to the progress of the study, for without it, it could not have continued on ethical or financial grounds. (The need for counselling stemming from participation in my study did not eventuate).

Informed and voluntary consent where there are unequal power relations

According to the National Health and Medical Research Council (NH&MRC 1999), ethical research involving humans must consider issues around informed and voluntary consent of participants, specifically when there is a dependent relationship or one where unequal power relations may exist between the researcher and the participants. This study with homeless people may be regarded as one where unequal power relations exist. The collaboratively developed protocol for ethical research guiding this study aimed to

ameliorate negative consequences stemming from this relationship. Strategies included organisational support in ascertaining individuals' capacity to give informed consent, as well as routine introductions. Homeless people accessing Ozanam House were introduced daily as they entered the premises, at which time a staff member reminded people: (i) who I was (a student); (ii) why I was there (to learn about their experiences and what happens at Ozanam House); and (iii) of each individuals choice to talk to me or not. I was typically introduced in the following manner:

...Good morning everyone. Welcome. For those of you who have not met Catherine, she is a student at University and she is here to learn from you, about your lives and what happens here. Feel free to talk to her if you want to.

Homeless people were aware that their continued access to the service was not affected by my presence in any way. The introduction process was reiterated through all one-to-one interactions to ensure participation was informed and voluntary. Further, it was generally left to the homeless person to initiate conversations with me. In **Chapter Five** I have expanded on the strategies used to neutralise perceived power disparities between me and research participants and I have elaborated on the ways in which individual participants became key informants.

While the strategy described above was useful for addressing issues of informed and voluntary consent during informal interviews, its appropriateness with participant observation was less clear. According to Agar (1980), the matter of consent around participant observation is a risk-benefit judgement and studies, such as this one on homelessness, do not generally expose participants to unnecessary risk. Ozanam House is also a semi-public space and as Lee (2000) points out, guests can expect not to know everyone in the setting and can expect their behaviour to be observable and subject to scrutiny by others. Lee (2000) concluded that direct harm rarely occurs as a result of unobtrusive observation in public.

Agar (1980) suggested a useful strategy in addressing informed and voluntary consent during participant observation was to devote time to discussing (i) how you will inform participants who you are and (ii) what you intend to do. He suggested evidence of the

success of this strategy is when participants began to say things like, ‘yeh, we know who you are’. As such, the introductory method outlined above, combined with maintaining participants’ anonymity, was adopted as part of the ethical protocol informing practice around consent during participant observation.

Full approval for the study with the ethical protocols was granted by the University’s Human Research Ethics Committee (approval number HREC 04/107, University of Western Sydney).

An emergent methodology: a post-positivist multi-method inquiry

No one specific or pure methodological approach advanced my research question satisfactorily, ‘*What is the experience of homelessness in Darwin?*’, or my further question, ‘*What are the key dimensions of that experience that influence the health homeless people?*’ The approach had to take into account the research context (at Ozanam House); the research aims; the relevant logistical and ethical issues (already discussed); and the available methods of data collection and their subsequent analysis (detailed in the following chapter). Subsequently, a multi-method approach emerged which aimed to provide the strongest response to the research question/s. With this post-positivist or qualitative inquiry, data were generated using participant observation, informal interview and individual narrative, drawing on the ethnographic tradition. The qualitative data were subjected to an ongoing recursive analysis – common in ethnographic approaches, as well as a thematic analysis - often used with qualitative data. (A detailed description of data collection and analysis methods is provided in **Chapter Five**). Through analysis, key themes emerged from the data. This type of emergence or discovery has similarities to grounded theory approaches, in that the study findings are ‘grounded’ in the data. In the following section I will explain why the ethnographic tradition has been particularly useful in informing this multi-method investigation.

Drawing from the ethnographic tradition

...man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search of meaning (Geertz (1983, p.5).

Ethnography is both a research approach and a research outcome with its historical roots found in Anthropology (Clifford, 1988). It is a written form of cultural interpretation or *some* aspects of a culture (Van Maanen, 1990). Traditionally anthropologists from the West have dedicated their inquiries to other 'primitive' cultures, however today anthropologists have increasingly conducted ethnographic investigations in a range of sub-cultures within industrialised countries, including institutional settings. Clifford (1988) described modern ethnography as "*simply diverse ways of thinking and writing about culture from a standpoint of participant observation*" (p9). Glasser and Bridgman (1999) commented:

Anthropology's methodologies, theories and modes of analysis make it especially suited to unearthing the subtleties of problems that arise as societies adapt to the complexities of contemporary life (p.x).

A descriptive account of ethnography is presented here by Le Compte & Schensul (1999) who regarded ethnography as an approach:

...to learning about the social and cultural life of communities, institutions and other settings that: is scientific; is investigative; uses the researcher as the primary tool of data collection; uses rigorous research methods and data collection techniques to avoid bias and to ensure accuracy of data; emphasises and builds on the perspectives of the people in the research setting; is inductive, building local theories for testing and adapting them for use both locally and elsewhere (p. 1).

Spradley (1970) and Agar (1973) argued that a successful ethnography is one which gives an outsider a description of the information and rules that are necessary to operate in a way that is acceptable to members of the culture sharing group. This description enables the outsider to see the world from the view of the insider; in this instance the homeless person. The description is a cultural portrait, and captures the everyday or lived experience of a cultural system or social group, and incorporates the researcher's interpretation of the group interactions and their perspectives.

While ethnographic methods of inquiry require a time commitment, there is evidence to suggest non-anthropologists have increasingly used participant observation of the everyday, where relationships of trust between the researcher and participants become central. Health, education and social researchers, for example, are now able to ask research questions which seek to understand a culture sharing group, presenting the emic view of those from within that culture. Such inquiries have made a strong contribution to policy development and creative practice responses in the area of homelessness, particularly in the USA and Canada (Glasser & Bridgman, 1999).

Snow and Anderson (1993) suggested a poverty or homeless culture is distinctive for its *“patterned set of behaviors, routines and orientations that are adaptive responses to the predicament of homelessness itself and to the associated conditions of street life”* (p76). In addition to adaptive behaviours and routines, Snow and Anderson (1993) pointed to three key elements that shape homeless cultures:

- the political climate which regulates how days are spent;
- the ecological environment, encompassing the distribution of institutions and marginal spaces in a community; and
- the emergent moral codes which provide an elementary guide to behavioural routines and social interactions.

They concluded that to understand a culture of homelessness requires *“examination of the institutional, political, ecological, and moral constraints that affect the adaptive responses the homeless fashion in order to survive”* (Snow & Anderson, 1993, p77). My multi-method investigation explored these constraints of daily life using participant observation of a homeless ‘community’ in an institutional setting.

My research aimed to contribute in a similar way to policy development and service delivery in the area of homelessness by generating an understanding of the homeless experience through participating in and observing the everyday in Darwin. As discussed, ethnography’s participant observation is a powerful method of inquiry which is

particularly well suited to explaining the problems affecting homeless people. It is rigorous and builds on the perspective of individuals, giving prominence to their social and cultural experience. It also recognises the importance of rapport and trust building between the researcher and the participants. This rapport and trust leads to the collection of data through informal interviews and individual narratives which has a great depth and richness, and as Geertz (1983) suggested, allows the researcher to search for meaning.

Summary

Exploring the experience and health of homeless people requires moving beyond simply understanding the behaviours, views and beliefs of the group. It requires learning ‘why’ they have these, rather than merely ‘what’ they have, i.e. searching for meaning. This chapter has outlined the multi-method approach developed in order to respond to the research questions about the experience and health of a homeless population in a particular study context, where research with vulnerable people played an important part of the process. This methodology aimed to uncover answers and provide insight into the ‘what’ and ‘why’ question on homeless behaviours, views and beliefs in order to better understand the homeless experience and health. The following chapter details the methods used to collect and analyse data, and commences with a discussion on the period the research was undertaken and my role as researcher at Ozanam House.

Chapter Five

Data collection and analysis

In this chapter I concentrate on the methods used to collect data, namely participant observation, informal interviews and individual narratives, as well as the approach to data analysis. I explain the strategies used alongside these methods which aimed to ensure minimal or no harm came to participants and which aimed to promote the generation of accurate and credible findings. I also detail the limitations of this study and conclude the chapter with an account of the process of withdrawal from field investigations. But firstly, I describe the period of data collection followed by an overview of the process of becoming an insider in the study setting. This process was a critical element in enabling me to gather in-depth and meaningful data from a vulnerable population.

Data collection period

Time was a critical factor in unearthing the complexities of contemporary life for Darwin's homeless population at Ozanam House. The extended period gathering data, between June 2004 and June, 2005, allowed for prolonged observation, particularly during the first seven months. In this time I familiarised myself with a new environment and slowly learned the social norms of behaviour. At the same time, guests became used to my presence and I was increasingly included in social, functional and organisational activities with guests, staff and the Management Committee. While there was no set time for me to arrive at the service, I tended to be fairly consistent and on occasion, when I had to do something on the way, I would be greeted by a guest volunteer sporting a grin and a light hearted "*you're late, where have you been?*". Usually when I left for the day,

volunteers would check that I was returning the next day. Some would ask me to commit to an arrival time and when I suggested 9.30am, they would counter it with a '9.00am'.

For the first seven months of fieldwork, I visited the St Vincent de Paul meal and shelter service regularly (except for periods of illness and travel etc) for between four and seven hours a day and worked as a volunteer alongside other volunteers, usually homeless people (referred to as guest volunteers), helping to set tables, wash dishes and do other odd jobs. This role facilitated the development of trusting relationships (to varying degrees) to occur with homeless individuals. From early on, Ozanam's guests were amenable to talking with me.

Negotiating a role and becoming an insider

The Staff at Ozanam House were key gatekeepers and advocates of my research. Staff granted me access to the study site and offered me the benefit of their long established and trusting relationships with Ozanam's homeless guests, introducing me and my research in a positive light. They also helped me navigate my way through sometimes unfamiliar territory, such as the complex family connections of some guests and the local informal camps, and supported me in becoming an insider in some circles.

I entered the field as a stranger or outsider, and like all researchers, I brought my own biases with me. Agar (1980) reminded us that when a researcher enters the field they will be categorised by the people within the setting; in this case the meal and shelter guests, volunteers, staff, Management Committee and members of the institutional organisation. The group members, according to Agar (1980) will define and redefine the researcher's role over time and make decisions about what the researcher wants to learn and what they are willing to share.

Rapport building

With this notion in mind that my role would be a changing one, defined by the participants themselves, I was conscious of the importance of building rapport with homeless people in order to learn their own perspective on, and experiences with, daily

life. According to Booth (1999), spending time on building trust with homeless people leads to a much better understanding of their issues. I was also cognizant of the fact that I may be perceived by guests as being aligned with, or the same as, staff. Such an alignment may have limited the nature of conversations among guests in my presence, particularly if conflict existed between a guest and staff. While I did not sense friction, I could not rule out the existence of tensions between staff and guests at Ozanam House that may be important to understanding the homeless experience.

To counter this perception, I worked to align myself with guests by deferring to them as fellow volunteers when the opportunity arose and only performing duties I observed being commonly undertaken by other guest volunteers. I acknowledged the staff position of power and control within the setting with symbolic gestures, such as knocking on the door, physically positioning myself apart from the staff and starting conversations in a more formal and less familiar manner. I worked at this alignment also by reinforcing my student status throughout the entire period of fieldwork. Staff were pivotal in asserting this student role, as noted earlier, they often made the initial introductions and I would later reinforce this through my own introduction. I believe this was effective as I became known as ‘the student one’ or ‘the student’. (As discussed in **Chapter Four**, Agar (1980) suggested these type of comments confirmed that guests were informed about the study and aware of the voluntary nature of participation). Those guests I had spent more time with called me by name. This approach was instrumental in addressing the NH&MRC (1999) concerns on conducting ethical research with participants where an unequal power relation exists with the researcher. This strategy of placing the researcher in the role of learner is one advocated by Booth (1999) who argued that by shifting the power in this way, the participant has the information and the power.

Geertz (1983) believed that human beings at some conceptual levels are the same throughout the world; however, *actual* human conceptions can be quite different from one group to another. In response to this, I attempted to suspend judgment during my research in order to understand a select homeless population from the perspective of its members and their own ideas about selfhood. In practice, I have attempted to represent

what Van Maanen (1990) referred to as “*the social reality of others through the analysis of one’s own experience in the world of these others*” (p. ix).

While I had worked to align myself with guests and be seen as a student, my presence had become routine, and the expectation that I could respond to various situations and requests normally managed by staff increased over time. For the most part this was not problematic as anything beyond the scope of what I observed other volunteers doing I would simply respond with a statement like, ‘*I don’t know, you should ask x*’. Outsiders to Ozanam House, however, such as health workers and new guests, would often approach me on entry. I suspect there were various factors responsible for this including my non-homeless appearance and my gender, and perhaps they sensed my observation of the comings and goings.

Over time it became increasingly difficult for me to continue with some of the strategies I had consciously adopted with staff in order to align myself with guests, as my behaviour would have been unnatural and/or inappropriate. My relationship with staff at a professional and personal level deepened throughout the fieldwork, and on occasion, I became their confidant. This had much to do with the organisation being in a time of significant change. On reflection, I do not think that the evolution of my relationship with staff had an adverse affect on my relationship with guests at Ozanam House, as these relationships were understood as discrete, with their own boundaries, expectations and level of trust.

Staff would often facilitate the beginnings of a lively and engaging conversation among guests and guest volunteers in which I gradually increased my participation. Toward the end of my fieldwork, these social activities became a focal point of the day at ‘Vinnies’ and were no longer dependant on staff involvement. Once the guest volunteers had finished serving food, washing up and finalising tasks associated with the delivery of the meal service to guests, they then often arranged meals and drinks for one another and sat down together. (Other meal guests often joined in as well and drank a cup of coffee and/or smoked a cigarette). This process was a type of symbolic ritual which worked to

establish individual participation in the social activities and also worked as a mechanism to express acceptance and inclusion of others. As a result, bonds between individuals were strengthened in order to sustain group processes. While this aspect of daily life in the institution is explored in greater detail in subsequent chapters, it is important to note here the type of exchanges that occurred in the setting, and that these exchanges and interactions generated some of the richest or thickest data in this thesis.

Building rapport with homeless individuals in the study setting was the most important dimension of 'recruitment'. The people who became participants in this study and the process of their recruitment (expanded on in the following section) occurred gradually over an extended period.

Recruitment of participants

In these seven (7) months of participant observation there was an estimated average of fifty (50) guests per day using the lunch service. Approximately 80% of guests were male and female guests seldom included non-Indigenous women. Aboriginal guests constituted about 35-45% of all guests with regular attendance patterns. At least half of the non-Indigenous guests attended the meal service daily, although many of the less regular guests over time became familiar to me.

During the meal service, I usually exchanged pleasantries with most guests. I would engage in a more in-depth conversation when the opportunity arose, sometimes up to five or six times during a service. Before and after the meal, I spent considerable time in discussion with guest volunteers and staff. Guests who had stayed on after their meal usually engaged in the conversations as well.

Peoples' in-depth perspectives, what they say they do, and what they actually do, only materialised more fully as time went on and as trust was built – my field notes being a testament to the gradual unearthing of life's complexities for several key informants. Much of this in-depth knowledge was learned through a further five months of fieldwork where I collected data from key informants through informal conversations and by

participating in various activities with them both at Ozanam House and beyond the institutional environment. For example, key informants invited me to spend time with them, accompany them to appointments or show me local places of importance. As Van Maanen (1990) pointed out, “*the best way to enter a person’s life world is to participate in it*” (p.69). This key informant data supplemented my earlier participant observation data and worked to develop a rich picture of the experience of homelessness in Darwin. Further, this additional five month period of field investigations allowed for the accuracy of the data to be checked, as well as a further exploration and checking of the findings that were emerging through data analysis.

Distinguishing key informants from other informants has been based on the nature of my relationship with them. Many of Ozanam’s guests had transient lifestyles, and relationships can be short lived, yet intense, and still make a strong contribution to understanding the experience. As such, those guests who constituted the key informants group included individuals, whom if I met by chance down the street, would stop and chat, catch up and probably organise to meet again. There would be an obvious familiarity with continuity in conversation. Key informants usually shared their recent experiences and feelings and often expressed their vulnerabilities. The encounter would usually be a positive reunion, undertaken with ease rather than awkwardness. I would generally be asked about my family by name and how the thesis was coming along!

Key informants tended to be more actively involved at Ozanam as volunteers and had stayed in the shelter; were resident there; or had been former shelter guests. I remained in contact with key informants throughout the whole year of fieldwork. For those who were based in Darwin for the entire period, my contact was frequent and regular. Other key informants left Darwin for a month or so, would later return, and I would resume contact with them through Ozanam House. I also remained in telephone contact with several key informants.

The time spent during contact periods was varied. I often observed their participation at Ozanam House for several hours at a time. Sometimes our discussions would be brief but

usually they were at least 15 minutes and often continued for more than an hour. It was usual for several key informants to be involved in a group discussion for an extended period (i.e. more than half an hour) in which I also participated.

During my study I maintained ongoing contact with up to ten (10) key informants. They were all Australian citizens. Nine (9) were male and one (1) was female. Three (3) were Aboriginal, four (4) were Caucasian of European extraction, and two (2) had immigrated to Australia due to war. Six (6) were from ethnic minority groups whose parents first language was not English, and English was a second language for five (5).

Excluding formal interviews as a method

In my initial research design, I had planned to tape record conversational style interviews with key informants. These interviews, I had thought, would unearth the subtleties of problems associated with life and add depth to my study. After conducting the first of only two such interviews I came to realise conversation became stilted in some ways, losing natural flow and eliminating the comfortable banter that typified our usual conversations.

Prior to this, I had observed and engaged in conversations with various individuals and had documented, over an extended period, dimensions of people's past, present and future. The stories of homeless people had unfolded as they negotiated daily life in a natural environment. On this occasion, the formal interview process removed individuals from a familiar context and failed to generate data that was as meaningful as what I had gathered through participant observation. The interviews did, however, provide reliable quotes and the opportunity to verify the accuracy of data already collected, particularly where I had documented conversations. Despite this 'data verification' advantage, it was logistically easier and more convenient for key informants to simply clarify or expand on previous discussions. I conducted a second and final interview with another informant and my observations were consistent with the first interview. Interestingly, both interviewees later commented how much they had enjoyed the process and offered to participate again. I overheard one interviewee explaining to another guest about the

research and how they had contributed; describing it as both fun and the opportunity to talk about things not thought of for ages.

Data recording

At the end of each day I would spend between two and four hours recording and reflecting on the events that had and had not taken place. Intuitively I felt it was not appropriate to take notes in front of guests while a participant observer at Ozanam House. I also felt confident that had I done so, I would likely jeopardize opportunities for developing rapport with guests. Instead, I would return directly to my computer and write up my field notes daily, recording my observations describing the social processes and events that had transpired.

Participant observation

Lee (2000) suggested that observation can be organised around five topics: (i) exterior physical signs such as clothing, hair and general appearance; (ii) expressive movement including the more obvious behaviours or actions; (iii) physical location, that is the organisation of the space for social interactions; (iv) *in situ* conversation such as samples of conversation among people; and (v) behaviour associated with time, for instance, how long people took to complete activities. Using Lee's (2000) five topics as a guide, I observed and later documented such things as:

- Who the guests were (age, gender, ethnicity);
- Whether they appeared to arrive/or sit with family, friends or alone;
- Whether individuals were trying to avoid others;
- The physical appearance of guests;
- How many guests arrived;
- The types of interactions between guests (i.e. friendly, helpful, distressful, violent, abusive, bossy etc);
- The types of interactions between guests and staff;
- The extent of interactions and activities (were they short lived, did they continue after lunch);

- The type and extent of use of other services at Ozanam (did they take bread, have a shower, access Centrelink, use the computer or phone, ask for clothes or money etc);
- The foods consumed and those that generated requests for second serves;
- The food that was discarded; and
- Any sharing, demand sharing or giving of money or goods.

My observations were overt and were undertaken only during the course of my usual and accepted participation as a student volunteer at Ozanam House. These same observations could have been made by anyone participating as a volunteer, guest or staff member in this setting.

Informal interview (conversation)

Using the same method of recording described for participant observation, I also recorded informal interviews (or conversations) in which I was involved. Informants were aware that I would (and had) documented these encounters. I had a good skill for recalling conversations verbatim, although could only retain the detail for a short period. As such, writing my notes daily was a necessary ritual and as part of this process I would highlight points for clarity and/or further explanation. Consequently, the interpretation of observations and social processes in the field setting and the subsequent recording of these events marked the beginning of data analysis. I continued the same process of data collection, reflection, recording and analysis throughout the whole period of fieldwork (with the exception of the tape recording of interviews discussed above).

Individual narrative

Roberts (2002) suggested that individual narratives permit a focus on individual meaning and experience, drawing together diverse events, happenings and actions of human lives into themes. Narratives are concerned with the stories used to describe human action.

Roberts (2002) added “*narratives can empower people by giving more intimate understandings of their lives and contexts*” (p.116). A narrative is therefore an

individual's experience 'storied' and as Roberts (2002) pointed out, refers to both the 'story' and a method of inquiry.

In this study I have collected data through informal interviews to develop individual narratives in order to capture the lived experience of homelessness. I have taken the liberty of using narrative to present the findings in **Chapter Eight**, which discussed trauma as key dimension of the homeless experience. In order to protect the identity of individuals and maintain their anonymity, I have used pseudonyms throughout this thesis. I have also used 'xxxx' or 'yyyy' etc, as a substitute for service names.

Data analysis

In addition to the analytical process already described, I applied a line-by-line thematic analysis to the complete data set on three separate occasions to confirm the experience of homelessness and:

- the identified key dimensions of that experience which had the greatest influence on health;
- the relationship of each key dimension with the homeless experience;
- the relationship of each key dimension with health; and
- the relationship between each key dimension.

Data analysis during the field investigations and then during the three-phase thematic analysis explored concepts using inductive and deductive techniques, often referred to as recursive analysis (LeCompte & Schensul, 1999). This cyclical kind of analysis is described by O'Leary (2004) as engaging in a process of constant comparison, whereby "*concepts and meaning are explored in each text and then compared with previously analysed texts to draw out both similarities and disparities*" (p.197). The researcher starts with a research question and a series of related hunches or concepts that are flagged for further exploration. Through initial interviews and observation, the hunches and concepts are elaborated and retested. This occurs through the:

...continued collection of data using the same or different methods - or both. The process continues until new information confirms a pattern, and the model appears to be complete (LeCompte & Schensul, 1999; p15).

The homeless experience and three key dimensions (or themes) of this experience which had a significant influence on health (each with sub-themes) emerged and were confirmed through this analytical process.

Data accuracy and feedback

To ensure the accuracy of these findings, data were checked on a daily basis through the process mentioned above and through ongoing dialogue with key informants, staff and Management Committee members. Following the first thematic analysis I had the opportunity to present an informal paper to Ozanam's volunteers and staff and outlined the emergent themes, and described the context of the study site and homelessness in Darwin. While the volunteers and staff confirmed the accuracy of my data, this process had unexpected benefits. It acted as a springboard for:

- guests and staff to volunteer detail that added a greater depth of understanding to some very complex issues; and
- checking the accuracy of the data on an *ongoing* basis.

It became more difficult to maintain a feedback system with informants once I completed field investigations due to limited contact, although I continued to check the accuracy of my data and my research findings with staff and Committee Members throughout the duration of my study and at the completion of this thesis. I also provided copies of papers for discussion which stemmed from this research which were presented at conferences or published in journals to staff and Committee Members. On one occasion, staff came to a locally based seminar where I presented this work. The informal approach to feedback was befitting of the nature of the organisation and my relationship with individuals within it.

Limitations of the study

All research has limitations. In my research the principle limitations related to:

- the reconstruction of daily lives of homeless people when I often only observed and participated in part of their daily life;

- the period of time spent collecting data through participant observation;
- the affects of a homeless lifestyle on the development of relationships with permanence with informants;
- how representative the Ozanam House homeless population was with the Darwin homeless population; and
- my not being a homeless person myself.

Participation at Ozanam House was only a part, albeit an important part, of daily life for homeless people in Darwin. Consequently there were limits to my capacity to reconstruct other parts of guests' lives. The reconstruction of individuals' lives and the homeless experience in this research has been achieved by participating in some aspects of daily life beyond the institutional setting and by engaging in ongoing conversation with key informants. To counter this limitation, I immersed myself in the integral parts of the everyday lives of these people wherever and whenever possible.

A further study limitation related to the length of time spent as a participant observer. I had planned to spend a full year collecting this type of data, however, organisational changes at Ozanam House (discussed below) prevented this from occurring. As such, all seasonal variations that influenced the participation of homeless individuals at Ozanam House can not be reported. Participant observation data did include the dry season, build up (high humidity and temperature with no relief) and the beginning of a wet or monsoon season. My observational data did not capture the full extent of the experience of homelessness during the monsoon season, despite this particular season being uncharacteristically dry. I spent, however, seven months as a participant observer and a further five months collecting in-depth data from key informants and checking the accuracy of data and the findings generated through analysis. By the completion of the second phase of field investigations, I was able to confirm the data had reached, what Creswell (1998) and Strauss and Corbin (1998) referred to as, 'saturation' - where no new information or dimensions emerged in the data, where collecting additional data seemed counterproductive and where 'new' data did not really add a great deal to what had been found.

The third limitation of my study related to the opportunity to develop deeper relationships, with a greater level of permanency, with more of Ozanam's guests. The transient lifestyle of homeless people in Darwin was one factor that presented challenges in relationships evolving from informant to key informant. Another factor related to the effects of drug and alcohol use and abuse on individuals' memories. It was difficult to develop relationships with individuals when they were heavily intoxicated or whose addictions impeded their capacity to recall events.

One such example relates to a female guest, in her mid forties, who had lived nearly all her adult life with a heroin addiction. When I met her she had detoxified and we engaged in many long and in-depth conversations day after day over a few weeks. I later met this woman in a different context and said hello. It was clear she knew my face but could not place me. She was anxious to know how we knew one another and requested me to provide the necessary prompts for her to recall. 'How' this woman knew me was the stimulus necessary for her to recall the content of our previous discussions – sometimes verbatim. A month later I bumped into her again in this same context and we found ourselves going through the same process. Despite these challenges in building deeper relationships, I have maintained links with many of the key informants who participated in my research.

A further limitation related to the homeless population at Ozanam House. Due to the service type, this population was not necessarily representative of the Darwin homeless population as a whole. For example, Aboriginal people accounted for approximately half of the primary homeless population (those living rough) in Darwin, although represented about 35-45% of the Ozanam House population during my study. A further example is the lack of non-Indigenous homeless women and children in my study. My study did, however, deal with a cross section of Indigenous and non-Indigenous people accessing homeless services in Darwin.

According to O’Learly (2004), hallmarks of credible post-positivist research use methods that are dependable, where generated data are authentic, and where the findings have transferability to other settings. Even with the limitations of my study, this research is still coherent and has systematically gathered sufficient meaningful and in-depth data in order to construct the experience of homelessness, illuminate the key dimensions of that experience which affect health, and provide sound insights into my research questions.

Withdrawing from the field

My role as volunteer/research student remained fairly stable until I eventually withdrew after seven months (June 2004 to December 2004) from participant observation at Ozanam House. The staff had been made redundant and the emergency shelter closed. The Management Committee took on a more active role and attended to the daily functions that had previously been the responsibility of staff. Some guests expressed their disapproval for the changes by suspending their participation at meal services, however this was short lived as they simply could not fend off the hunger through other means. Regular guest volunteers responded to these changes by non-attendance (again for a short period), visible distress, articulating their staunch objections to one another and expressing their hostility toward ‘Management’. Many guests and guest volunteers experienced these organisational changes as a crisis.

The organisational changes were also the catalyst for my decision to withdraw from daily participation in the field. The Management Committee directed various questions to me about the service and I became acutely aware that much of the corporate knowledge and stability at Ozanam House stemmed from the longer term volunteers. I also realised my own sense of responsibility had developed following an incident that occurred one morning when a man in his early 30s collapsed and started to convulse. My response was automatic and I commenced first aid. When the man regained consciousness I provided support during and after his recovery. Previously, however, when the service had been staffed, I may have commenced first aid but the staff would have quickly taken responsibility for managing the situation. With my continued presence at the service I felt an increasingly unspoken expectation by others, and of myself, to exercise a duty of

care, which indicated a clear shift in role away from volunteer/research student. I saw the consequences of this changing role having a profound affect on shaping the very culture or lived experience I came to learn about, reinforcing in my mind the need to withdraw from daily field investigations.

Despite the realisation that my continued daily participation would have been in conflict with my research design, it was a difficult decision to withdraw. I personally wanted to see a good service provided to these people that had so generously let me into their lives, some of whom I had grown very fond. I felt I could make a positive contribution and was concerned guests and the committee would see my departure in a negative light, as if I had let them down. There were even occasions I agonised over whether to continue with the research at all as it seemed somehow insignificant and selfish in the scheme of things.

As recorded by this thesis, I did not give up the research, ‘go native’ or stay in the field. During this period I maintained almost daily contact with my supervisors and felt a strong sense of obligation to them and the University. I also knew I did not possess the necessary skills to respond professionally to the needs of homeless people accessing Ozanam’s services and gained some sense of comfort from the notion that my completed work could contribute to policy development or improved service delivery. I was able to reconcile my personal conflict with an acknowledgement that this experience was common among researchers, and ultimately, I was determined to succeed in completing this degree.

Summary

In this chapter I have described my role, and how I negotiated it, as a researcher at Ozanam House. I have described the methods used to collect and record data. The method of data analysis has been provided which was used to generate the key research themes. Through these methods of data collection and analysis, the homelessness experience of people accessing the services at Ozanam House was gradually formed,

which enabled an exploration of not only 'how' health was conceived, but also 'why' it was understood in a particular way.

The next chapter is a largely descriptive one which introduces the study site. It is the first of five chapters which deals with the data generated and analysed in this inquiry.

Chapter Six

Ozanam House: the study site

The focus of this chapter is the study site, namely the St Vincent de Paul's Ozanam House, where the majority of the material for this thesis has been generated. Located in the Darwin suburb of Stuart Park (see **Figure 3**), Ozanam provided a free meal service and men's crisis accommodation. The chapter describes the Society's goals and philosophy of service delivery. The organisational, management and financial structure is presented as well as a description of Ozanam House as a place of change. I then turn to a brief discussion on the place and its surrounds, the main service components and a description of the guests and volunteers who utilised the service. The chapter concludes with an overview of the other business conducted by guests at Ozanam House.

A Society of St Vincent de Paul service

...Vincentian spirituality is more a lifestyle in which to be engaged than it is a subject to be studied... (Fr. Prager CM. as cited in the '*Manual of the Society of St Vincent de Paul Australia*', 1991, p.13).

The 'Vinnies' spirit

The Society of St Vincent de Paul (colloquially known as 'Vinnies') has been active in Australia since 1854. Members of St Vincent de Paul participate in Society business in groups known as Conferences. While Conferences had been established in all states by the end of the 1800s, it was not until 1949 that Australian and British defence force troops founded a Conference in the Northern Territory, the St Mary's Conference in

Darwin. Nationally there are more than 40 000 members with seven conferences in the Northern Territory (SVDP, 2004; SVDP NT, 2006).

Ozanam House, named after its French founder Frederick Ozanam, is a St Vincent de Paul Society (SVDP) service. As such, Vincentian spirituality was regarded an important aspect of service delivery by staff and Management Committee members, with Vincentian ‘lifestyle’ articulated in the most recent edition of the *‘Manual of the Society of St Vincent de Paul Australia’* (The Society of SVDP National Council of Australia, 1991). This Manual has evolved over 160 years, following its first publication in 1845. The periodic revisions reflect the Vincentian’s response to the Society’s growth and changing social and economic situations.



Figure 3: Local Map of Stuart Park, Darwin (Goway.com, 2007).

The primary function of the Manual is to inform members of the Society rules and to guide them in their practical application. The Manual embodies the spirit and aims of the Society’s founders; described as the ‘spirit of the Society’. The mission aims to:

... to deepen the Catholic faith of its members – to go out into our nation to heighten awareness of Jesus Christ.

We do this by sharing ourselves – who we are and what we have – with the poor on a person-to person basis.

We seek to cooperate in shaping a more just and compassionate Australian community, and to share our resources with our twinned countries.

Our preferred option in this mission of service is to work with the poor in development, by respecting their dignity, sharing our hope, and encouraging them to take control of their own destiny (The Society of SVDP National Council of Australia, 1991, p.iii).

The Society aims to relieve suffering through person-to-person contact and also by adapting assistance to the localised needs, places and circumstances. The spirit of advocating for the poor, even when it is unpopular, is also regarded a key area for the effective aid to “*people afflicted with the worst forms of poverty*” (The Society of SVDP National Council of Australia, 1991, p. 5).

The philosophy, goal and mission of Ozanam House

In addition to the prescriptions set out in the Manual, Ozanam House, Stuart Park, Darwin, is guided by ‘*The Policies and Procedures Manual, NT, Volume 3*’ (SVDP NT, 2003), which describes the philosophy of Ozanam House. The primary objective is “*to show Christian love towards ‘the poorest of the poor’ (those whom society rejects) and to relieve suffering. This takes priority over all else*” (p. 1). This mission is situated within the broader St Vincent de Paul spirit which regards all human life as sacred, with all people equal in dignity and value (The Society of SVDP National Council of Australia, 1991).

The goal of Ozanam House is to welcome the homeless, lonely and suffering. People will not be turned away due to lack of money and will be given the benefit of the doubt where doubt exists over their circumstances. Ozanam’s policies and procedures also emphasise that the poor often need to be welcomed and respected as equals, with inherent worth and dignity. This need is identified as often greater than the need for food, shelter and clothing.

The mission of Ozanam House, as set out in the policies and procedures document, is to provide ‘Christian love’ as opposed to a ‘welfare service’; the distinction being that Christian love involves ‘service to a person which is motivated by love’.

Organisational structure, finance and politics

At the time of this study Ozanam House was managed by a Special Works Committee (referred to in this thesis as the Management Committee), comprising members of the St Jude’s Conference, established specifically for this purpose. The relationship of the Ozanam House Committee to the Northern Territory organisation is illustrated in **Figure 4**.

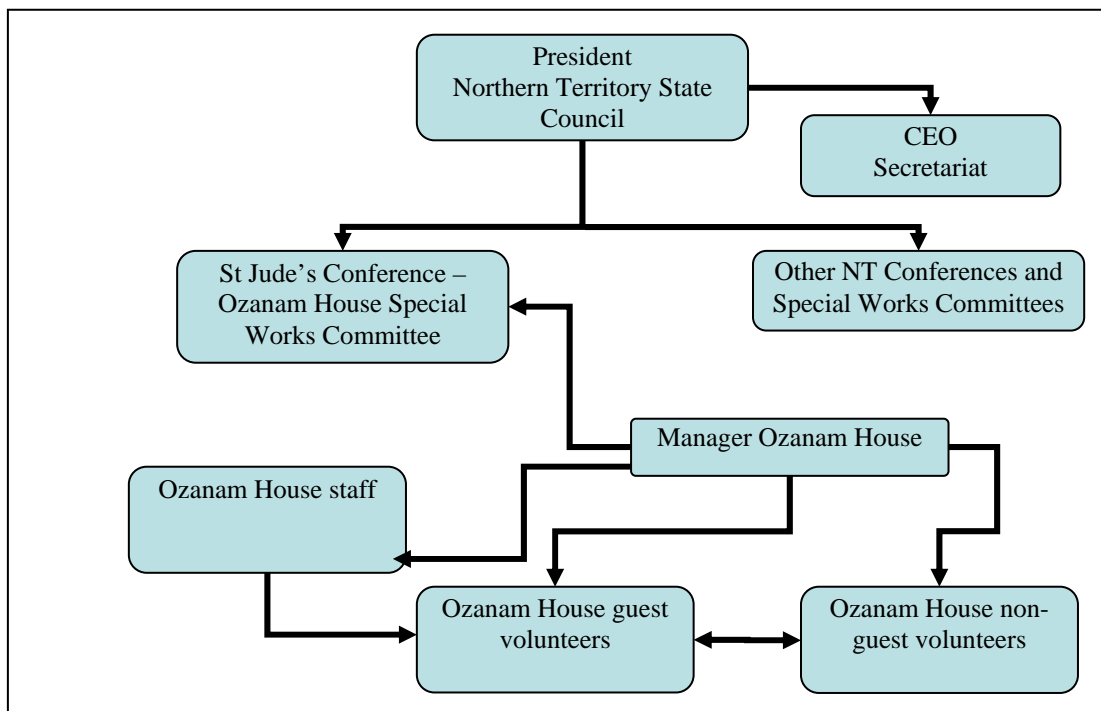


Figure 4: The St Vincent de Paul Society organisational structure as it relates to Ozanam House.

At the commencement of my fieldwork in June, 2004, the Management Committee included four active members who volunteered at weekend meal services. The Committee was accountable for the budget and enacted the decisions and responded to

the pressures of the President of the NT State Council and the Chief Executive Officer (CEO) of SVDP NT. The Committee met monthly with staff members to fulfil their management duties.

There were three permanent full time staff and two casual staff. The full time staff typically worked weekdays and some weekend shifts, with the casual staff employed on a regular basis on weekends. The day to day functioning at Ozanam House was coordinated by the permanent staff members. Two staff worked together from 6.30am, finishing between 4.00pm and 5.30pm, with the third staff member starting by 3.30pm and finishing at 10.30pm. Staff on the early shift took responsibility for food supplies, cooking, administrative duties, general housekeeping and maintenance. The afternoon/evening staff member was responsible for assessing and booking in guests to the shelter, along with administrative duties.

Although staff had functional responsibilities aligned to the type of services offered across each day, much of their time was dedicated to one on one contact with guests and the building of relationships between staff and guests and also among guests.

Subsequently, the nature of their support was diverse, however it usually involved:

- counselling;
- social engagement and facilitation;
- assistance in securing accommodation;
- accessing household provisions;
- support with the completion of paperwork;
- explaining processes of other organisations;
- washing clothes, providing fresh clothing and shower facilities/needs;
- the coordination of voluntary work;
- the mediation of disputes;
- referrals to other agencies;
- transporting or arranging transport to accommodation or other transport, such as plane flights; and

- the arrangement of medical appointments and accompanying guests to hospital and the clinic.

Finance

The services at Ozanam House are supported through two primary sources:

- (i) SAAP funding distributed through the office of the CEO; and
- (ii) volunteer contributions.

In 2004, SAAP funding amounted to more than \$277 000. The value of volunteer labour was difficult to exact, but included an average of 242 person hours per week. This translated to a conservative estimate of \$260 000 per year (calculated on hours spent on key task areas in line with award provisions¹³). This figure did not include the unpaid hours worked by staff or the donation of other goods and services that contributed to the running of the service. It was generally agreed by staff, Management Committee and the Institution that the service operated on a ‘tight budget’.

The capacity of the Ozanam House service to embrace the spirit of the Society in their service delivery from within an economic rationalist framework was increasingly compromised. This was a view put forward publicly by both staff and Management Committee. The principles and ideology associated with this framework were perceived to be at odds with the Christian ethos of serving the poor. This conclusion was echoed by Tyler (2004) in his evaluative paper ‘*Ozanam House: Strategies for Renewal*’, wherein economic rationalism in this setting was described as:

...the face of the harsh “lean, mean” world of the neo-liberal state with its economistic model of outsourced services and its hard-nosed philosophy of mutual obligation (p.47).

¹³ This figure was calculated from the provisions set out in the Social and Community Services Industry, Community Services Workers NT Award 1996, Community services worker level 1, pay point 2 (95%), casual employee, current as of June, 2004.

Mounting tension at Ozanam House

Between June, 2004, and November, 2004, the pressure over the budget escalated, and the crisis shelter was earmarked for temporary closure. Staff and the Management Committee negotiated these pressures from differing perspectives, affected by their own experiences, priorities and responsibilities.

Prior to the commencement of my fieldwork, one staff member had been seriously assaulted by a guest who had been denied access to the meal service. The staff member explained:

...the guy thought he was training for an AFL match...I was the ball, and he put the boot in all over, concentrating mostly on my face. I felt like an upturned turtle and could not get up while the man kept kicking away.

The staff member sustained bruising all over the body, a broken cheek bone and an injury to an eye. After the recovery from the physical injuries, the staff member returned to work. Until this incident, staff had typically worked alone during shifts. This assault, however, was the catalyst for two staff members working together on the early shift. The staff member indicated this structure was essential for three reasons. The first was in order to respond to increasing administrative responsibilities. The second was to provide a cook due to the departure of a voluntary cook, and the third, to ensure the safety of staff in the work place. The latter reason had primacy: *“this way we can look out for one another”*.

The Committee was unable to support the new staff structure for two reasons. They remained unconvinced it would prevent assaults against staff, and secondly, the structure did not fit within budgetary constraints. Despite this, the early shift continued to operate with two staff members.

Through this issue emerged a lack of clarity associated with the role and responsibilities of the senior staff member, the Management Committee and the CEO. Staff experienced a perceived loss of power and control over their workplace environment, and felt frustrated and increasingly distrusting of the Office of the CEO. Exchanges of

documents confirm that the relationship between the staff and the Office of the CEO was volatile. Consequently, staff felt their capacity to negotiate on workplace contracts and a new (and substantial) central administration fee was substantially diminished.

Tyler's (2004) '*Ozanam House: Strategies for Renewal*' report generated much criticism by staff. Despite this strong criticism, several of the sentiments and recommendations included in the report were implemented during this study including:

- the development of an outreach service at Ozanam House;
- the prevention of Indigenous homeless people from taking advantage of the crisis accommodation service;
- the restructuring of Ozanam House encompassing the redundancy of existing staff; and
- relieving the Management Committee of their "*responsibility for general regulatory compliance by their absorption by a regional or Secretariat body for Society Hostels, while the local body could concern itself with the day-to-day management*" (Tyler, 2004, p32).

By mid November, 2004, tensions at Ozanam House between staff, the Management Committee and the Office of the CEO had climaxed and a decision was made by the Committee to make all permanent staff redundant and to close the crisis shelter. The day to day operations were to be coordinated by the Committee until the over-expenditure on the budget was recouped. At this time, the shelter was to be re-opened.

Redundancy and shelter closure

Following the handing down of this decision, the retention of one staff member to manage the meal service was successfully negotiated. One casual staff member resolved to no longer work at the service in protest over the recent events, and the remaining casual was terminated due to misconduct. Only three Committee members continued to be active.

Staff, Committee members, guests and volunteers along with many local organisations expressed distress over the resolution to close the shelter. Guests and volunteers were particularly upset about the redundancy of the staff and were equally concerned about their own future.

For the remainder of my fieldwork (completed by June 2005) Ozanam House continued to provide a free meal service. Committee members initially participated in the day to day operations, spring cleaned and managed administration. After a transitional phase, the permanent staff member coordinated the meal service on the weekdays and the Committee on the weekends.

The place and its surrounds

Ozanam House was located in Westralia St, Stuart Park, only a few kilometres from the Darwin city centre and within walking distance of Fannie Bay foreshores, the Parap shopping precinct and One Mile Dam, an Aboriginal town camp. Guests often walked or rode a push bike to Ozanam House, and on occasion arrived by bus, mini-cab or private vehicle.

Ozanam was situated within close proximity to a variety of commercial enterprises, with a local shopping centre directly across the road. Shops included a medical practice, pharmacy, mini supermarket, two liquor outlets, butcher and financial management service. There were two further liquor outlets within close proximity. A park with play equipment, a sand pit, grassed areas and some large shade trees was located adjacent to Ozanam. There were no public amenities in the park.

Land available for development in Darwin is scarce. With growing demand for housing and the proximity of Stuart Park to the city, the suburb has undergone gentrification over the past decade. Today there are a number of low rise medium density unit blocks in the immediate vicinity of the service, with several properties oriented toward the park.

Alongside these changes to urban planning and development, there has been a marked increase in community pressure to remove the St Vincent de Paul Society to an

alternative location. Community members, including those with commercial interests, have lobbied successive members of Parliament and the Society to further their campaign. Despite this ongoing pressure, the Management Committee and staff at Ozanam House continued to provide services to some of the most poverty stricken members of the Darwin community.

The nature of reported community generated complaints related largely to Aboriginal Long Grassers ‘loitering’ around the park and shopping centre. Shop owners reportedly objected to people begging, humbugging and abusing their customers. Other residential community members had expressed their objection to people having sex, drinking, urinating and defecating in the sandpit and under trees in the park¹⁴. In response to the complaints surrounding the park and in meeting basic needs for homeless people, St Vincent de Paul with the financial support of the NT government’s Community Harmony Strategy¹⁵ constructed an ablutions block on the Ozanam House site (see **Photograph 1**). After its construction, the nature of complaints changed emphasis and community objections related primarily to the presence of the ablutions block and Ozanam House itself attracting people to the park and local area. Ozanam House eventually limited the hours of access to the facilities, but this decision was a response to their own changed organisational and financial position.

A public telephone was located on the nature strip along side the park. Car parking was available both on the street curb and within the shopping centre car park. There was a vacant block – an abandoned business – adjacent to the shops and fronting the Stuart Highway. The shop car park underwent beautification during my study, with new

¹⁴ One of these trees, a Banyan (*Ficus virens*), was a remnant monsoonal tree. The root system of this tree provided greater privacy than other tree species for urinating or defecating underneath. By September 2005 Darwin City Council had erected a decorative metal fence to a height of 1.5 metres around its perimeter for the purpose of public health and safety stemming from people defecating and rubbish accumulating under the tree. The Council parks Officer advised that human waste was more likely to be beneficial to the tree than detrimental (provided damage did not occur to the root system over time) with the decision to fence ‘socially’ based (Darwin City Council Parks Officer Jonathan, pers com, 13/10/2005).

¹⁵ The Northern Territory Government’s Community Harmony Strategy aimed to address long standing concerns for the health and wellbeing of ‘itinerants’. It had three main strategies: the first to reduce anti-social behaviour; the second to provide infrastructure such as accommodation; and the third to address health treatment and care (NT Department of Local Government, Housing and Sport, 2005).

curbing and garden beds constructed. A bus stop was located close by on the Stuart Highway.

Guests of Ozanam House often waited for services to commence and sought shade and covered areas in the park, along the fence line of the House and within the Ozanam property. Some guests stayed after breakfast and waited on the premises or in the park until lunch was served. People in the park were usually in family groups and were more usually Indigenous Australians. Guests waiting inside the service were both Indigenous and non-Indigenous. People waiting under the awning of the local shops were rarely guests at Ozanam House but rather customers waiting to purchase various goods, including alcohol¹⁶. These customers were often accompanied by children and regularly left by mini-cab.

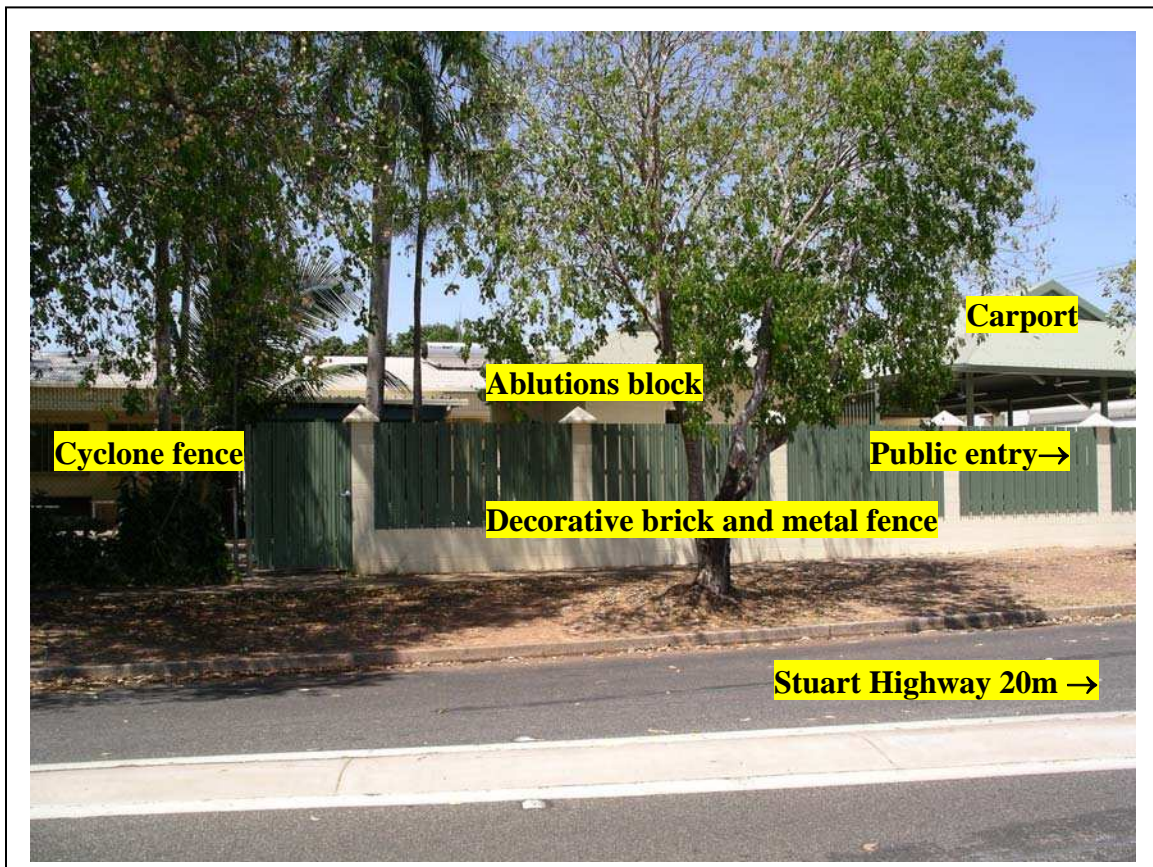
The premises

Ozanam House, built around the late 1960s, was a single story concrete block and brick building with a corrugated iron roof. The external walls were clean and painted yellow. Ozanam House, at the time of this study, did not meet the current building code requirements for building construction in cyclone affected areas, according to recent building and engineering audits commissioned by the organisation.

The property was bound by a 1.8 metre high fence on three sides, and the St Vincent de Paul shop on the fourth. The front fence consisted of cyclone wire for part of the length with the remainder constructed of yellow painted brick piers with decorative caps and dwarf wall with green metal infill panels. This decorative fence spanned the full street frontage. The fence adjacent to the park and at the rear of the property was also 1.8 metre high cyclone wire. The carport area and ablutions block were situated to the front of the property (see **Photograph 1**), and were of recent construction.

¹⁶ Arrangements had been made between many Aboriginal customers and the shop owners whereby the shop owner retained customers' bank cash cards. It was not unusual for the shop owner to have the customers pin number that provided access to their account. While the cost of goods at these outlets was often much higher than the alternative larger supermarkets, the smaller more expensive outlets offered this informal service.

The property was grassed behind the front fence and forward of the main building. There was a mature mango tree along with other smaller tropical plants¹⁷. The area under the tree provided good shade and was popular with guests as a place to socialise and work on art and craft. The front of the main building had an attached veranda with bench seats. There was another popular covered area nearer to the ablutions block with a table and chairs, cooled by a ceiling fan. Guests, and on occasion staff, tended to congregate here to chat and smoke.



Photograph 1: Ozanam House looking from across the street

At the property entrance, via the open driveway gates and the new carport, there was an office area. It had a few smaller rooms off it, including a kitchenette. The furniture and furnishings were a collection of bits and pieces donated over the years. There were a few religious icons on display including a framed portrait of Frederick Ozanam, the founder

¹⁷ Much of the vegetation, including the large shade trees, have since been removed.

of the St Vincent de Paul Society. This space was often very private, positioned away from the flow of general people traffic. An area had been set aside for guests to access computer facilities and a telephone for local calls, and a bubbler dispensing cold water was outside an access door (see **Photograph 2**).

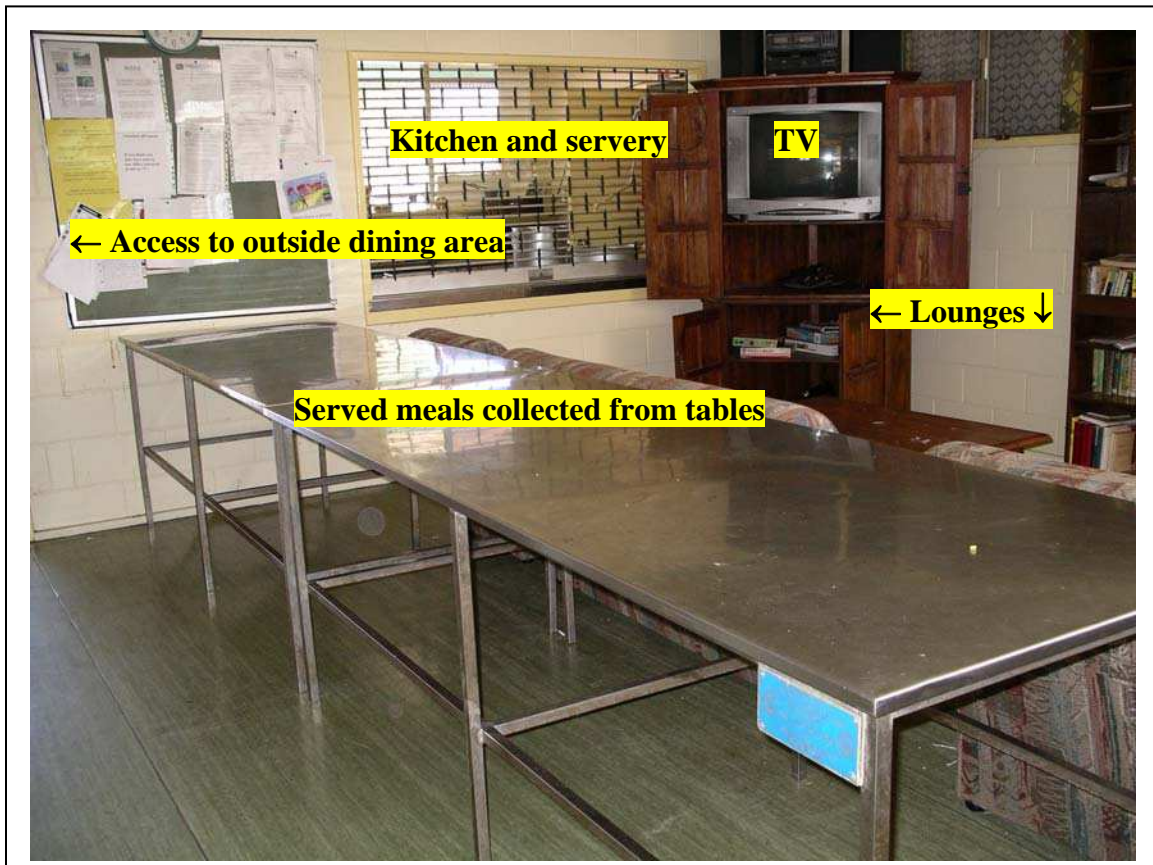
Adjacent to the office there was a small room, used on occasion as a bedroom, and routinely as a makeshift office for outreach workers, such as Centrelink and Legal Aid. Next to this room there was a store with a few poorly functioning fridges and freezers. This room led to the dry store for the kitchen but was rarely open.



Photograph 2: Ozanam House entry, carport and office area

The main building had a veranda spanning the full length. There were benches located on one side of the entry door to the meal service. Bread, donated by local bakeries, was placed in plastic bags and available to guests free of charge. Once inside, there was a

lounge room with TV, two commercial stainless steel tables, refrigeration and freezer units. At the rear of this room the kitchen was situated and could be seen from the entry and lounge area through a servery which was fitted with a security roller shutter. The concrete floors were covered with dark linoleum and the internal walls and ceiling showed signs of age and neglect (see **Photograph 3**).



Photograph 3: The lounge, servery and kitchen

The kitchen was equipped with a commercial style stove and oven and featured stainless steel bench tops and a deep double sink. It was the size of a typical Australian domestic kitchen, but had a dry store adjacent which provided sufficient shelving for food supplies. Cooking equipment was basic although staff and guests worked effectively with the resources available to them. The kitchen too showed signs of age and neglect, although there was some talk of an upgrade.

The men's shelter

The men's overnight shelter was located on the left hand side of the main building when viewed from the street. The dormitory style room contained ten single beds which had direct access to a communal bathroom facility and the dining or rear yard area of the property (see **Photograph 4**). The entry door was fitted with an observation window. The beds were stripped daily and washed by staff or guests. They were then dried in an industrial high-temperature dryer. This was reported by staff to be an important part of the infection control practices employed at the service in controlling the spread of scabies and other infections.



Photograph 4: The men's shelter

The dormitory style accommodation was favoured by staff over individual rooms as the service was not staffed over night and guests had the potential to self harm, harm others

or experience some other medical emergency. The dormitory style allowed guests to 'look out for one another', and raise an alarm when a problem arose. The staff believed that the loss of privacy with this model was outweighed by the safety imperative.

Access to the shelter was by a referral agency or through self presentation. Many guests were known to the service staff, both Indigenous and non-Indigenous, having been meal guests or having been in the shelter on previous occasions. Guests arriving from out of town, including interstate, would often make Ozanam House their first port of call or would be promptly directed there from other local government and non-government agencies. Interviews for new guests were conducted in the afternoon typically between 3.30pm and 4.30, but often guests known to staff would secure a bed at other times. Information, required by the SAAP agreement between government and Ozanam House and by Ozanam House itself, was gathered on each 'client'. Data obtained related to client age, needs, length of stay, where the person had previously been sleeping, reason for seeking support, prescribed medication and any pressing problems, such as those associated with alcohol or drug dependency or mental health conditions.

St Vincent de Paul employed a policy which required staff to be non-judgmental of clients, limiting the potential for prejudicial decisions about access. On rare occasions a guest would be refused access despite the availability of beds. This was most often due to a known history of sexual assault or violence, either at Ozanam House or elsewhere, and an assessment of the potential changes in dynamics among all other shelter guests by their inclusion. Staff described decisions to turn people away as difficult. Often staff explained the decision was made in the context of exercising a duty of care to the existing guests. Staff had also refused access to guests in the shelter as a result of being personally threatened or because the guests had been previously banned for a period of time. Existing guests would on occasion provide discrete warnings to staff about potentially disruptive or dangerous guests that were known to them. For the most part though, refusal was based on the availability of beds. In such cases, shelter staff supported meal guests in finding alternative accommodation with other agencies. On

occasion, shelter staff would arrange for the guest to be accommodated in an inexpensive local hotel at the expense of the service.

Some guests, however, believed they had been refused access to the shelter due to their Aboriginality and/or sexual preferences, or because of their involvement in organisational politics. In these instances, guests reported that they had not been supported in finding alternative accommodation.

A nominal fee of \$10 per night for food, shelter and facilities applied. Decisions around payment were negotiated on an individual basis, and on occasion, the service would reimburse paid fees to assist with rental bonds and related expenses once alternative accommodation had been secured. For many guests, however, Ozanam House was a revolving door and guests did not enter into alternative accommodation following their stay.

The length of stay was generally not to exceed two weeks and was often influenced by the next scheduled Centrelink¹⁸ payment and the circumstances of the individual. There were, however, anomalies to this two week rule. Some guests assumed special responsibilities, such as resident cook or night watchman, staying for extended periods of several months. One guest was a permanent resident and continued to stay at Ozanam House following the closure of the shelter, volunteering daily at the service to pay his way. This guest had lived for more than a decade in the institution after sustaining an acquired brain injury. Medical advice at the time recommended against relocation of this guest to an alternative residence citing the likely adverse affect on the quality and length of his life.

After booking in, usually between 3.30pm and 4.30pm, the shelter guests were expected to remain on the premises until morning. Guests, however, were free to leave at any time, and on occasion did. Rarely were the reasons for early departure known to the

¹⁸ Centrelink was/is a Commonwealth of Australia department responsible for (among other things) the distribution of government welfare payments such as unemployment benefits, single parent pension and the disability pension.

service. The premises were staffed until 10.30pm and guests were not permitted to have alcohol, illegal drugs, pornography or weapons at any time. With the exception of staff and Committee members, only those guests staying in the shelter were permitted on the premises after booking in and only shelter guests were allowed access to the dormitory. In order to secure individuals' belongings, the dormitory was kept locked during the day. There had been occasions where guests' medication and other items had been reportedly stolen from personal belongings. Staff encouraged guests to keep medication in the office, however some guests were reluctant to alert staff to their medical conditions, particularly those relating to mental health. When guests did leave medication with staff, staff took the opportunity to monitor and support the guest in taking the prescribed dose.

Ozanam House provided lockers and some shelter guests utilised this facility during the day to access to their belongings. This facility was available to anyone to store personal belongings, with the keys retained by the service staff. The retention of keys was not aimed at controlling access to peoples' belongings, but rather ensuring people *could* access their belongings by ensuring keys were not lost.

Guests staying in the shelter were expected to contribute to the daily house keeping of Ozanam House. Contributions often included cleaning, making beds, washing-up, replenishing supplies, cooking and serving meals, outdoor and garden maintenance and assisting with shopping and the receipt of food deliveries. On an *ad hoc* basis guests would assist with other tasks, such as cleaning out freezers, washing walls, clearing leaves and debris from the gutters and roof, cleaning store rooms and taking runs to the local waste collection depot (tip). The majority of guests raised no objection to participating in housekeeping with many taking pride in their assumed responsibilities. Many shelter guests who continued to work routinely at Ozanam House as volunteers beyond their stay in the shelter are referred to as guest volunteers in this thesis.

The meal service

A free meal service was provided everyday for breakfast and lunch. Breakfast was served at 8.00am and consisted of porridge, Weetbix (cereal) and toast with a selection of

spreads (jam, Vegemite, peanut butter and honey), accompanied by tea and coffee. On the rare occasions eggs had been donated, they were offered to guests. These were highly prized and generated lively debate and conflict among volunteers and staff regarding their distribution.

Breakfast was served by guest volunteers. As with all meals, guest received their meals at stainless steel tables located at the outside dining area (see **Photograph 4**). During this period usually a volunteer and/or staff member would commence preparation of lunch. Several guests would shower after breakfast, with the use of the ablutions block continuing throughout the day.

The data I collected during this study concentrated on the period following breakfast, around 9.00am, typically until the mid afternoon. As such, the lunch service has been well documented.

At 11.00am lunch was served and continued to be available until 11.30am. The front gate was opened and guests welcomed by staff. A queue would form with some guests collecting a bag of bread as they made their way inside. Some guests consistently worked to be at the front end of the queue, improving food selection options. Once inside the main building guests would carefully examine then select a pre-served plate from two stainless steel tables in the lounge area (see **Photograph 3**). Many guests appeared to experience anxiety around waiting and selecting a meal. If a guest took too long choosing a plate, another guest may select their desired meal. On occasion, food would discretely be relocated from one plate to another before collection. Despite this, meals were generous in size (often food piled high) and guests were permitted to have additional serves, provided they were consumed on the premises. Guests regularly requested a plastic bag to take food away but staff discouraged (and prevented) this practice, citing health regulations.

Lunch usually consisted of chicken, rice and either salad or cooked frozen vegetables. Frozen chicken was purchased at less than 50 cents a kilo and arrived whole, in pieces or

semi-processed into kebabs or schnitzel. Rice was prepared in an industrial steamer and salad items were washed and cut up. Vegetables were boiled, drained and butter added for flavour. A water based sauce/gravy was often drizzled over meals to enhance flavour and to generate heat. It was usual for staff and volunteers to start dishing out food at 10.30am, half an hour before the food would be consumed. The purpose of this was to ensure the meals were ready and the guests not kept waiting. It also allowed the guest volunteers and staff to eat before the meal service so they could recommence duties, such as serving soup and washing up, although there was a tendency for volunteers and staff to eat after the meal service had finished. Further, it permitted staff time to talk with guests and to respond to a variety of requests and needs.

Ozanam House had several gas barbeques and periodically a barbeque would be provided for lunch with sausages and meat balls (rissoles) as an alternative to chicken. Attempts to vary daily meals occurred in waves. Periodically pasta would replace rice, the rice would be cooked in stock, or spaghetti bolognese would feature as the main meal. These occasions were met with outward expressions of appreciation by guests, making special reference to the quality of the food.

The use of chicken as the staple meat for lunch meals often generated good humoured responses. On rare occasions guests would be visibly displeased and politely articulate their objection to consuming it everyday. Some guests would highlight the need for their nutritional requirements to be met and would suggest alternatives such as steak, turkey or ham. On occasion a guest would appear resentful and angry for receiving chicken, making comments like, *“You can’t keep feeding us this shit every day”*.

After collecting a meal (lunch) guests would then pass the kitchen and move to the outdoor eating area at the back of the property. Two stainless steel tables were positioned forming a work space for volunteers who were washing-up or serving. From these tables bread and hot soup was served daily to accompany the cooked meal, along with cups and cordial. On occasion, fruit or some other desert was also distributed here. From time to time verbal conflicts between guests would erupt at this table, typically because someone

was perceived to have jumped the queue or bumped into another guests and failed to apologise.

Another table provided tea and coffee, which was more popular at breakfast. Guests would take their meal to the tables (see **Photograph 5**), where plastic utensils were placed along with salt, pepper and other condiments. Regular guests tended to sit among the same group of people and often at the same tables. Other guests determined where they would sit based on seating availability and where other people had located.



Photograph 5: Meal tables for guests at the rear of the property

There was often food left over from lunch. This food was either used for dinner by the guests staying in the shelter or for lunch the following day. Little waste was generated in the kitchen and variable amounts of waste were generated by the guests. Discarded food depended on: the quantity served; its taste and quality; whether the chicken had bones or

not; and the individual circumstances of the guest. For example, guests who were obviously drunk or suffering the affects of a hangover rarely consumed salad. Guests who were drunk discarded chicken with bones and would avoid hot soup when cups were filled. Bones were seen as fiddly and soup hazardous and messy. While tasty and popular, the soup was often thick and contained vegetables, retaining its heat well. When consumed from a cup it had the propensity to surge into the mouth of guests causing burns and spillage.

On completion of their meals, guests were expected to scrape their plate into the bin and stack the dirty plastic plates, disposable utensils and cups for washing-up. This process was occasionally a source of conflict between some volunteers and guests, particularly if plates were not properly scraped or when utensils needed to be retrieved from the bin. Most volunteers, however, were not overly concerned by these acts. Guests with no further business at Ozanam would then leave the premises through the exit at the rear dining area which lead to the Stuart Highway.

One exception to the usual processes and interactions at Ozanam House occurred on Christmas day. It was a carefully planned event offering the greatest diversity and quality in food. The Management Committee, staff and volunteers developed a menu and were each allocated responsibilities from shopping, preparation of dishes and cleaning to serving food, washing up, decorating and setting tables. Food included peanuts, soft drink and other starters followed by a main meal of roast turkey breast with cranberry sauce, sausages and rissoles with bush tomato chutney accompanied by potato, pasta, Asian noodles and green salads. Desert comprised a selection of puddings, cakes and brandy custard. With more than 100 guests, little food waste was generated and numerous meals were packed into takeaway containers for later consumption. By 12.45pm there were still many people eating and talking, and spirits appeared to be high.

The meal service was well attended by many homeless members of the community. Although everyone was welcome to attend, access was controlled by a staff member at the entry gate. Those who: had previously been banned for a period; had previously been

asked to leave (due to threatening physical or verbal abuse to other guests and staff); arrived at the meal service too 'intoxicated'; or on occasion had arrived too late were refused entry. Access for late arrival guests was considered on a case by case basis. A typical scenario would see the guest request access, provide an explanation for their lateness, draw attention to their hunger and make promises to be on time in the future. Staff would reiterate the time in which meals could be accessed and make decisions on late access based on merit, the number of guests still at the service and availability of food. Despite the rules on intoxication and time of meals, seldom was a guest refused food.

With the exception of those guests staying in the shelter and other volunteers (guest and non-guest), the majority would have eaten, socialised, sometimes showered, conducted any other business and left the breakfast service by 9.00am and lunch service by 12.00pm.

Meal provision as a reliable, free and anonymous service was the most critical factor in achieving the outcome of improved wellbeing among crisis accommodation guests. For example, on occasion staff would encourage individual meals guests to stay for a few nights of respite in the shelter when their physical and mental condition had obviously deteriorated. The meal services also directly served a critical function in meeting basic nutritional requirements and sustaining a level of physical health among many of Darwin's most impoverished community members. The meal service was also a mechanism for the establishment of trust between service provider and guests, affording the opportunity to respond to a diverse range of issues affecting daily life. This is expanded on in later chapters.

Ozanam's guests: Who are they?

Drawing on Chamberlain and MacKenzie's (2003) homeless definitions, patterns indicate that most of Ozanam House guests attending both meal and shelter services moved between primary and secondary homelessness, and occasionally secured housing arrangements comparable to tertiary homelessness.

There was a great ethnic diversity among guests at Ozanam House, including people from a range of countries in Asia, the Pacific Islands, the Middle East, the UK and Europe. New Zealanders along with European and Aboriginal Australians were well represented. The participation of Aboriginal guests at Ozanam House, being a SAAP service, is an indicator of the most extreme poverty affecting a disproportionate number of this population in the Northern Territory. Keys Young's (1998) research on Indigenous homelessness found that Indigenous people only use SAAP services as a last resort due to the cultural stigma attached to homelessness. Further, they noted that they had "*typically lead very difficult lives and experienced a number of problems or crisis over fairly long periods of time*" (p. viii). Ozanam House was often the only service available to most guests to meet basic needs.

For all of Ozanam's guests it appeared that a short reprieve from living rough contributed in a significant way to their wellbeing before they returned to a state of primary, or sometimes secondary, homelessness. Again, the role of Ozanam House in health and social relations is discussed in detail in **Chapter Nine** and **Chapter Ten**.

Ozanam's guests tended to be unemployed, receiving a Centrelink pension of some form. A small percent of guests received no form of income at all, despite eligibility to claim a government pension. A few generated income on an *ad hoc* basis from the sale of art and crafts, prostitution, gambling, the sale of drugs or on occasion, through casual employment.

Employment opportunities were hindered by drug and alcohol addictions, poor health, lack of skills and education, poor literacy and the discrimination and criminalisation resulting from homelessness and poverty. For those receiving government welfare payments, drug (including tobacco) and alcohol addictions and gambling consumed most, if not all, available income.

Aboriginal participants in this study had less control over how their money was spent than non-Aboriginal participants. As one guest explained, '*it is our way*', a practice stemming from cultural expectations around sharing with kin. Centrelink's welfare payment (pension) day was often a stressful experience for Aboriginal participants in this study as family members would extort often all available income, leaving the individual with no money for 13 days until the next welfare payment was due. Some participants used avoidance strategies and others secured the support of homeless service staff to protect their cash cards or accompany them to the bank in order to retain money. The retention of money was often associated with the need to travel. Once money was exhausted, participants then engaged in extracting money from other family members. Many non-Indigenous participants, particularly those who had been homeless for an extended period in Darwin, also shared limited financial resources with other homeless people. This was most evident among those who were in relationships with Indigenous people.

Education levels of all guests rarely exceeded high school, although a few had undertaken trades. English was a second language for many guests. Consequently, English literacy skills were often lower than the rest of the population. While there were a number of common characteristics and conditions affecting all of Ozanam's guests, there were also some differences between those staying in the shelter and guests utilising the meal services.

In the shelter

Shelter guests of this service were from diverse ethnic backgrounds. They often experienced a sustained adverse existence within their usual experience of tertiary homelessness. According to the guests themselves and staff, they had hit 'rock bottom' within this existence, often described as the 'ones that slip through the gaps' or the 'skid row poor' by non-government service agencies. These terms inferred these guests simply had 'nowhere else to turn' and 'nowhere to go'. It was a desperate time for the individual and at Ozanam House they sought comfort, social and emotional connections and support, treatment of illness/injury and food.

The shelter service provided crisis accommodation for up to ten adult males. Typically guests were between 25 and 50 years old, unemployed and in receipt of a Centrelink pension. Guests who presented without income were assisted by staff to secure Centrelink welfare payments. Where possible, guests were supported in securing alternative accommodation during their stay at Ozanam.

Alcohol and drug use, misuse and addiction were commonplace among guests along with serious illness or other adverse conditions, both physical and mental. Shelter guests reported chronic diseases such as kidney failure, cirrhosis of the liver, dementia, psychiatric conditions, hepatitis C and drug and alcohol addiction. Guests in general reported other short term conditions, including physical injury resulting from fighting or accidents, detoxification from drugs and/or alcohol and periods of mental illness, such as depression. These adverse physical and mental health conditions were exacerbated by the sub-standard living arrangements found in the Long Grass. Under such circumstances, shelter guests had reached crisis point. This is explored in detail in **Chapter Ten**.

Guests had often experienced the death of someone significant to them and had been involved in violent acts either as the victim and/or perpetrator. A relationship breakdown with individuals or groups was also usual. Many guests felt traumatised by past events in their lives. At least five of the non-Indigenous guests who became active informants in this study had been adopted out as babies. The profound role of trauma in homeless lives is explored in depth in **Chapter Eight**.

Unlike other SAAP service in Darwin for homeless people, Ozanam House was well utilised by Aboriginal Australians, making up an estimated 35-45% of shelter users over a six month period. Although many of the Aboriginal guests in the shelter were known to the service staff due to using the service over several years, their occupation of the night shelter was erratic. Usage was influenced by health, wealth, social responsibilities and activities, business, the weather and sometimes just timing.

Many of the Aboriginal men were chronically homeless and had been living in the Long Grass for extended periods – often years - staying at Ozanam when they had reached a crisis point within the context of this homeless existence. While all had a country or community of origin in which they could use for purposes of identity, most were displaced from that origin and camped in the Long Grass in informal but semi-organised groups. Also for purposes of identity, many would describe themselves as ‘Long Grassers’. This term was used for self identification purposes by many non-Aboriginal shelter guests who experienced primary homelessness in Darwin and who had been homeless for a long period of time, i.e. years. The significance of ‘place’ to their identity and the role of shame for Aboriginal Australians in this study are explored in **Chapter Nine**.

The non-Indigenous shelter guests arrived at Ozanam House from a variety of places. Some led highly mobile lifestyles and nearly always lived rough, whereas others were mobile when they were in between homeless services. Some came from tenuous accommodation arrangements, such as hostels, boarding houses, squats, informal camps, caravan parks, friends and other SAAP services, moving in and out of homelessness or from one form of homelessness to another. (The pathways to Ozanam House are examined in greater detail in **Chapter Seven**).

At the meal service

The meal guests were predominantly people who were homeless, or those at risk of homelessness. As with the shelter guests, people accessing the meal service were affected by adverse mental and physical health conditions, both chronic and short term. Few of the meal guests had employment, with their primary source of income being Centrelink welfare payments.

Several guests could not secure employment due to workplace injuries sustained in former employment. They were either unaware of the availability of workers’ compensation, unable to cope with the stress associated with meeting the demands of

insurance agencies, or had been unsuccessful in making a claim. One guest who had pursued a workers' compensation claim against an employer commented:

I will never give up on life, but you can't beat xxxx, they are too big and can afford everything, you have no chance against them... the insurance company hassled me so much even though I had two letters from doctors describing my injury. I just gave up on this.

Meal services were attended by both Indigenous and non-Indigenous adult men, and Indigenous women. Infrequently young children would accompany adults (usually during school holiday periods), but rarely did non-Indigenous women access the meal service. The few non-Indigenous women attending Ozanam House during my fieldwork included: two Japanese tourists in their early twenties, fruit picking their way around Australia; a woman in her mid thirties suffering from Hodgkinsons disease, always accompanied by her partner; a woman, also mid thirties with Cerebral palsy; a twenty year old women on holidays in Darwin who had a relationship breakdown with the friend she had been staying with; and a woman in her late forties who had recently withdrawn from a long standing heroin addiction.

Guests who were Aboriginal nearly always arrived with someone, usually a family member, and accounted for an estimated 35-45% of all meal guests. Their use of the meal service was similar to that of the shelter; it was erratic and influenced by health, wealth, social responsibilities and activities, business, timing and the weather. For example, a death would have required some guests to travel away from Darwin for a funeral, not returning until sufficient funds had been accrued for travel expenses. On Centrelink's welfare pay day, and sometimes the following day, or days when royalties generated through mining on traditional lands were due, Aboriginal guests were sometimes completely absent from the meal service.

Among the Aboriginal meal guests were people staying in the Long Grass (both long and short term), those from formal town camps (such as 'One Mile Dam') and those visiting Darwin from rural and remote locations. Within each of these categories there were guests that were well known to the staff at Ozanam House.

Non-Indigenous male guests tended to be more consistent and regular in their pattern of attendance with approximately 50% of this group arriving on a daily basis. Centrelink pay day did not appear to influence attendance patterns and typically this group would arrive as individuals.

Volunteers

Ozanam House was heavily dependant on input from volunteers in the delivery of their services. Voluntary work around meals usually involved: assisting with preparing, cooking and serving food; washing and drying plates, cutlery and cups; gathering condiments; cleaning tables; emptying bins; and hosing down the area. Volunteers could be categorised into two groups; guest volunteers and non-guest volunteers.

As mentioned earlier, there was an expectation that shelter guests would contribute to the daily operations at Ozanam House. Other regular guest volunteers included individuals who had previously stayed in the shelter or had previously accessed the meal service. These volunteers were often very poor and/or homeless.

Regular guest volunteers reliably undertook specific tasks at the service. They equated the value of their role to that of any paid position, yet they did not seek and generally did not receive any financial remuneration for their work. These guest volunteers were active contributors to the daily operations and shared their analysis of service delivery based on careful observation and other evidence. They usually notified someone if their pattern of attendance was going to change or would inquire about the wellbeing of another volunteer if they were absent. These guest volunteers were typically motivated by a combination of factors including: the desire to help people worse off than themselves; a sense of responsibility; an expression of gratitude; the making of a positive and valuable contribution; and something of worth to do each day. Perhaps the most significant motivation related to the opportunity to be a part of a social network in which they felt valued, cared for and involved, and in which they could reciprocate or explore

reciprocating these feelings. The social significance of Ozanam House to guest volunteers is explored in detail in **Chapter Nine**.

There were also a few former meal and shelter guests who volunteered their services on an *ad hoc* basis, with less regularity, and they did not necessarily assert ownership over specific tasks. For example, a meal guest may have spontaneously picked up a tea towel or wiped down tables before they left.

Those volunteers who were not guests of the service were spiritually motivated and/or had a desire to serve or help the poor. They were typically educated and had employment. While they shared many of the motivating factors of guest volunteers and perceived their participation as important, they were less inclined to construct social networks through their participation at Ozanam House. This group of volunteers included the Management Committee (all Vincentians¹⁹), of which three members regularly volunteered, along with a few other community members. The Management Committee's level of participation increased throughout this study, peaking in November and December, 2004. In addition to duties surrounding the delivery of meals, Committee members worked on policy development, staffing, advocacy, budgeting and reporting.

While it was difficult to place an accurate dollar value on voluntary work, staff estimated that these contributions equalled all other operational expenses, i.e. half of the operational costs were donated in kind through volunteer contributions.

Social interactions at Ozanam

I have commented that social benefits played an important part in the motivation of guest volunteers. They believed that because of their contribution they were valued and welcome. Volunteering placed individuals in good stead for socialising in a group both with staff and with other guests, with Ozanam House providing a physical place and the social support necessary for these interactions to occur.

¹⁹ Vincentians are members of the Society of St Vincent de Paul

Over time there were examples of volunteers socialising together beyond Ozanam House. On occasion, social events were organised by the service in appreciation of volunteers or to farewell staff and were financed by the service or staff. While the 'free lunch' was certainly one enabling and motivating factor to participate, the opportunity to socialise with staff was particularly important. Such events were recalled fondly by guest volunteers for many months to follow. These events also provided some volunteers with the evidence necessary to demonstrate to themselves and others that they could situate themselves within a social context. This was an important process in negotiating the individuals' identity and is the focus of a discussion in **Chapter Nine**.

Despite interactions such as those presented above, few such places for social business existed for this population in Darwin, with many guests spending the day moving about trying not to attract attention to themselves. Lack of money and an inability to meet the perceived expectations of the mainstream society in terms of outward appearance restricted this population from accessing other sites of social interaction, such as cafes, pubs and restaurants.

At Ozanam House some meal guests perceived those who volunteered as the elite; a perception that was prevalent among non-Indigenous guests. For these guests, the volunteer group was viewed as the 'in group' enjoying special privileges, as evidenced by the nature of association with the staff and Committee members and also by their social engagement with one another. Because it was perceived as an enviable position, some guests welcomed the invitation to help out, particularly when the invitation was extended by other guest volunteers. In contrast, when staff invited guests to help, their participation was more about mutual obligation and would not necessarily ensure their involvement in the social banter that typified the existing regular volunteers.

The extent of social interaction among guests during meals was variable. Some days guests would arrive at the service, engage in little discussion and leave within 20 minutes. On other days, guests would sit for an extended period after their meal and engage in

lively discussions. Guests tended to socialise more with background music. Talkback radio appeared to be an impediment to discussion.

Social interaction tended to be influenced by the ethnic constitution of meal guests, individuals' physical and economic circumstances and the Ozanam House rules. These factors were highly variable and could promote or restrict engagement. For example, an Aboriginal family may stay one day and talk for a while over their meal and the next day eat and leave without delay due to the presence of another Aboriginal group or pressing business. The days following Centrelink welfare pay days often attracted non-Aboriginal guests sporting hangovers, not wishing to talk, where as mentioned earlier, Aboriginal meal guests were notably absent under such circumstances, sourcing meals from takeaway and other shops.

Guests, in theory, were not permitted on the premises if they were intoxicated by alcohol or drugs in order to manage potentially volatile situations emerging as a result of their participation. 'Intoxicated', however, was a difficult state to measure and was based on an assessment made by a staff member as guests presented at the entry gate. The inclusive ethos of service staff and management shaped this rule and defined 'intoxicated' as being intoxicated accompanied by unacceptable behaviour. As such, some guests were frequently and obviously heavily intoxicated but were not refused access and at times, were assisted to obtain a meal. Service staff explained that most people observed this rule.

Consequently, the intoxication rules had a profound affect of socialisation at Ozanam House during meal services. Guests would work hard to conceal the extent of their inebriation, and consequently, would rarely engage in conversations that extended beyond meeting immediate needs, such as *'where are the forks?'* or *'can I have a plastic bag?'*

Other business at Ozanam

In addition to crisis shelter and meals, Ozanam House provided a range of other services.

These are summarised in **Figure 5**.

Crisis accommodation clients

- ★ Referral and assistance in securing alternative accommodation (SAAP or other)
- ★ Case management

Support for crisis accommodation and meal clients

- ★ General counselling
- ★ Referral for primary care needs (specialists, hospital, medical centre, GP's etc)
- ★ Support in the management and undertaking of daily activities (arranging transport, fare assistance, reminder service, completion of applications forms, explanation of processes, accessing other services etc)
- ★ Provision and support of unpaid employee positions

Programs for crisis accommodation, meals service and others

- ★ Outreach programs (corrective services, response to domestic violence and other health and wellbeing crisis)
- ★ Life skills development (involvement in, and/or responsibility for, a range of practical tasks including cleaning, food preparation and cooking, shopping, stock take, light maintenance, art and craft etc)
- ★ Art and craft workshop

Facilities for homeless and poor clients

- ★ Laundry and clothing supply
- ★ Hot and cold water shower (including towels, clothes, shavers, soap etc) and toilet facilities (including toilet paper)
- ★ Access to 29 individual lockers
- ★ Short and long term storage facilities
- ★ Storage/filing of important documents
- ★ Access to telephone for local calls and computer facilities for homeless clients

Information centre

- ★ Administration, data collection and research support for SAAP National Data Collection, Menzies School of Health Research, CDU, University of Western Sydney, Telstra, Human Rights and Equal Opportunity Commission, NT COSS, Disability Discrimination Commission, Family and Children's Services and the Community Harmony Project etc.

<ul style="list-style-type: none"> ★ Contact point for police, mental health, family members, hospital etc <p><i>Other</i></p> <ul style="list-style-type: none"> ★ General supervision and support of clients, volunteers and staff ★ Outreach point for Legal Aid and Centrelink services ★ Collection and distribution point for bread for breakfast program in island communities

Figure 5: Service provision at Ozanam House, June, 2004 to December, 2004.

Summary

From the evidence discussed in this chapter, it is clear Ozanam House played an important role in the day to day life experience of homeless people in Darwin. The service was well utilised, yet as discussed, there was uncertainty surrounding its capacity to continue to provide for the homeless population in the ways described in this chapter. Exactly how approaches, including philosophical approaches, to service delivery at Ozanam House impacted on the experience of being homeless in Darwin is an important area for investigation. By understanding this, there is greater scope to predict the outcomes of a changed approach to service delivery on the health and life experience for this population.

Many Ozanam House guests formed a sense of belonging or reconstructed some of the positive dimension of home through their ongoing interaction with the meal and shelter service. Although the reasons for this type of connection varied from person to person, the setting was important as the interactions that took place at Ozanam House were generative of certain behaviours in homeless individuals and among mainstream society. In my study, many of these behaviours were associated with the management of stigmatising processes; a key dimension of the homeless experience which had a significant influence on health, explored in **Chapter Nine**.

Ozanam House also played a pivotal role in supporting homeless individuals to manage their 'health' in order to function and meet the day to day demands associated with Long Grass living. This is expanded on in **Chapter Ten**. The following chapter provides an account of the logistics and homeless knowledge base, which together, enabled homeless

people to access Ozanam House and other services, experience life and address health needs. This theme emerged as a key dimension of the homeless experience which influenced the health of this population.

Chapter Seven

Homeless knowledge base and the institutional landscape

This study aimed to gain an insight into how healthful environments could be created for a homeless population that reflect the experiences and hopes of the homeless themselves, and how such environments could be constructed so that they are supportive of health and a better quality of life. In order to answer the research questions and respond to these research aims, this study has reconstructed the experience of being homeless and in doing so, has identified three key dimensions to that experience which have a significant influence on health. These key dimensions included: homeless knowledge and mobility patterns; trauma; and a stigmatised identity. These dimensions together with the experience of homelessness provided a detailed account of the ways in which health was understood and managed on a daily basis. In this chapter, the second of five chapters to discuss the research findings, I describe the first of these key dimensions; homeless knowledge and the institutional landscape.

On discussing the sociology of deviance, Erikson (2003) observed that the agencies set up to control or prevent deviance, in this case homeless institutions, in actuality provide the individual with a source of strength. He commented:

It is now a thoroughly familiar argument that many of the institutions designed to discourage deviant behaviour actually operate in such a way as to perpetuate it...such institutions gather marginal people into tightly segregated groups, give them an opportunity to teach one another the skills and attitudes of a deviant

career, and even provoke them into using these skills by reinforcing their sense of alienation from the rest of society (p.15).

This chapter discusses the use of homeless service agencies by Ozanam's guests. In doing so, I illustrate how Ozanam's guests accumulated a 'homeless knowledge' that facilitated planning and action around meeting daily needs. This knowledge had been obtained through personal experience, shared experiences with other homeless people, and from other institutions. There were logistical challenges which homeless people had to negotiate. This, together with the function homeless services fulfilled in their transient lifestyle, provided the framework or backdrop for life management for this population. Understanding the mechanisms in which this knowledge is accumulated and then applied is an important consideration for policy and strategy development that is geared towards improved health outcomes for homeless people.

Ozanam House: the end of the line

Chapter Three identified the shortage of crisis accommodation and services for single adult males, particularly those males of Aboriginal or Torres Strait Islander descent. It was also highlighted that as an individual's needs increased or became more complex, there was a reduced capacity for service agencies to respond to these needs. In Darwin, Ozanam House represented the 'end of the line' for homeless individuals, servicing the neediest members of the community with the most complex issues. This sentiment was effectively captured by one staff member who explained the imperative to comply with institutional rules. The staff member commented:

...this is the end of the line. Where are you going to get your next meal if you can not get it from here...nowhere is where...so they think very carefully about this as they can be banned from coming for a time, and if you take from the belly, that is where it really hurts.

During a conversation about the imminent closure of the hostel, another staff member echoed the general held view that Ozanam's guests were at the bottom rung of the social ladder, the skid row poor, and that they required a high level of support. The staff member asked the following rhetorical questions:

...Who is going to take them to Danila Dilba to get a doctor? Who will hand out medication or take clients to use their flexicards? What is going to happen when these people walk up the street with faeces running down their legs? Who will help them and encourage them to shower? Our clients are so vulnerable, who is going to care for them?...who is going to look after the poor people?

Indeed many of Ozanam's guests are among the most disadvantaged in Darwin and require a high level of support in order to meet their most basic daily needs. This chapter describes how Ozanam's guests reached this place and state of living.

Choosing Darwin and traversing the institutional landscape

To reiterate a previous point, Darwin is geographically isolated from most of Australia and has a significantly higher homeless population per capita than any other place in the country. Yet Ozanam's guests were rarely from Darwin itself. Non-Indigenous guests tended to be from southern states, arriving homeless, and Indigenous guests were from remote locations in the Northern Territory and often only became homeless after spending extended periods in Darwin's Long Grass.

The reasons individuals in this study gave for leaving home were fairly consistent with the findings of both Maypilama *et al* (2004) and Memmott and Fantin (2001). They included:

- Relationship breakdown;
- Grief over deaths of loved ones;
- Fear of violence;
- Illness, particularly depression;
- Fear of sorcery;
- To escape disputes or conflict or feelings of confinement;
- To be free;
- Overcrowding and lack of resources;
- No future at home; and
- To access services and events.

A combination of reasons resulted in Darwin being selected as a destination. Primary reasons included: creating distance from places no longer tolerable or desirable; improved climatic conditions; better employment prospects; friends and family; access to goods; and importantly, a place where services existed for, and were accessible by, this population. A common explanation for coming to Darwin is captured in the statement made by one informant:

Since I up and started on my move last year, it has sort of started another chapter in my life. I know for a fact if I had stayed there I would have been in jail now or would have been six foot under. One of two things probably. I just got out of the scene, I had enough. I packed a bag and was gone.

Charities, transience and travel

Charity institutions and other agencies involved in providing goods and services to homeless people played an important role in the decision making process of Ozanam's guests, particularly around travel. Their presence meant that individuals were able to travel with the knowledge and confidence their basic needs could be addressed in new locations, and as such, these agencies had a profound impact on the movement patterns of homeless people across Australia. Their presence permitted survival in a transient lifestyle, where the latter was both forced and a choice. As observed by Spradley (1970), "*there is an intimate relationship between mobility and other features of their homeless life style...*" (p.179). Consequently, agencies working with homeless people supported transience in two distinct and connected ways: the first, through sending people on after a period of stay had been exhausted; and the second, through being identified as an option at a different location. Through these mechanisms, Ozanam House and other charity agencies in Darwin and around the country ensured travel to and from this remote location remained a possibility.

Ozanam's guests who arrived in Darwin often did so via hitchhiking in cars and trucks or by bus, and less often by ferry and air. Discount internet and other airfares were obtained, sometimes with the support of service agencies, when sufficient cash could be accumulated to cover the ticket costs. Travelling invariably involved walking and sleeping rough. Regular stops were made in order to attend to personal hygiene, obtain

food and other supplies, and sometimes these stops depended on the availability or proximity of charity services. Shelter was often secured during the journey to Darwin through other St Vincent de Paul and charity organisations. The following passages describe part of typical journeys made by Ozanam's guests on their path to Darwin.

...on the Gold Coast in Queensland I was living rough. I moved on, hitching, and got to Townsville. I made some friends where I was staying and we decided to come to Darwin together. One guy had a van and we supplied the food and alcohol for the trip.

I started hitch hiking and got a \$50 counter cheque off Centrelink so I had some money on me so I got some smokes, cold drinks then I started hitching on the highway and a truckie picked me up and he asked where I was going...

Many guests travelled up the east coast as far as north Queensland (such as the above informant), or travelled via Alice Springs up through the centre of the country, on route to Darwin. Katherine, located 310 kilometres south East of Darwin, had a homeless night shelter and many of Ozanam's guests, particularly non-Indigenous, had stayed there prior to staying at Ozanam House. On arrival in Darwin, Ozanam House would often be the first, if not second, port of call for this population, as illustrated by the following quote:

I arrived last night and came straight from the airport here. I didn't know the place closed a few weeks ago so I slept in the mall.

Institutional knowledge and planning

Homeless peoples' knowledge of the resources available to them and their management of those resources, were fundamental to their ability to move effectively across large geographical distances. Many of Ozanam's guests knew exactly what services were available, where they were located, how to get to them and how to access what they needed. Guests had a wealth of knowledge about different institutions across the country and Darwin. I observed and participated in many such detailed conversations which discussed food quality, location and décor, Christmas celebrations and gifts, sleeping conditions, staff, other guests and the general atmosphere and other peculiarities of various agencies. This knowledge was well illustrated by one key informant when he described his journey to Darwin:

I went to the xxxx and yyyy in the city who gave me assistance with accommodation and other things. After living in zzzz I decided I had had enough

of the place...it was no good for me. It was too easy to get smack [heroin] so I left...I arrived just before Christmas and went to www for the homeless. I spent Christmas with the service. They gave a gift to each guest, a package of clothes in small, medium or large and some tobacco.

In addition to the above quote, several quotes illustrated the use of multiple services by guests. These include:

I'll see you Friday, I have to pay a bill tomorrow and go to the xxxx on Thursday.

I have been to Vinnies all over the world!

I like to give some money to xxxx in exchange for meals I receive from Vinnies or yyyy.

As soon as I got to the city I stayed at the xxxx Hostel. I rang up a couple of places and I said I haven't got nowhere to stay is there anywhere I can stay until I get paid...I rang xxxx and they said, "are you driving and have you got any money". I said no. "No worries. We will ring up the youth van and they will come up and get you". Sort of like the yyyy here. They did that and I stayed for a while, a couple of months. There were activities and I was getting on with one of the teachers there which was good...like every Tuesday we would go to the beach and go there for a game of footy, game of cricket, go swimming. Last year when we went to beach we seen sculptures...that was a spin out and a half!

I do not sniff [petrol] but I have been drinking too much lately...too much wine. I sometimes stay at xxxx and you can get a meal at dinner, then the Long Grass and maybe then Vinnies. I want a rest so I am going to spend my next pay at xxxx for a rest.

Later that day the above guest made his way to the hospital and was admitted through the emergency department. The guest was able to rest for four hours in a hospital bed and was provided with food before he departed.

Guests had often met other guests through services and could share common experiences. Many guests had preferred service agencies and it is no surprise that the guests at Ozanam House tended to prefer St Vincent de Paul. This sentiment was effectively captured by one key informant (I) during a discussion with a respondent (R) about a bread delivery program facilitated through Ozanam House.

(I) ...the bread run, I think it is a good thing...Who are you with?

(R) Vinnies

- (I) I've only got time for you blokes, you know I have no fuckin' time for the xxxx, I hate 'em, they are money money money...and the yyyy are ghosts...

Another key informant makes the same point:

...I would rather stay at Vinnies than the two xxxx's put together. All the xxxx's are worried about is getting their money and that is it. As soon as you go there, pay your money, and piss off in your room. If you fight you are chucked out, that's it. Where at Vinnies, you can sit down and talk, like to you and staff and other people... The way I see it, the St Vinnies organisation cares more about the homeless than the xxxx's do. That is all I can put it down to.

The decision to move over large or shorter distances and the anticipated use of service institutions was often planned in tandem, and benefited from detailed knowledge of the available services. Although climatic conditions and family illness or death were common drivers for distance travel, travel was not motivated by any one specific reason.

Localised travel across Darwin was a daily practice for most guests, and was often motivated by the planned use of Ozanam House and other services. For most guests, accessing the meal service, shower, toilet facilities and shelter constituted the primary activities conducted during planned visits. A range of secondary activities were also met, such as meeting with Centrelink, obtaining fresh clothes or a referral for medical treatment. Often these activities were regarded as important, however, guests could not necessarily plan for them with reliable or consistent outcomes. For example, a guest may have pressing business that prevented him from spending time waiting to see Centrelink officers, or suitable footwear may not be available on the day. Consequently, less planning around secondary activities occurred. As the secondary business became more pressing, for example, a visit to the clinic, greater attention to planning resulted.

On occasion, the knowledge of a service and the people who accessed the service, were more important to guests for the undertaking of other business; business that did not relate to the activities intended to be provided by the service provider. This scenario is effectively captured by one key informant who explained the process of locating drug users to sell ice (methamphetamines]. He commented:

...she had nine grams of ice weighed up in bags. She asked, "do you know where to sell it?" And I go "yeh, try it on the food bus line". Can half tell because you see track marks...see the track marks on some of the people there, gosh...I helped

by selling to the people as they came to the food van. We sold six out of nine and used the rest for ourselves...the food van was great. It had fried rice, meat, heaps of things...

Further examples of other business where guests applied their knowledge of the Ozanam service and service users to their advantage included debt collection, the settling of disputes and the extortion of money and cigarettes. Although these business opportunities appeared to have primacy at times, the legitimate services offered by Ozanam House remained important.

Knowledge accumulation

The knowledge of the services available to homeless people by Ozanam's guests had been accumulated over time through personal experience, through the sharing of experiences of other homeless people and through advice from other service agencies. One informant, talking about Ozanam House, commented:

...I learned about this place from the other people who sleep in their cars at East Point. This is where I also learned about the sandwiches from the bus on the esplanade at night time.

Obtaining information about police and council attitudes toward homeless people from other homeless people was commonplace, as illustrated by key informants who stated:

...I slept rough at the beach in my sleeping bag. I stayed there about 2 or 4 weeks. That's when I met John and he knew the place. He knew the people and the coppers around there. He knew how touchy the coppers were about homeless people. They don't like them...put it this way, if a copper seen a homeless person walking across the road they would probably speed up and...

In xxxx the cops hassled you, but here it is the other way around, the council guys get you...they threaten to fine you and move you on. Other 'travelers' [homeless person with car], some who have been in Darwin for a very long time, even years, told us where the hidden spots are, and we go there. They are other people like us, living in their cars.

Another informant had used several services in Queensland and the Northern Territory. The informant demonstrated his/her knowledge of the Ozanam House service, and at the same time, made comparisons with other services. This type of comparison was often

made, with examples such as the 'bread run' discussion presented above, and in statements, such as those outlined in the following passage:

This service is really good because it is providing what people need...a shower, a place to wash your clothes and a meal, whereas when I was given a voucher once for food, you could spend it on what ever you wanted, even cigarettes...and I did buy cigarettes...and I want to give up this dirty disgusting habit.

The police were one such service agency that introduced guests to Ozanam. A key informant who had been living in bushland near Darwin for more than six years described the event that lead to his arrival at Ozanam. He commented:

...then children, as big as you and me, started to throw rocks at me, I was very frightened. I never go near them and keep to myself...so I go to the police and tell them what they do, they then make some calls and take me to Vinnies...I spend some time in the hospital and they check my body and my mind and then I go back to Vinnies.

Some guests acquired their knowledge about Ozanam House through the hospital, reinforcing the notion that the service managed 'high need' guests. Ozanam had a reputation for not turning away guests, however, the referral process between the hospital and Ozanam House was often problematic and contentious. Each organisation had duty of care obligations to exercise, and without a point of referral, homeless people could potentially occupy hospital beds for a longer period than if they were discharged into the care of Ozanam House. This often occurred without the knowledge or consent of Ozanam staff. As one staff member explains:

...patients are put in taxis and sent here without any prior advice, and sometimes with only a phone call saying they are on their way. We do not know what the needs are of the person concerned. We also have a duty of care to this person but also to every other person staying... Patients arrive here with pill dispensaries and our policy is that no medication is to be kept in the rooms because medication has been stolen from peoples' bags. But we have no knowledge that they have them. There are also numerous counts of patients arriving without medication and scripts... the problems come from the need of the nurse to vacate the hospital bed, exercise a duty of care to the patient by discharging them to an address and also observe privacy requirements. They are also fearful that if they say too much about the patients needs, we would not take the patient.

Summary

The evidence discussed in this chapter indicates that Ozanam's guests made effective use of the resources available to them in order to arrive at their desired destination/s. Guests typically had a good knowledge of the services available to them and planned their use in order to conduct activities, including those activities which had, and had not, been sanctioned by the service, in an efficient and effective manner. This often involved the use of multiple services, particularly during long distance travel. Once guests arrived in Darwin, transience continued at a local level. This study has found that guests tended to acquire a more detailed knowledge of the services available to them through their own experiences, the shared experiences of others, and through information provided by other services.

The evidence shows that as individuals moved from being homed to being homeless, there was a fundamental necessity to understand the homeless institutional landscape and form a 'homeless knowledge' base. This necessity was most often triggered by, or associated with, the experience of an intensely traumatic event. In the following chapter, the third of five chapters to discuss the research findings, I describe the role of trauma in the homeless experience using individual narratives and explain how such events led to, and sustained, people as homeless and houseless, finding unconventional notions of home in the Long Grass.

Chapter Eight

The lived experience of trauma

This chapter discusses the role of trauma in the lives of Ozanam House guests. In this study, trauma emerged as the second key dimension of the homeless experience which had a profound influence on the health of the population under study. Agar (1973), in his seminal study of street junkies (heroin addicts) in Kentucky, USA, pointed to the occurrence of certain prerequisite events being obtained before an outcome could occur. For example, ‘copping’ (buying heroin) is a pre-requisite of ‘getting off’ (injecting heroin), and a prerequisite for ‘copping’ is exchanging ‘bread’ (money) for ‘stuff’ (heroin) which assumes a ‘junkie’ (heroin addict) has money and also a dealer (seller) to exchange with. In this example there is an obvious relationship between a desired outcome (getting off) and the events that lead to its attainment. If we consider presentation at Ozanam House as an outcome of a series of pre-requisite events, we can begin to postulate the relationship of those events or the transactions that occur in the getting of a meal and in living the homeless life. In this thesis, an event refers to a profound experience of a guest that propelled them from a mainstream existence and sustained them in a homeless existence.

Like Agar’s (1973) prerequisites for ‘getting off’, the prerequisites for presenting at Ozanam House were rarely stand alone events, although the sequence of events did not necessarily follow a common path. Most guests experienced multiple events over an extended period of time. Although the prerequisite events for homelessness have informed contemporary thinking about it being a multilayered and multidimensional complex ‘problem’, homeless policy in Australia has tended to match solutions to

homelessness with the perceived structural causes. According to Robinson (2004), the structural elements take on a new shape and force when lived, hence her advocacy for the study of the lived experience of homelessness using biographical methods in order to gain an insight into “*the development of compounded trauma and how this trauma informs homeless people’s interaction with the world*” (p.10).

This chapter aims to describe the lived experience of these events and the circumstances that surround decision making from the perspective of the homeless person; an insight which is largely omitted from published literary sources and policy. The approach taken in this chapter is to present short biographies of a selection of Ozanam’s homeless guests which captured their experiences.

Trajectories of trauma

In my study, a single, or a series of traumatic events was experienced by a substantial number of guests and was often the first event to occur moving someone from being homed to being homeless. Primary traumatic events included:

- the unnatural death of a family member or person significant to the guest (suicide, murder, freak accident, ‘payback’ and accusations of sorcery or fear of sorcery);
- multiple deaths in a family or among people significant to the guest, sometimes over a short period of time, such as within a few months;
- historical events (including war, conflict, displacement and the systematic forced removal of Aboriginal children from the family by the State);
- physical and sexual abuse (particularly where overcrowding was prevalent);
- unwanted pregnancies or ‘wrong side’ babies (pregnancies stemming from sexual assault and wrong kinship ties or incest that lead to abortion or adoption, accusations or fear of sorcery).
- family breakdown (including adoption, exclusion, forced removal of children from the family by the State, death, physical and sexual abuse); and
- incarceration (Holmes, 2006).

Living with the experience of a major trauma had a profound affect on the life quality and health of many guests. Trauma was generative of other events which were occasionally experienced as traumatic in themselves, referred to as secondary traumas. In addition to experiencing a number of the above events, other traumas included:

- alcohol and drug abuse;
- prostitution;
- chronic gambling;
- disease; and
- homelessness.

Living with the experience of a traumatic event had a significant affect on the life quality and health of many of Ozanam's guests. It was common for guests to experience a series of traumatic events that led to, or sustained, their homeless lifestyle. Following these experiences, guests consistently reported an acute sense of fear and described their need to have a high level of awareness (hyper-vigilance). The life circumstances of Ozanam's homeless guests placed them in precarious situations, where their feelings of fear and subsequent heightened awareness and arousal were necessary and could be seen as a normal or anticipated response to stressful conditions. The life worlds for these people meant they were vulnerable and would likely be exposed to events that were traumatising. This is illustrated by the following account:

...A few nights earlier it had rained and I was stretched out on a slippery dip at Mindil Beach as the ground was wet. A car came driving up and when it was about 20 metres away it stopped and waited for a while. It drove on a bit further and did the same thing, then returned to the original spot. The car had around four white men in their mid 20s. One man got out and fired a gun at me while I was on the slippery dip, and hit me in the arm. The men were laughing and got back in the car and drove off in a hurry. I went to the police and reported the incident...I was glad it was only a slug gun, because if it was a shot gun they would have done some real damage. The other thing that worries me is that next time it might be because they think they can get away with this...what is to stop them from getting away with something more?

Trauma, with its associated fear and heightened awareness, played an important function in the daily decision making processes and behaviour of the homeless people in this study. Decisions about where to sleep or whether to drink, for example, were often made

in the context of avoiding trauma, keeping safe and as a response to trauma itself. The following vignettes capture part of the lived experience of homelessness as it was shaped by trauma.

Vignette #1, Steve

When I met Steve he was in his early 30s. As a new born baby, he had been put up for adoption by his natural mother. He was his mother's third child, and shared the same biological father as two older siblings. His biological parents had never lived together. Steve explained:

...she was only 18 and alone and could not look after a third kid, so put me up for adoption. They did not tell my natural mother if I lived or survived the birth...My [adoptive] Mum and Dad saw me at the orphanage. My Dad wanted a son. Before I was adopted my Mum lost a daughter through cot death. I have an older sister, also adopted. When Mum and Dad saw me at the orphanage, as soon as they saw me they said 'yep'. They had to wait 4 months to get me because I was in hospital with stomach and heart pains. I was kept for observation. Mum told me, when they could finally get me and take me home they were driving down the road to the house and saw my uncle and aunty coming the other way, and they held me up to the windscreen to show me off. Then they did a u-turn to follow them, to show me off again...Nan treated me as though I was her own grandson.

Steve believed his heart problems, and a syndrome he had been diagnosed with, had delayed his adoption. He was 18 months old when he finally went with his adoptive parents and went on to lead an essentially happy childhood. As a child Steve and his family moved around a bit within the same district:

...when I first went to prep [kindergarten] I was sort of slower than most kids. I had to repeat grade one twice because I was a bit slow. Mum and Dad found out and sent me to a special class in primary school to help me with numbers and spelling. I would just get through...My mother's father passed away when I was about 10 and my Mum's brothers were not happy because they wanted my Mum to pay for everything. Dad was getting agro to the point where he would do something. He never got round to doing it and they ended up talking things around.

In high school I used to have a drink and a smoke and get up to mischief. When I went to year seven I started rebelling against my parents. I did not want to go to school and I would always sit in front of the fire or heater with my face right up to it, and I would say to Mum that I couldn't go to school because I am sick, I have a temperature. I did not like school because most of the teachers could not care less

unless you were getting top marks all the time. I passed some things but always failed maths, all the way through. I got better at learning but I left half way through year nine. I saw a job and wanted to leave school, so I did. It only lasted 3 weeks. I went back to the school to ask if I could come back and they wouldn't let me because all of the things I used to do at high school.

Back then I had a bit of a temper. Probably to this day I still have. But I have calmed it down. I hate saying this, but just because I have a sort of [pointing to jaw]...this part sticks out a bit. I used to get teased a lot at school. They used to call me 'long chin' and stuff like that and I used to keep things bottled up, bottled up and bottled up, until I can't keep it any more. We were in a science class and this kid was always at me, at me, at me about it. He was looking over a microscope with one eye shut. I thought, 'fine, payback time'. I just hit him on the back of the head and the microscope gave him a black eye...And in year seven I took my Dad's starter pistol to school and pointed it at a kid's head and fired it.

Steve eventually completed year ten at another institution and found secure employment on a farm. When he was 19 he had his first intimate relationship. His partner relocated and he left his farm employment to join her. His father had pressured him to go back to work and Steve had responded by telling him to "*go and get fucked, you're not me father, get stuffed*". Steve soon returned to work and became engaged to marry his partner. The time spent apart became a pressure on their relationship. His partner accused him of having an affair, and their relationship broke down. Steve commented, "*I was feeling violent so I left. Then I left the area*". Today Steve still laments over his life's bad experiences, the lost opportunities and dreams not realised.

In the context of feeling rejected for his perceived stupidity and physical unattractiveness, this relationship breakdown had a profound affect on Steve and marked a significant traumatic event in his life. Steve moved away from home to the city, without employment or a place to go and began to drink and take more drugs. He soon formed a relationship with a woman who had a son, whom he referred to as his step son.

In Darwin, he spent extended periods at Ozanam House, and in between times, stayed in a range of places. While staying at one such place he recounted a suicide attempt and described the traumatic event that had taken place which led to this incident:

...I kept on having flash backs about my step son. I can see it now. The body on the road. A white blanket. I can see his head and the white tube. And his hard yakka boots. They were still done up and they were not on his feet. They were on the road. And he had about 10 sleepers around his ear and they were embedded in the road. I just keep on seeing that, kept on remembering all the good times me and Anna [Steve's first partner] had. That is when I was on medicine to stop having fits...I had probably 30, the whole container.

The bloke I was staying with, I used to hang around with a bit and have a few cones. He knew I had taken them and waited two days before he mentioned anything. He ended up telling Vinnies and they rang the coppers. The cops come around and I said 'what the f... do you want?'. As soon as they saw me, I was on death's door. The cops said 'we have a report that you tried to commit suicide'. I said, 'yeh so, I want to die, leave me alone'. The copper goes 'we have to wait here for the ambulance people'. I was drinking bourbon out of a can while they were there. I was nearly going to have a cone but I thought, no.

The ambulance people helped me down the steps and the coppers helped in case I fell. I was swaying backwards and forwards...I got to hospital, straight in a wheelchair I went. I stayed for a week then. I feel better now but it is as though half of my life is gone and I can't replace it. I have got to a stage where I sort of thought, well...since Anna, all the girlfriends I have ever had, none have ever matched up to her. I have had three, and not one, not one have matched up. Not one. Going back home would just bring it all up again. I know for a fact if I go back there, I would turn around and say something I would regret to Anna.

Steve had learned his step son had been sniffing paint before 'playing chicken' with the traffic. Steve believed the paint supply shop to be responsible. He wanted to burn down the shop. Steve explained that the events surrounding the 'accidental' death of his step son led to a falling out between him and the child's mother. He left and quickly formed another relationship with a woman who was a heroin addict and was introduced to the substance. Steve quickly formed a habit which, on occasion, was supported by theft.

...I know now that I should not have done what I did...When you are on drugs it is no good breaking in houses and stealing stuff so you can get money for drugs and that. If you can't have the money just go without until you have the money for it. I know it is hard. It is hard. It is not as hard on the smoko than what it was on the other stuff [heroin].

Steve eventually stopped shooting up heroin, speed and methamphetamines. He was free to leave the city as he was no longer dependant on having access to a reliable supplier and gradually travelled north up the East coast of Australia, on route to Darwin. In

Darwin, Steve negotiated his feelings around his step-son as well as his failed relationship.

We had wanted to have children together. That is one thing I will never ever forgive her for. I will always have it in the back of my mind. The only way they will be mine is if I adopt them. We get married and I adopt them. I'll stay in Darwin until I feel more comfortable about going down there...Another thing that makes me want to go down is my Dad. When I rang the other day he had just got back from the specialist...I hate to say it, but if something happens to Mum and Dad, that's it, I'm gone. Out of here, gone! I should rephrase that, my mother, I should say. I don't hate my Dad that much but...I know if anything ever happened to him...I hate to say it but say some drunk was in a car accident with them and hit them, I would not give up until the day I found that drunk who was responsible for it and...because the way I am at the moment, I would die to protect Mum and Dad...and Anna and her kids. If anyone hurt anyone of those five, I would kill them.

The death of Steve's step son was a traumatic event. It occurred in the context of loss, betrayal and rejection surrounding the trauma of his first failed relationship. He turned to drugs to feel better. Steve's fear of reliving trauma had immobilised him, and as a result, he was displaced and homeless both physically and emotionally. Steve was incensed by Anna having met another man and having had two children with him. Despite his pent up anger, he expressed his love for his adoptive parents, Anna and her children, through his readiness to offer his life for theirs, and avenge any misfortune they should encounter. It was a confusing time for Steve as he tried to make sense of unresolved mental dilemmas. He was also fearful and cautious of feeling the effects of trauma.

Vignette #2, Polly

Polly was 38 years old at the time of this study. She was an Aboriginal woman and her country was in the northern part of the Territory. Largely illiterate, Polly finished school and had paid work for a brief time in her community. By age 18 Polly lived in the Long Grass in Darwin. She had escaped the confinement of community life, her kin and her memories, and was searching for excitement, money and alcohol.

As a young teenager, Polly had experimented with alcohol and by the age of 13 she had contracted her first of many sexually transmitted infections (STI). Polly had only ever

had sex when she had been drunk. She was 17 when she fell pregnant, and as a slight girl, she was 4 -5 months gestation when she learned of the baby. Polly said:

I did not want a baby. All that humbug²⁰. I was only 17... I killed my baby myself by hitting my stomach and the baby died. I spent a long time, maybe 5 or 6 weeks in the hospital and they cleaned me. The baby did not come out and I got sick with an infection so they scraped my stomach inside.

Polly recalled her sadness and explained she drank more to feel better. This experience marked a significant traumatic event in Polly's life that eventually led to homelessness and presentation at Ozanam House.

Polly spent the next 20 years in the Long Grass, drinking everyday. She lived with her father, brothers and sisters and members from her own and other communities, linked usually through marriage. Staying in a group was a safety measure against such things as physical and sexual attacks and evil spirits, with sorcery underpinning many of Polly's daily activities.

Occasionally, Polly would return to her home country, typically necessitated by a death. In order to travel Polly had to have additional funds which she obtained through a range of sources including royalties generated by mining on her country, humbugging²¹, welfare payments and prostitution. As alcohol could not be taken into the community, and only beer was available through a carefully regulated distribution system, Polly never stayed more than a week.

Prostitution, as a form of income, was sometimes forced on Polly by more powerful members of her family group (mob). Her sister would ply her with cask wine until she succumbed to pressure and would then "go with white or half caste men". Polly said:

They don't care for me. They do not respect me. They want me to go with white men to get money for grog.

²⁰ Polly used the word 'humbug' in this context to describe feelings of being hassled and bothered by family and community members, as well as the inevitable demands associated with being a responsible mother.

²¹ Humbugging here refers to begging or hassling people for money and other goods or services.

During the period of my research, Polly experienced prolonged abdominal discomfort and received advice from a doctor that she would be dead within a year if she kept drinking. This news had a profound affect on Polly's life, and marked a further traumatic event. With the help of her non-Indigenous partner, 30 years her senior, Polly gave up alcohol.

Other traumatic events were experienced during Polly's sobriety. She had gained weight and according to Polly, was regarded as "looking good now" by her mob. Consequently, she described increased pressure to prostitute herself or share her money and explained that her mob believed she could generate more money for them now she was sober, more attractive and not spending all her welfare payments on grog. This situation caused Polly to live and re-live her fear associated with the trauma of dying prematurely. She had come to equate the Long Grass with drinking and imminent death. As such, Polly was insistent she needed her money to pay rent in a one bedroom flat she had secured:

I need my money for living and for food. I do not want them to spend it on alcohol. I need it to live...if I lose my flat I will end in the Long Grass and I will die...I don't want to die, I want to live.

In addition to the pressure placed on Polly to share her money, she was also expected to share her flat. Family would visit her flat daily to humbug her for money, cigarettes, food and a place to sleep. Sometimes they wanted a place to drink without being threatened or moved on by the police or council officers. Fearful of losing her flat and dying, Polly resisted letting her family in. This rejection of her family's demands was often met with animosity, and whether she let her family in or not, the conflict usually led to a disturbance in which complaints were generated against her. This situation occurred despite Polly being very active in trying to manage the conflict by contacting the police and night patrol in order to prevent complaints from being made. These complaints, however, led to her eviction from two different rental flats. Polly explained that to stay dry, she could not choose her family and they responded with anger. This anger compromised her tenure in a flat, yet the flat was critical to Polly's capacity to remain dry.

A great deal of Polly's life was spent avoiding family members. Polly exclaimed:

I am very tired from this life and want to be left alone.

Although Polly felt this way, she had to negotiate the tensions arising from the desire to be left alone with the desire to spend time with her family. Polly placed great value on the opportunity to speak in her own language, where a shared understanding of the topics being discussed existed.

Polly had eight siblings. One brother had been incarcerated for killing his wife. Another brother had been killed when he was hit by a taxi. A sister was killed by electrocution at a disused car yard. Another sister was killed when she was shot by her husband and one sister drowned. She had two sisters and a brother who lived in Darwin's Long Grass.

Reflecting on her family, Polly said:

We can't drink this moselle [cask white wine]. We drink it, we die.

Polly was deeply affected by the death of her sister who had drowned and felt partially responsible for her being dead, but not the death itself, as this was well beyond her control. Polly explained that the death was not caused by swimming drunk, but rather the evil spirits took her sister because Polly would not stay with the man she was promised to, bringing this punishment to their family. Polly explained:

...when I run away they use magic. My sister, she was with the white man at the shop and he took her blood from here [pointing to the side of her stomach]. Then she is in Darwin, drinking here and swimming, then she drowned. It was caused by the man taking her blood... Everybody talked about it and everybody knows it was the magic...because in Aboriginal way, my sister can be punished for me, because I was running away.

Polly explained the devil or evil spirit would take blood and bury it in the ground, and in a few days you would be dead.

You have to be very careful so they don't get your blood...maybe it is a person, someone you know or maybe it is a dog...sometimes they will say 'you come and drink with us', but they want your blood, it is a trick...that is why families must stay together – when they sleep and drink. It is more dangerous at night, so we sleep together to be safe so they can't get us...they get your blood and usually when you are away from the community here in Darwin in a few days you will

die. It always happens this way. Maybe you just die or maybe there is an accident...The white people, they don't know, it will happen.

Sorcery, witchcraft and malevolence by others, reinforced by the death of her sister, worked to sustain the fear experienced by Polly in everyday life. Living in the Long Grass exposed Polly to both evil and uncontrollable risks. And while the death of her sister had been one of a series of traumatic events, Polly lived a traumatised and fearful existence. Despite the personal achievements she had made, she remained caught in a socio-cultural system that did not provide the support necessary for her to feel safe and secure.

Vignette #3, Olivia

When I met Olivia she was in her early 20s and had come to Darwin on a budget holiday. She initially stayed with a friend, however, their relationship quickly deteriorated and Olivia was asked to leave. Olivia's boyfriend had followed her to Darwin and they had insufficient money to return home. With few options available, they slept in the car, moving about to avoid the council officers and police.

Olivia regarded her homelessness as 'temporary', and favoured the term 'traveller' as a description of her situation. Living in her car was not the first experience of homelessness for Olivia and Ozanam House was not the first homeless service she had used. When Olivia was 15 her mother had intended to marry a man whom Olivia did not like and she believed the feeling was mutual. This resulted in her leaving home and she had experienced periods of homelessness ever since. She explained:

...he [the mother's partner] wanted me to work at school so I could get a better education and ra ra ra... At first it was good. He was buying my affection and would take me everywhere I wanted to go and buy me stuff. Then we just did not see eye to eye...but my mother loves him so I will not object if she marries him.

Olivia's father had been killed as a result of a car accident. Olivia explained he was "*collected by a semi-trailer*" after pulling her mother free from a wrecked car, and intimated she had been witness to this event. This event marked a significant traumatic experience for Olivia, which had shaped many aspects of her life since. Olivia had

struggled with the loss of her father and found it difficult to accept another man in her mother's, and her, life. Olivia indicated she continued to have a good relationship with her mother and maintained contact when it was possible.

After obtaining some money Olivia and her boyfriend planned to return to the area where her mother and new partner resided. They planned to live in the car until they arranged a room in a share house. It was Olivia's dream to go back to work as a bartender in order to save money so she could "*go on the road again and come back to Ozanam House*". Olivia was visibly emotional when she said her parting farewells to other Ozanam guests. Some guests embraced her and others gave her gifts of food and kind words for the journey. These gestures were met with more tears and Olivia appeared reluctant to leave.

Vignette #4, Edwin

Edwin was in his late 30s at the time of this study. He was homosexual and had an effeminate nature. He often wore his long hair in a butterfly clip, and occasionally wore a head band tied across his forehead. He typically wore fitted track pants with a tight nylon shirt gaping to reveal his chest. He was small framed, below average height and graceful in his movements. Edwin was gently spoken and highly intelligent. Personal presentation was of paramount importance to him and he demonstrated great compassion for other homeless people at Ozanam House.

Edwin had lived in two southern cities as a child. He had been sexually abused by his step father, which marked a profound traumatic event in his life. He commented:

I had accepted this [the abuse] at the time because I believed it was ensuring the safety of my sister.

His mother had knowledge of the abuse. Edwin said:

My step father would leave my sister's bedroom with an erection after saying goodnight and I would give him massages after work, which involved sex, while my mother was in the lounge room. My mother said she thought he was no longer 'doing that'. My sister returns to the family home and is treated like a princess, and has now had two failed marriages. She is pretty fucked up...I only return after I have tried out some new self help treatment.

Before moving to Darwin, Edwin had worked for the police and was responsible for gathering information on paedophile rings, drugs and other sexual activities. As part of this work, he had been a guest at parties where he believed members of the judiciary, police force and other prominent members of society had also been guests. Edwin indicated the parties often involved children and illicit drugs. He commented:

I had to participate in activities in order to continue to collect information.

Edwin described feeling traumatised by his involvement in these activities and how he became increasingly fearful for his safety. He received several warnings to ‘watch your back’, and understood he had been identified by a police officer at one of these parties.

He said:

I realised the seriousness of my position and decided to take the warnings seriously. During this time I was diagnosed with post traumatic stress disorder and put on various medications. I then moved to Darwin.

Edwin was homeless when he arrived in Darwin. At some stage, he had a motorbike accident. As a result, he suffered a brain injury and described losing 30 percent of his IQ. Edwin believed his memory had also been affected. In hospital he had been on morphine to manage pain and later developed an addiction, obtaining supplies with a doctor’s prescription at a chemist. With a health care card, each filled prescription cost less than \$5.00. Edwin’s addiction affected his ability to travel as he needed to remain in close proximity to his GP to obtain regular prescriptions. Consequently, his use of homeless services such as Ozanam House was regular.

Edwin, like Polly and Steve, experienced several traumatic events which shaped his life. Trauma had left him feeling displaced, influencing both the choices he made and the risks he took in his life. Edwin’s morphine addiction kept the pain associated with trauma at bay and made living homeless a tolerable existence, but at the same time, maintained Edwin in a cycle of homelessness.

Vignette #5, Mike

When I met Mike he had a mental health condition and at times, seemed a little confused and paranoid. He thoroughly enjoyed a conversation and the opportunity to share stories

about his life. Mike was always bare foot, very lean and tanned. He was about 40 years old. He was softly spoken and did not drink alcohol.

Mike had travelled to Darwin about six times. He had been homeless for at least a decade, and at the time of my study, he had been living in Darwin for more than three years. He lived outside, anywhere, and called the city of Darwin his home, and indicated he never stayed in homeless shelters or any form of conventional housing.

Like several of Ozanam's guests, Mike did not accept any form of government welfare payments. He survived on money saved from when he used to work, from scavenging and from accessing homeless services. He commented:

I visit the xxxx's sometimes but I mostly get food from here [Ozanam House] and sandwiches from the food van. Oh, the sandwiches are great, they are really good...you should have them some time.

Mike was born in America and moved with his (adopted) parents through Vietnam and arrived in Australia by the time he was 5 years old. Mike was used to attracting the attention of police and council officers for being homeless, and found it ironical that he was not harassed for his ethnicity. He commented:

...the sheriff does not hassle me for being an immigrant.

Mike was adopted out as a baby and knew little about his biological parents. He believed his natural father was dead, and had searched for his natural mother about five times in his life. None of these searches had amounted to anything, with his most recent attempt eight years earlier. Mike had not ruled out a further search, however explained he felt disappointed his mother had not attempted to find him.

After moving to Australia, Mike's adoptive parents placed him in the care of a 26 year old man when he was five years old. This man was his guardian until he was about 14, when he died of cancer. Mike had been the primary carer of his guardian until he was admitted to a hospice.

His body decomposed, and he lost all his hair. He had a growth on his side...smelled.

Mike explained he still felt anger toward the hospital doctors. He had felt rejected by two sets of parents, and the dying process and death of his guardian were experienced as traumatic.

Vignette #6, Kim

Kim was a teenager when he was forced to join the Vietnamese armed forces and fight in a civil war. He was later sent by the army into Cambodia to liberate the people from the brutal rule of Pol Pot and the Kmer Rouge. He fought for nearly three years and during this time, Kim, like millions of Kampuchians and fellow Vietnamese soldiers at the time, witnessed terrible atrocities:

...people were just slaughtered. They would be cleaned up with a tractor into a pile and buried in a shallow grave. Pol Pot would shoot anyone that was intelligent, so there were no more doctors, lawyers and teachers, only people who would do what they were told...I was often hungry.

While in Cambodia, there was an acute shortage of food, and Kim was severely malnourished. When he was within 10 kilometres of the Thai border, Kim and several other soldiers decided to desert the Vietnamese Army, and attempted to flee to Thailand. They were quickly captured and placed in a Prisoner of War Camp where Kim stayed for a further three years.

During his time in the camp, Kim's sister had provided him with financial assistance and eventually negotiated a path to Australia where he immigrated as a refugee. His sister had married an American soldier she had met while bartending and migrated to the USA. This had caused considerable friction in Kim's family as the Americans had also been regarded as the 'enemy' by Kim's family. Kim's father did not approve of Kim receiving money from this source and subsequently, both siblings had brought great shame to the family. Kim's father has no contact with his daughter after she migrated to the USA.

Kim commented:

Ho Chi Minh was at war and then all these American troops invaded. They were not wanted, they were the enemy. When I was in the POW camp my sister wanted me to come to the USA and I refused. I never want to go there. The Americans are no good...

While in Australia, Kim had a daughter with a woman of Vietnamese and Chinese ethnicity he had known from school in Viet Nam. He explained he did not stay with the woman as he believed a marriage would never succeed due to their different ethnic backgrounds. This view, he believed, was one that was shared by his parents and the parents of the woman. He explained:

I have a long memory of all the war time stories that date back thousands of years between the Vietnamese and Chinese. You can not forget this...we learn it at an early stage in our life in our stories...we know. My partner's father does not like me and I do not like him. So it will never work because of our heritage. I told my partner, 'I do not like your family and your father, I only like you'.

Kim had experienced rolling traumatic events from the time he was a teenager until well into his adult life. He witnessed men, women and children being murdered, raped, tortured and starved. As a soldier, he also killed people. After years of warfare, he was confined to a Prisoner of War camp, before immigrating as a refuge to Australia. Once in Australia, Kim had a relationship which failed and left him estranged from his partner and child. Homeless in Darwin, Kim smoked marijuana regularly and volunteered daily at Ozanam House to keep busy, to make a useful contribution to society and to manage his pain.

Trauma's symptoms shaping identity

In the above section I have described some of the traumatic events that profoundly influenced the lives of a number of Ozanam's guests. Trauma, often the first event leading to homelessness, did not permit life to be experienced in the same way as the dominant society. Physical and mental health conditions often deteriorated as a result of trauma and the symptoms of trauma. Poor health for these guests was further exacerbated by the stress associated with the physical, social and economic environments of Long Grass living.

Trauma had many symptoms for Ozanam's guests. The experience of loss of house and home was varied, which was consistent with the multiple understandings people ascribed to home in this study. Whatever that type of loss was, it was experienced as traumatic in

itself and generative of intense grief. This is consistent with Anthony's (1997) findings in that loss of home was experienced much like the grief associated with the death of a family member. Other typical symptoms of trauma included alcoholism, drug addiction and excessive gambling. These symptoms too were sometimes experienced as traumatic events. Ozanam's guests often worked to physically and emotionally distance themselves from painful thoughts, and as such, the over-consumption of alcohol and other drugs were desirable and considered essential for many. The exception to this relates to a few guests with diagnosed mental health conditions, who did not take any drugs – prescribed or illicit – and who did not drink alcohol. These guests believed they had been unreasonably diagnosed and then labelled as 'manic depressive' or as suffering from 'delusional psychoses'.

The symptoms of trauma and the events in the lives of Ozanam's guests had social consequences. Guests believed they were regarded as anti-social, deviant and a lesser class of people and struggled with feelings of rejection, believing they were not understood or no different from the people they regarded as being important in their lives. Several of Ozanam's guests defined the start of their homelessness from the time they perceived they 'had nothing and no one'. Coupled with the broader social consequences, many of Ozanam's guests felt profoundly lonely.

Loneliness was exacerbated for single homeless people, usually non-Indigenous, as opposed to homeless people who lived in family groups or with partners. This finding is consistent with LenMack Consulting (2005), who concluded that single homelessness excluded people from normal human relationships and society itself. As discussed, Rokach (2004) found that among other things, key causes of loneliness among homeless individuals stemmed from unfulfilled intimate relationships, loss of relationships through relocation or significant separation and social marginality. She further suggested that loneliness could adversely affect the physical, mental and spiritual wellbeing of individuals and their general satisfaction with life.

By the time guests had arrived at Ozanam House they generally already identified themselves as a 'homeless person' or 'Long Grasser'. As such, guests appeared to be functioning in various contexts often regarded by mainstream society as 'anti-social'. One such example relates to incarceration. While this may previously have been experienced as traumatic, once experienced during homelessness this was often no longer the case. Incarceration had many benefits to homeless individuals, particularly if it represented an opportunity to become connected with family and was regarded a safe environment to be in. For this reason some of Ozanam's guests welcomed jail and enjoyed periods with externally determined routines, the certainty of food, bed, clothes and safety and the opportunity to do jobs – no matter how menial. This suggests that guests may have had fewer reasons than others to be law abiding citizens as the penalty for being caught was not necessarily understood as a punishment. Rather, it was viewed as an opportunity to avoid some life stressors and participate in a social process without having to manage stigma. (Stigma is discussed in detail in the following chapter).

It should be noted here that key informants in this study who had been incarcerated had experienced a traumatic event beforehand. Once released from prison, guests typically had few options where they could go to. This situation was compounded by limited money and resources. These homeless guests then embraced the 'Long Grasser' identity as it was less stigmatising than being a prisoner. Being a Long Grasser or living in the Long Grass was less stigmatising for participants in this study than being labelled 'homeless', capturing a way of life with perceived enviable dimensions. Guests who described themselves as being Long Grassers appeared proud of this identity.

An individual's capacity to cope with their homelessness appeared to be improved when they accepted a homeless identity and the associated social exclusion, loss of rights and perception of fear by the 'homed' society. Adopting a homeless identity was necessary for day to day business to be undertaken with effect and this changed identity worked to pacify or neutralise feelings of disability.

Knowledge, including institutional knowledge (discussed in **Chapter Seven**), about the homeless way of life and homeless services was accrued most effectively once an individual had accepted their identity as a homeless person. Once 'homeless' and well engaged with the related services, systematic displacement became an ongoing feature of life for Ozanam's guests. Drug and alcohol addiction were commonplace, and the physical and mental health condition of Ozanam's guests was exacerbated.

As discussed in **Chapter Two**, a traumatic experience may be described as being overwhelmed with feelings of fear, helplessness or horror, which can develop into a psychiatric condition known as Post Traumatic Stress Disorder (PTSD). Re-experiencing the traumatic event both mentally and physically is common and can lead individuals to feeling fearful and endangered. The anxiety and physical agitation associated with the re-living of trauma can affect sleep and concentration, with individuals having little or no control over the symptoms of trauma (Carlson & Ruzek, 2006).

According to the National Center for Post Traumatic Disorder (NCPTSD) (2006a), avoidance is the most common approach to managing or surviving trauma. Multiple behaviours of the homeless people in this Darwin study could be regarded as avoidance strategies, for example, staying away and disconnecting with places, activities and people which acted as reminders and avoidance of situations which invoked an emotional reaction. Furthermore, the associated problems that can result from post-traumatic re-experiencing and avoidance identified by the NCPTSD (2006a) have also been observed among this Darwin population under study. Observations included: depression through loss and relationship problems stemming from an inability to feel close or trust others; feelings of detachment, disconnection and social isolation with loss of support; physical and mental health problems due to long-term anxiety; avoidance of medical care; and coping mechanisms such as alcohol and drug use.

The NCPTSD (2006a) asserted that the unpredictable and uncontrollable nature of daily life, the lack of social support, the experience of multiple traumas, along with a social environment that is generative of stigma and shame are factors that predispose

individuals to PTSD following a traumatic event. These factors were usual among Darwin's homeless and indicated homeless individuals were at an increased risk of developing PTSD.

The prevalence of physical and sexual related trauma among homeless people exceeds that of the general population, and as discussed, one Australian study with a homeless population has found that the lifetime prevalence of trauma was almost universal (Buhrich *et al*, 2000); a finding replicated in my own study. Like in Buhrich's *et al* (2000) research, my study did not assess the prevalence of PTSD, but rather documented the traumas and other predisposing factors to PTSD that people experienced. My study found that all of the predisposing factors to PTSD, in particular the experience of multiple traumas, were observed among the homeless people participating in this study.

The behaviours exhibited among the homeless youth which Robinson (2005) described, such as excessive alcohol and drug use or self harm, were also shared by Darwin's homeless participating in this study. While Robinson (2005) situated these behaviours in a framework of 'displacement' and 'socio-spatial relationships', such behaviours were identified as common symptoms associated with post-traumatic re-experiencing and avoidance strategies, as discussed earlier (NCPTSD, 2006a).

Summary

The human response to trauma, trauma avoidance strategies and the effects of loneliness in homelessness are frequently described in accounts of poverty cultures (see Agar 1973; Spradley, 1970; Sansom, 1980; Glaser and Bridgman, 1999). Trauma, therefore, is an important factor in better understanding and responding to homelessness as it occurs within poverty cultures. Although the extent and form of trauma in Australian homelessness is only beginning to be understood, the work of Buhrich *et al* (2000), Coleman (2000) and Robinson (2005) have advanced thinking in this area. In this Darwin study, I have found that multiple and major traumas were experienced by the vast majority of study participants and this had a powerful effect on daily life (Holmes, 2006).

Further, this study has illustrated how the common responses to trauma act to reinforce homelessness, a finding shared by Robinson (2005).

These findings suggest that conceptualising this population as a traumatised one will be critical for the delivery of appropriate services and the creation of environments that are supportive of health. The difficulty here lies with the current approaches to treatment, as the NCPTSD (2006b) have stipulated that homelessness must be ‘addressed’ before treatment can commence.

Trauma was found to be a significant dimension of the homeless experience which affected the health of the homeless population under study. In this study, the role of stigmatising processes was also identified as an equally important dimension. In the following chapter, the fourth of five chapters to discuss the study findings, I explore this complex process and its implications for the personal and public identities of homeless people in Darwin.

Chapter Nine

Deviance, stigma and identity

...What can you learn from studying bums like us? (Ozanam House guest)

...I know they [the organisation] think I, and the rest of us, are just a piece of worthless shit... (Ozanam House guest volunteer)

Like trauma, the stigma experienced by all of Ozanam's guests had a direct and significant affect on the health, wellbeing and life quality of individuals. Stigma, as the third key dimension to the homeless experience identified in this thesis, influenced notions of health and health seeking behaviour (discussed in **Chapter Ten**). Consequently, conceptualising the dynamics of stigma in the daily life of homeless individuals is central to responding to the health and life quality of this population.

Stigma influenced the identity and experiences of Darwin's homeless. The participants in this study were afflicted with all three of Goffman's (1963) identified stigmas. They had physical deformities, for example, missing teeth, ulcerated wounds and 'home made' hair cuts. They were marred with multiple character blemishes such as alcoholism, prostitution, homosexuality, mental disorders, poverty and unemployment. The Indigenous guests, in particular, experienced tribal stigma. Whether homeless or not, Aboriginal people in urban Darwin were brought to the public eye often for their interactions with one another in public places, including drinking, shouting and brawling, at any time of the day. Tribal stigma for homeless Aboriginals resulted from being Aboriginal along with the characteristics of being homeless, such as having offensive body odour and appearing dirty and dishevelled.

Ozanam's homeless (both Indigenous and non-Indigenous) were also stigmatised for their poverty and related trauma. Drawing on Goffman's (1963) stigma theory, this chapter describes how homeless individuals managed their stigma and moved between being 'discredited' and 'discreditable' individuals in the eyes of normal society. The role of the Ozanam House as an institution for homeless persons, in shaping a personal and social identity, is also explored.

To revisit the literature review (**Chapter Two**), according to Goffman (1963), a stigma refers to an attribute of an individual that is deeply discrediting, making the person different from the social group, "*of a less desirable kind...reduced in our minds from a whole and usual person to a tainted, discounted one*" (p.3). It is an individual's relationship to the expectations of the social group that defines, and determines whether an individual is credible or not. Goffman (1963) argued that individuals at risk of deviant stigma, are either the 'discredited' or the 'discreditable's. When the stigma was known to others it constituted an individual being a 'discredited'. In this case, the stigma was not able to be hidden and/or the individual had revealed it.

Conversely, the 'discreditable's worked to conceal their stigma. Goffman (1963) explained that while the 'discredited's focussed on managing tensions during social interactions, the 'discreditable's emphasis was on managing information about their differences. He argued that through effective management, this latter group could be regarded by others as non-deviant due to their avoidance of stigma symbols and by their use of dis-identifiers.

Social processes construct what is 'normal'. To draw once again from my literature review, Becker (1963) argued, "*social groups create deviance by making the rules whose infraction constitutes deviance and by applying those rules to particular people and labelling them as outsiders*" (p.9). Misztal (2001) contended normality is influenced by the level of danger perceived by people living in common physical areas, and the

'normals' are those that do not break the rules and who are not regarded dangerous by the social group.

Ozanam's guests and volunteer guests were acutely aware that their differences were not tolerated by the 'normals'. This awareness was well captured during a discussion between two guests. One volunteer guest remarked:

...People do not like it if you are different or have different ideas about things. I have felt this often with people... I feel this all the time, everywhere. Like if you go to the bank and do not agree with their ways or policies they do not like it, or you. I can tell when people do not like me because I am different. I can always tell. It is the things they say and the way they respond to you.

Then another guest suddenly and forcefully interjected:

It is in their body language. It is written all over their face, in their eyes...you can always tell.

Despite this realisation about the perception of homeless people by the 'normals', Darwin, the place, played an interesting role in shaping the identity of individuals. Darwin remains both a symbolic and tangible place where an individual can go for escape. Northern Territorian historian, David Carment (2005), observed that Territory represented a frontier to Australians in terms of both an idea and a place, with words such as 'bush', 'outback' or 'never never' used to describe it. At Ozanam House, both Indigenous and non-Indigenous guests alike, regarded Darwin as an escape - a place that Carment (2005) described as having 'unknowns', the 'rude' and 'dangerous', and which offered 'anarchy' over order.

Subsequently, many homeless people viewed Darwin as a place where their homelessness would be somehow less stigmatised than in other Australian urban centres. Yet for the stigmatisers (the 'normals'), the notion of Darwin as an urban frontier, full of Mavericks, did not necessarily extend to include homeless people, resulting in the assignment of less stigma to this population. In some instances, it probably served to strengthen stigmatising processes as 'normals' disassociated homeless people from their own self-identity as part Maverick. As such, Darwin (and the Territory) played a unique role in

shaping the identity of some homeless individuals, reconstructing it to incorporate 'Maverick', enabling a sense of pride to be associated with this Long Grass or alternative lifestyle. Of course, this was not the reality for everyone, and occasionally it was temporary or even held in tandem with conflicting realities. For example, one day a man would boast about his freedom, about doing whatever he pleased without having to answer to anyone, and the next day, languish over a lost identity.

The interaction between stigma (often derived from trauma) and identity, as derived from the field data, is presented in this chapter in three 'interconnected' sections. The first section is concerned with homeless peoples' perception of the self and of their homelessness. The second section explores how homeless people are perceived by others in normal society, as well as by the Ozanam House institution. The third section of this chapter is concerned with the implications for interaction in society, including social interactions generated through participation at Ozanam House. I have used the term 'interconnected' to describe the organisation of this material in the three sections because of the interface between self perception/identity, the perception of others which explains how stigmatisation occurs among this population and the implications for social connectedness and public identity.

The processes described in each section of this chapter are situated within a context where a dichotomy exists between the provision of a service to homeless people which embraces a particular spirit and philosophy and the inherent tensions bound in the judgements made by 'normal' human beings around stigma and deviance. This dichotomy is complicated by the '*Ethos of the St Vincent de Paul Society in Australia*' (SVDP, 2004) that guided service delivery practices whereby everyone was welcome and the poor were to be served without judgement. In meeting the spiritual needs of people, Vincentians were to bring God's unconditional love to those in need. Further, the goal of Ozanam House, as discussed in **Chapter Five**, was to welcome the homeless, the lonely and the suffering. Ozanam's policies emphasised that the poor often needed to be welcomed and respected as equals, with inherent worth and dignity. This need was identified as often greater than the need for food, shelter and clothing (SVDP NT, 2003).

This chapter teases out this dichotomy as it emerged through the data, and presents the complex challenges for service agencies as they negotiated the associated tensions. It explores the relevance of stigma, deviance and identity to their work of service to homeless people.

Managing stigma: Homeless peoples' perception of the self and of homelessness

Managing the person and personal belongings

A man's belongings are an extension of his personality: to be deprived of them is to diminish, in his own estimation, his worth as a human being. Clothing is the most personal of one's belongings. It is a rare adult whose sense of self does not suffer in nakedness, or who does not feel a threat to his identity when he has to wear someone else's clothes (Tuan, 1974; p.99).

Managing personal appearance was critically important to many homeless individuals. This was most evident through behaviour and articulated interests, plans and desires. Not appearing homeless, presenting like homed normal people, was pivotal to 'passing off' as a non-stigmatised individual.

Individuals avoided carrying personal possessions, including bedding, in favour of stowing or maintaining few belongings, in order not to look homeless, for practicality or for convenience. Many of Ozanam's non-Indigenous guests explained that having belongings 'with' you forced greater mobility as they attempted to avoid confrontations with the police and as they attempted to appear to the general public like they had something to do or some valid purpose. At the same time, carrying belongings was impractical and difficult and impeded mobility, particularly in the hotter, more humid or wet months. For some Indigenous guests, impeded mobility interfered with daily business. As such, guests reported stowing their belongings in public places which often led to their loss or theft, and on occasion, confiscation by council officers. Loss of belongings was distressful and frustrating for all of Ozanam's guests, and worked to remind guests of their life conditions that permitted such events to occur.

Indigenous guests had a greater capacity than non-Indigenous guests to use the natural resources available to them. Guests would rub their arms and legs with a specific type of leaf to repel insects, gather pandanas and other locally occurring flora for art and craft, and catch fish and collect other marine foods to eat. Indigenous guests frequently described building fires to keep warm in the cooler months. This occasionally eliminated the need for maintaining bedding, but further limited sleeping options to the individual. To avoid detection (being moved on, fined or arrested), people were forced into locations that were more difficult to access and which introduced additional discomfort. For example, some mangrove areas provided a suitable location for a fire, although mosquitoes and sand flies could be so menacing and persistent as to make sleep impossible, while the use of these areas was also restricted by tidal inundation.

...During the day we sit under the trees mostly at Fannie Bay and talk. When it is cool at night I would choose somewhere where there was lots of wood for burning so I could keep warm. The police and council would come, especially if we started a fire [at Fannie Bay]. I think the people in the houses complained and did not want us there, so at night we go into the bush where we can not be seen and light fires to keep warm...the mangroves behind the oval there.

The practice of having a fire meant that some Aboriginal Long Grassers were less likely to be concerned about having and storing bedding. Others were quite concerned about bedding and worked hard to keep special blankets they had acquired, storing them at Ozanam House and accessing them daily.

Aboriginal Long Grassers in this study differed from non-Aboriginal Long Grassers with respect to their management of personal belongings. It was less common for this group to carry a backpack or other type of bag. Although Aboriginal Long Grassers may have appeared to have fewer belongings, this does not mean that the few items they had were less important. I observed instances where individuals had lost items, such as tools, knives and clothes and had been obviously upset by the loss. (Loss of cigarettes, money and cash cards was more common among Aboriginal guests and generated feelings of anger, frustration and loss of autonomy). Staff also described how guests would lament the loss of items. Aboriginal guests were more likely to store belongings (such as

bedding, important documents, health care cards and artefacts of sentimental value) in Ozanam's lockers, office and store areas. Important belongings were also entrusted to the care of non-Indigenous 'normals', including Ozanam's staff (expanded on below). One female guest, Polly, temporarily secured accommodation and, when faced with eviction, had two concerns; her mortality and her belongings:

...I can not go to the Long Grass. I will die. What will I do with my things?
Where will I go?

Polly eventually distributed her belongings to a few 'normals' for safe keeping, feeling confident she could recover them when she was ready.

It is important to consider the relationship between material possessions, stigma and identity. In Aboriginal communities, the cultural attitude toward 'ownership' is well documented. Aboriginal people have ownership over their knowledge and spirituality, generated through experiences and understandings. This knowledge is conceptualised, intellectualised, moderated and articulated through, for example, stories, dreamings, the spoken word, designs and art and ceremony, with meaning gained by an intrinsic link to place and the landscape. For example, Sansom (1980) described the ownership of the spoken word in an Aboriginal fringe camp in Darwin and Merlan (2005) described the story of the little red rainbow serpent owned by Katherine Aboriginals. Road excavations dug up the serpent, which would become angry with unknown sweat or smells, expressed through storm, wind and rain. On discussing Aboriginal spirituality, Liberman (1980a) asserted the right to land, where ancestral spirits take forms in the landscape, is critical for the vitality of the Aboriginal civilization. Aboriginals' spiritual beliefs are marked in the landscape, creating an intrinsic link between people's identity and place. Liberman (1980b) also highlighted the process of knowledge accumulation on Aboriginal Law through adolescent education via ceremony, also linked to place. One final example here, discussed by Myers (1991), referred to Aboriginal paintings depicting stories which become spiritual and cultural representations.

There is growing evidence that Aboriginal people not only own their knowledge, spirituality and culture, but can and do place importance on the ownership of material

possessions of both a useful or practical nature (such as bedding) and of a sentimental nature. Possessions (including food, alcohol and cigarettes) are often described as fluid entities, moving from one person to the next, being given or demanded. While there is clear evidence of this fluidity, anthropologists such as Peterson (1993) have begun to observe the accumulation of possessions by Aboriginal people. This accumulation, however, is difficult in a demand sharing culture. Although Aboriginals have long placed the highest value on generosity (Hiatt, 1982, as cited in Peterson, 1993), sharing and giving, according to Peterson (1993), was often a direct response to verbal and non-verbal demands and not as a result of generosity as a moral imperative. Consequently, strategies to counter the demands made by those perceived to be lazy or manipulative have been documented, such as the consumption of most of the food collected before returning to camp (Hiatt, 1982, as cited in Peterson, 1993).

Several strategies have been observed among Ozanam's Aboriginal guests to avoid the cultural expectations around demand sharing, and included: the secret consumption of food and alcohol; the hiding of cigarettes, cash cards and alcohol; the entrustment of clothes, CDs and players and food to the care of a non-homeless, non-family individual; and lying. Demand sharing of food, alcohol and cigarettes was more commonly tolerated by Ozanam's Aboriginal Long Grassers. Other material possessions, however, with sentimental and/or practical importance, would necessitate one or more strategies to be employed to avoid having to share/give.

Aboriginal homelessness, however, involved a spiritual disconnection with place, as well as social exclusion, and the inherent loss of what can be owned. In this context, to become homeless resulted in the loss of one's individual, public (or social) and also cultural identity. Aboriginal identity, according to Keen (2004), was defined by an individual's or groups' language, region or country and totems, determined by a given context. For example, a person could select an identity based on which connections they decided to reveal. This poses the question whether ownership of possessions takes on a greater meaning to an individuals' identity once the individual becomes homeless, and finds themselves in Darwin. These possessions may be symbols of de-stigmatisation where

a new 'normal' is being constructed, modelled on the Darwin 'normal' dominated by Eurocentric peoples. Or alternatively, the importance of personal possessions to identity in Indigenous communities may in fact be changing, and the attitude of Aboriginal Long Grassers towards ownership of belongings is consistent with these changes. It is likely both these processes are at play.

This dual significance of possessions, and in particular, the construction of an identity based on a new normal, is well illustrated by Polly's story. Polly saw the accumulation of belongings as demonstrative of her success at being a good person and no longer a Long Grasser. This was facilitated by having a lease on a flat; another symbol of her changing identity. Polly went to extreme lengths to maintain her flat and belongings, including: hiding from, and lying to, her Long Grasser family; sneaking in and out of her flat; and spending time at the casino, where the staff and security could exclude her inebriated family members, precluding them from their relentless humbugging. Polly used these strategies not only out of fear for her health and wellbeing, but out of fear for loss of her developing identity. The more she accumulated, the greater the imperative was to retain these symbols of her new identity, of which she was enormously proud. Polly did not only accumulate possessions, but also new knowledge. She was learning to read and write in English and this was also a source of great pride and something to own that could not be lost or handed over to others.

I had known of four flats in which Polly resided and with each one, she was increasingly excited about inviting me over to 'take a look'. In each flat, the lounge room was usually quite bare, with all her possessions secured in the bedroom, just in case she had unwanted family visit. The flats were also very clean and looked un-lived in, much like when someone is selling, waiting for inspections by prospective purchasers. In the most recent flat I noticed a new 500 plus litre fridge, large enough for a big family. This was a particularly important possession, despite it being empty. In any case, it was too risky to store food in. Protecting food from demand sharing was near impossible for Polly. As Peterson (1993) explained, demand sharing of food among Aboriginal people is learned from birth and when babies cry their needs are quickly met. At the same time, however,

they are also taught that while their demand is being met, they too may have to give on demand.

If giving is the natural expression of goodwill, the positive valuing of the demand sharing of food is established and reinforced from the moment of birth, and its potential as an index of the state of social relations is powerfully inculcated (Peterson, 1993, p.863).

Ozanam House provided lockers to guests for safe storage of a limited volume of possessions. While lockers were well utilised, some guests were reluctant to use them, as they were forced to engage with the service to access their belongings and access was only available until early afternoon (with the exception of those male individuals staying in the shelter with a locker). Storing all belongings at the service was also restrictive and impractical, as some items were needed regularly. As such, lockers were particularly useful for important documents or valued items which were not needed on a daily basis.

For many participants in this study, the more a belonging was valued, the greater the risk of losing that belonging. Further, the longer an individual had been homeless, the less likely they were to own personal possessions. On one occasion a group of about six of Ozanam's non-Indigenous guests were sitting around talking when a young man arrived looking for emergency shelter for the night. The man was carrying several bags and suitcases. One of the group made comments to the effect that the man '*was clearly green in terms of being homeless, and ought to either go back home or get rid of all that stuff before it was lost to him anyway*'. The group laughed gently in agreement as they exchanged stories about the rapid loss of their possessions.

Spradley (1970) argued, albeit from an Anglo perspective, that maintaining personal belongings was significant for homeless people, as these possessions gave form and structure to whom a person was, namely their identity. The process of loss, when there were already so few belongings remaining, including identification papers, watches, wallets and clothing, affects personal identity (as opposed to social identity), in that "*his very self is changing as he loses the few remaining symbols of his identity*" (p.145). As discussed, for Indigenous guests the loss is perhaps linked also to discovering a new

identity. But for all guests regardless of ethnicity, some personal items maintained what Spradley (1970) described as ‘an umbilical cord’ to a non-stigmatised identity; of a time when the individual may have been regarded as having a ‘normal’ social and personal identity.

The idea of having a job

Not all conditions associated with homelessness were necessarily experienced as stigmas by the homeless individual. This was most evident in employment status, with non-Indigenous guests more likely to experience greater stigma associated with unemployment than Indigenous guests.

Many non-Indigenous guests, generally under 40 years of age, routinely talked about desired jobs or careers. To a lesser extent, Indigenous guests, also usually under 40 years of age, talked about jobs, such as car mechanic, nurse, garbage collector or translator. English skills were regarded as an asset, realised through individuals’ interactions with government agencies. For several Aboriginal guests, jobs or work was conceptualised as a ‘white fella’ thing to do.

The idea of having a job, however, was unrealistic for nearly all of Ozanam’s guests as meeting their daily needs was a fulltime career. Education and skill levels were typically low, and when the other conditions of homelessness were layered over this, having a job remained just an idea. Job ‘ideas’ stemmed from boredom, frustration and the desire to do something legitimate during the day. Job ‘ideas’ were also used as stigma dis-identifiers. Employment was regarded as responsible, a legitimate societal function, and above all, normal. Job ideas enabled individuals to project a more palatable identity among other homeless people and the ‘normals’ in the institutional setting. The following quotes are examples of the types of ‘job idea’ conversations that took place at Ozanam.

I’m thinking about trying to get this job through Colin trimming trees in an orchard. \$15 an hour is all right...by 10.00am Friday I will be water skiing on the lake and if I don’t fall off then I am not doing it hard enough.

I want to work on a community, maybe Bagot, collecting garbage or something.

I have been sleeping in the Long Grass. I came here looking for work and have stayed with friends but I do not want to overstay my welcome. So when I ran out of money I went to the Long Grass. I have qualifications ... and have worked before in the NT. I tried to get work there again but they said there was none and there was a lot of competition. I am going back to see my family tomorrow. My family will be shocked to learn that I, the only one with formal qualifications, was living so badly. My life is a paradox. My binge drinking practices caused many problems in my family and that is why I left in the first place.

The next set of descriptions of job ideas have sentiments of Vinnies being the beneficiaries of their potential income or benefits derived through employment.

...I want to get a van and deliver sandwiches and stuff in the mall in town to people who need it. I will give all the money I make to Vinnies.

I have given some serious thought to settling down, maybe doing something during the day, like helping in the opp shop...maybe in exchange for a roof over me head...ahh, Vinnies is the key, Vinnies is my home, not just this one, all of them...can't live without the big Vinnies.

Some guests talked about their shame about needing to use Ozanam House. For example, one guest from country New South Wales, said he felt ashamed about coming to Vinnies. *"This service was for people who really needed it, and not me. I am starting a bar job tomorrow and won't need to return"*. Another guest who had been staying in the shelter had secured accommodation in a caravan park. Although he had been comfortable and had expressed gratitude about the support he had received, he was relieved to leave. *"I'm getting out of here...yeh, anythings gotta be better than here...but I'll probably see you again here though"*. This statement reflected an important perception of the inevitability of the cycle of homelessness for many individuals.

Several guests believed that if 'normal' people realised they received charity, they would assume the guest did not have employment. (Having employment and receiving charity was perceived by guests as 'using' and not a matter to declare). As such, many meal guests preferred to wait inside the Ozanam premises until the service was ready and open rather than in public view on the footpath. For some this was an expression of shame and/or embarrassment over needing to use the service. For others, it was related to

physical or social comforts. Some Aboriginal family groups would wait for meals in the adjoining park or on the footpath, where they could avoid conflict and unwanted attention, and have a drink. Being seen outside Ozanam House was not a primary concern.

Indigenous guests did not perceive government unemployment benefits or other pensions in a negative vein, whereas non-Indigenous guests were very sensitive about these benefits. Several people did not receive any form of government support at all. Receiving charity and welfare from Ozanam, however, was stigmatising for all guests. Blunden (2004) argued that welfare recipients were increasingly stigmatised and individuals scrutinised as to whether they were deserving or not. Volunteering for the service was one mechanism in which homeless individuals could argue for a 'deserving' position. In addition to the important social benefits, by volunteering, guests saw the opportunity to pay back welfare received in kind, and not feel indebted. (On occasion a guest volunteer believed the service owed them, and would take supplies of food from the storeroom when they left for the day).

Although volunteering at Ozanam House facilitated homeless people to develop a range of skills, build self esteem and wellbeing and also provided an important social network, the data showed examples of it hindering an individual's potential to explore paid employment opportunities. Guest volunteers often worked for considerable periods each day and treated their role much like a committed and paid employee found anywhere else. Ironically, the greater the desire not to be perceived as a 'bludger' and to 'earn their keep' the less able the individual was to explore employment opportunities. This was possible as the service was dependant on good, reliable volunteers.

Guest volunteers were proud of their association with Ozanam House. Many acquired a meaningful role with designated responsibilities, which was fundamental to their identity. As one guest volunteer commented:

This is important to me. Each day I wake up at 6.30am, get dressed and walk to Vinnies to help with breakfast. I prepare dinners, even though I am not staying

here, because the night manager can not cook. Coming here is like having a job to go to. I see it like a job. I like being able to help out those people who need it.

From my first day of fieldwork I was acutely aware each guest volunteer had their own jobs with specific functions. As such, I was careful always to wait until a volunteer asked me to do something, or I would ask where I could help out. One day a guest volunteer had arrived later than usual and a staff member placed out the plates ready for serving food. The guest volunteer was furious and shouted, “*that is my bloody job, who put the plates out?*”

In the case of this Darwin homeless population, the community perception that Long Grassers want money for nothing, exhibit no sense of responsibility and have no ambition, have no work ethic or pride and choose to sit around all day drinking at the tax payers expense, has little merit. This study has found that many of Darwin’s homeless exhibited a strong work ethic in various areas and valued responsibility when given the opportunity. Some, particularly guest volunteers, articulated their ambitions. Understanding homeless peoples’ attitudes towards employment and the implications for identity are important areas for further investigation. Although there were clear benefits to homeless individuals and homeless services dependant on volunteer labour, the interaction between volunteering, identity and employment is a complex one. Guest volunteers can become further entrenched in welfare services and remain outside the employment market; the exact opposite outcome intended by many services who aim to prevent dependency while achieving other outcomes. The challenge for service providers lies with determining what constitutes ‘an opportunity’ to demonstrate work ethic, enhance skills, manage responsibility and develop ambition, while at the same time, managing stigmatising processes which adversely affect identity.

Shame as stigma

The emotion of shame is perhaps the most powerful in Aboriginal life. But it is not only a restraint; it can be a goad as well. Like most of the emotions of negative valuation, it is stronger than those which are positive (Stanner, 1979; p.95).

Keys Young (1998) found that for Indigenous Australians to be branded 'homeless' could bring major stigma and shame to communities. Bauman (2002) contended that shame is the most powerful emotion in Aboriginal life and invokes fear, the fear of shame. Shame stems from a failure to be recognised (Biddle, 1997) and when someone is shamed, so too are others, causing reverberations across a whole community. According to Bauman (2002), the uncertainty around identity among Aboriginals living in Katherine created a fertile ground for shame:

Shame can be avoided by the empowering experience of knowing one's proper place in Aboriginal society, of having one's identity embedded in a regional network of kin, socio-cultural practice and mutual recognition (p.206).

To become homeless is to lose one's community and therefore one's embedded identity; it is to feel shame, become shamed in the eyes of others and to bring shame to others. For many Indigenous people in this study, homelessness was experienced as shame. For example, one Aboriginal man I had talked with frequently worked under the Community Development and Employment Program (CDEP) and generated additional income through selling his craft. He was a chronic gambler and explained he had past problems with alcohol and women, but did not elaborate on the consequences of these problems beyond the shame he felt. He avoided conversation about his country and community, and rarely divulged information about his past. One day we met by chance at the shopping centre. While we were chatting, some men, perhaps in their late 20s, stopped to talk. I later asked if these men were family. He explained, quite happily, that they were not, but rather had been students he had taken on a study trip interstate. *"I was a teacher, and taught these boys...that was a long time ago"*. This aspect of his past had never featured in our conversations. Following this event, however, he periodically discussed his experiences as a teacher. This was a fragile situation because exposing this aspect of his past self permitted a contrast to be made with the person he had become. These students were symbols and evidence of his past non-stigmatised identity, a time when he had a sanctioned role in delivering knowledge.

A further example of the shame linked to homelessness is illustrated by the use of the term 'Long Grasser' instead of 'homeless person' as a dis-identifier. 'Long Grasser'

refers to those people who camp or live rough in multiple locations, i.e. in the Long Grass. Some *are* profoundly homeless, and others are not, and are living the camping lifestyle (Holmes, 2006). It is for this reason that Ozanam's guests, particularly Indigenous guests, were inclined to identify themselves as Long Grassers. This identity was perceived to carry less stigma and shame than being labelled homeless. To be a Long Grasser invoked a sense of self determination, with choice in and control over one's life, rather than invoking shame stemming from social, cultural and physical exclusion from country and family. Tobias, an Aboriginal guest at Ozanam House, explained his observations on the process of becoming and remaining a Long Grasser:

I used to hang around the Long Grassers at Fannie Bay. It was at this time I felt homeless even though I had a flat nearby. I felt lost and disillusioned... Aboriginal people become Long Grassers for a few main reasons. The first reason is that they want to live or be away from their communities. This is usually because of the 'pay back system'. For example, if I kill someone, maybe someone else from their family will try to kill me...this is an extreme example. The second reason people want to be away from their community is because they want to be free...free from being told by others what you can and can't do. When you are a Long Grasser you are not only free from your community but from everyone and you can do what you like whenever you like. So you see they leave their communities and come here and they drink and take drugs and there are some benefits but you get into the cycle and it is very difficult to get out. When you are a Long Grasser each day you just do whatever. You sort of respond to the things around you. You never know what you will do, your day is not planned at all. This can be appealing, but for me it became a problem.

Being a homeless Long Grasser for Tobias brought himself, his family and community shame, but not for being a Long Grasser *per se*, but for the reasons he had become homeless and lost. He was excluded from his community under Aboriginal Law for alcohol related domestic violence; the shame stemming from exclusion from community and country. Feeling homeless and lonely, with a perceived lack of order in daily life, served to remind Tobias of his shame and his lost identity. During a period of incarceration, Tobias eventually accepted his loss of privileges with his wife (such as telephone communication and the right to offer advice or give instructions), and out of boredom, as he puts it, he turned to Christianity. This had a profound affect on his identity.

When I met Tobias he was able to return home. He explained he now felt empowered and happy as a result of Christianity. I once asked how he thought he would cope when he returned to a community where alcohol was central to daily social life. He replied:

I know this proverb, when I was in prison I learned to like proverbs and sayings, and would write them down. 'Challenge' is like an untamed dragon with a gift in its mouth. Tame the dragon and the gift is yours. I want to return to my people and show them there is a better way to life. I want them to learn what I know.

Ozanam House provided a safe environment for homeless individuals to reveal or explore their spiritual beliefs. During my fieldwork I met several homeless people who discovered Christianity during homelessness. For example, Zac commented:

When I was at a [homeless shelter] what actually turned me was the people from that Hillsong Church in Sydney. They used to come there of a Sunday and ask 'who wants to go to Church?' I thought to myself, should I or not. Yeh, I'll go. Got to the stage I was going and I was the leading pupil. I never got baptised when I was a child. I only got baptised last year at the Hillsong Church. I don't know if it is Catholic or... They knew I was struggling and did not have a place to live and that, and knew it was coming up close to Christmas. They put me in the pool and being 6ft, they had difficulty putting me under water and bringing me up. Then they did the thing on me and go 'we hope to find our son Zac a place to live before Christmas'. What happens? Two days before Christmas I got a flat.

Many guests had formed strong social and emotional connections with Ozanam House, and described Ozanam as 'home'. Paradoxically, using a homeless shelter meant that at some level the individual had accepted the 'homeless' label, yet at the same time this connection further removed them from being 'homeless'. This is consistent with the findings of Veness (1993) who claimed a homeless shelter is regarded as closer to the socially-prescribed definition of home than the alternatives, in this instance, the Long Grass. Echoing the sentiment of many guests, Joe (who was negotiating the staff changes at Ozanam House) commented:

I need to drink because my mum passed away last week and now they [the staff] are going. How can they do this? This is my home in the Long Grass and these people have been my family. They are like family.

Joe was feeling particularly low because his money had been demanded by family members during the week before his mother's death. When he asked for money to travel to the funeral, they either did not have any, or were unwilling, to share. According to

Babidge (2006), Aboriginal funerals are significantly important events, revitalising kinships and notions of belonging. As such, understanding the imperative for family to attend funerals is what defines family, as related people are either included or excluded from the funeral process.

...the particular mobility of those who leave jobs behind for the day, or for a few days, confirms to their family the importance of their identity as Aboriginal people. Notably, Aboriginal people who do not embrace the responsibility of travel for funerals are spoken of as having 'gone White', a specific embodiment of dominant Australian society's apparent emphasis on individuated personhood (Babidge, 2006, p60).

The stigma, felt as shame by Indigenous guests, for becoming and being homeless was managed by moving away from their communities to Darwin. Yet for some, being in Darwin, away from communities and land, was a constant reminder of their shame. As such, living homeless in Darwin saw individuals potentially discredited and discreditable at the same time.

Personal appearance and hygiene

Douglas (1966) proposed that dirt represents disorder. She argued, "*we find that certain moral values are upheld and certain social rules defined by beliefs in dangerous contagion...*" (p.3). Following this position, it could be posited that homeless people represent a source of contagion and disorder for society, breaking the social rules of purity through an apparent lack of attention to personal hygiene. Simply put, if our social belief maintains that cleanliness is next to Godliness, we must therefore concede that dirtiness is where evil may be found.

The common situation of losing personal belongings (as discussed above) was also problematic in terms of stigma as individuals were less able to maintain their personal appearance and hygiene standards, and 'pass off' as homed. This necessitated individuals to access Ozanam House and other homeless services to attend to basic personal maintenance. In such circumstances, access to these institutions becomes a 'double edged sword', as although they provided on the one hand an important service in

disguising their homeless condition, on the other hand the simple act of using the service disclosed and/or reinforced their homelessness and stigmatised homeless identity.

Attending to personal appearance and hygiene was an important function of daily life for most of Ozanam's homeless guests. Many used Ozanam's shower facilities by choice, would launder clothes or obtain fresh clothes from the St Vincent de Paul shop. Guests occasionally purchased new clothes and were appreciative when service staff noticed. Some guests placed great emphasis on hair cuts and styles. For example, one guest who always wore a baseball cap, asked if I would cut his hair with clippers. The guest carefully monitored (along with several other guests) the carrying out of his detailed instructions in order to achieve a very precise style. He was insistent I use scissors to trim the hair around his ears, the hairs growing from the lobe and cartilage areas, and the stray hair from the ear canal opening. He commented, "*I am turning into a werewolf*". After more than an hour of grooming he asked if I would mind if he 'fixed it up'. When complete, he returned his cap to his head. Despite being satisfied with his cut, the cap concealed the unwanted grey in his hair. Following this, I received a few other requests for hair cuts, although the cuts never materialised.

Many of Ozanam's guests had head lice (as I did too!). Lice were a common problem that did not discriminate between homeless or housed hair, yet was seen to be associated with being unclean. As Phelan *et al* (1997) postulated, increased levels of stigmatisation due to aesthetics may lead the public to avoid the homeless as they "*are viewed as dirty, smelly, lice-ridden, or diseased*" (p.333). While the condition is irritating more than anything else, it is difficult to treat effectively with re-infestation being almost immediate. For some guests, having lice was a stigma symbol of their homelessness and of being dirty or contaminated and was yet another matter to be managed. The most affordable treatments required shampoo to be applied to the hair and massaged into a lather, then left to sit for ten minutes before washing out and combing with a fine toothed nit comb. This proved logistically difficult for some due to the time and money needed for treatment and the competing demands on Ozanam's shower facilities. A couple of female guests asked if I would allow them to wash their hair at my house. I obliged. We

sat out the back and took turns hosing our hair, shampooing and combing one another, carefully checking after each stroke for signs we had removed the ‘contagion’. The women were quite pleased to find lice in my hair. This interaction illustrates a process whereby these women were able to de-stigmatise, for a time, what they had formerly regarded as a symbol of their homelessness.

Another guest, Steve, introduced in **Chapter Eight**, had felt stigmatised his whole life by his physical appearance. To reiterate an earlier quote:

...I have a sort of [pointing to jaw]...this part sticks out a bit. I used to get teased a lot at school. They used to call me ‘long chin’ and stuff like that and I used to keep things bottled up, bottled up and bottled up, until I can’t keep it any more.

Occasionally, this individual would explore employment opportunities and calculate potential earnings. Periodically, he would outline more ambitious plans for making a lot of ‘easy quick money’. This typically involved selling marijuana, alcohol or kava to dry Aboriginal communities (where alcohol was regulated or prohibited). These schemes never materialised beyond ideas as the individual did not have the capital to make initial purchases, the contacts to gain supplies or deal in illegal substances, nor the funds or licence to hire a car to access these remote locations. After hearing about many such schemes I asked the individual what he wanted to do with the money. He explained he only needed enough money to get to Bangkok, Thailand, where reconstructive plastic surgery was cheap. He had learned about such procedures in magazines and on television and believed his chin could be reduced by at least half and his teeth rectified. He indicated he thought more about cosmetic surgery since becoming homeless and commented, *“I just want to look normal, be like everyone else”*.

One guest would cover her mouth whenever she laughed, or would avoid laughing at all. I had noticed she had difficulty eating various foods. After I observed this behaviour for more than a year, one day the woman announced that the doctor was going to fix her teeth, *“make them look good as new”*, and provide her with a set of false teeth. The woman was delighted over the possibility of looking better.

Dis-identifiers were commonly employed by homeless people in order to establish relationships with degrees of normality between homeless people and others (particularly service staff and other non-homeless individuals). On my first meeting with one guest, Aaron, I recalled being asked for recommendations on toothpaste. Aaron indicated that he had tried a few different types but was dissatisfied. Many of our following conversations either commenced or included a discussion in this vein, with lengthy deliberations over the cost, effectiveness, size, scent and authenticity of selected toothpastes and deodorants. He also provided a detailed account of which pharmacy sold what and where to locate the items on the shelf. There was a clear expectation I would use this knowledge to make my own selections and share my experiences during our conversations. The topic of deodorant and oral care was also regarded by Aaron as 'normal', in contrast with the stereotypical homeless person who has offensive breath and body odour.

The final examples in this section illustrate the significance of appearance and hygiene to Ozanam's guests but also highlight the shame that can be felt as a consequence of other homeless individuals. The first example refers to a couple of Aboriginal men from the same family eating lunch together. They were both intoxicated. The younger man ate his food then sat back and watched the older man for a time. The older man was eating his rice, chicken and salad with his fingers. The younger man was disgusted and humiliated by his kin's behaviour, and repeatedly shouted, "*You eat like that!?!... look at you... you eat like that!?!?*"

This situation is consistent with what Goffman (1963) terms as identity ambivalence, whereby a stigmatised individual closely observes one of his own kind behaving in a stereotyped manner,

...pitifully acting out the negative attributes imputed to them. The sight may repel him, since after all he supports the norms of the wider society, but his social and psychological identification with these offenders holds him to what repels him, transforming repulsion into shame, and then transforming ashamedness itself into something of which he is ashamed (p.107-8).

The second example relates to an altercation between two guest volunteers, one worked daily and the other on an *ad hoc* basis. The latter volunteer arrived one morning to help out and after putting on a pair of gloves, he attempted to find a job serving up food. The regular guest volunteer blocked his moves to help, claiming there were already enough people helping out. The *ad hoc* volunteer was confused and felt excluded. The regular guest volunteer later commented:

I am not happy with him serving up. It was not because there were too many people, but because he wears the same clothes most days and has a big beard and spits when he talks. People do not want to eat food when it is served by someone who looks like that...they do not like it.

The importance of appearance to homeless men was raised in Spradley's (1970) ethnographic work. Contrary to popular belief that homeless people have lost all self respect and have little concern for their public image, Spradley (1970) found public humiliation was the central issue for more than half of those he interviewed. After observing homeless men facing drunk charges, it was some time before he learned they had spent up to five days in a crowded 'cement drunk tank'²² with no opportunity to prepare themselves prior to their court appearance. They were particularly concerned about their inability to attend to their physical appearance and the feelings of degradation. This study also demonstrates the importance of appearance to Darwin's homeless.

The Long Grass as a dangerous place

Due to fear, the living environment and the lived experience of homeless people in this study, many individuals considered themselves in a perpetual state of danger. This was effectively captured in an interaction between a staff member, a well known guest, Robert, and me. The following event highlights the very real fears Robert faced in daily life. It also points to the fact that Robert was aware he moves in a world not fully understood by the staff member or me, for this understanding can only come through experience. It also revealed the moment when Robert realised he does not fully

²² A cement drunk tank refers to a cell, largely made of cement, in which arrested homeless alcoholic men were held until their court appearance. There were no beds in the cell, lights remained on 24 hours a day, there was one toilet and wash basin, and urine and faeces covered the floor. They often held around 35 men, although it was a common experience that men could not lie down due to the overcrowded conditions. Men were not excluded from the 'drunk tank', even when they had obvious signs of communicable diseases, such as Tuberculosis.

understand the world we move in, the tension being evidence of the established rules of interaction being broken.

The staff member and I were in the office chatting when Robert arrived wanting to have a shower. He lifted his shirt a little, and revealed what we believed to be a pocket knife. The staff member said, "*I don't want to see it. Take it off your body and leave it in the office while you shower. You are not allowed to bring that in here*". Reluctantly Robert agreed to leave the knife in the office. Much to our surprise, he pulled out a knife that had a blade at least 60 cm long. We were both shocked, and laughed nervously, although did not feel threatened.

Robert returned from his shower and the staff member asked if he would come in and sit so they could discuss the knife. He was annoyed, a little drunk and a bit aggressive, but sat down. The staff member started by talking about the knife, and attempted to explain that it might get him into trouble. Robert was furious, and began to talk loudly:

...what do you two white people know about living in the Long Grass...you come and live in the Long Grass and see, you will need protection from someone hitting your head with a brick while you are asleep...don't you tell me until you have lived like me...

The staff member worked to calm Robert down. His head was bowed and he was fuming. The staff member explained that he was right, and that we did not know what the dangers were but felt concerned that someone might take the knife from him and hurt him with it. (The staff member was also concerned he might hurt someone unintentionally when under the influence of alcohol). Robert calmed down, had a cup of tea, and sat quietly for a few minutes. It was at this time he realised he had broken the social rules within Ozanam House and while attempting to validate his own fears, he induced fear in us. In a gentle tone, he said:

...I would never come here and chop your heads off...I would not do that. I would not use this here. There is no danger here.

He then relinquished the knife as a gesture of apology. Over the next half hour he inquired about my family and explained about his family and the importance of demand

sharing. He illustrated this by giving his newly lit cigarette to his uncle Joe on demand, who returned it when it had been smoked to the butt.

Mobility as stigma management

In an earlier chapter, I discussed the mobility of homeless people in this study and pointed to the function homeless services played in this regard. In addition to structural causes of mobility, managing stigma associated with 'loitering' in public places contributed to much of the localised movement patterns. Movement was used as a dis-identifier of homelessness by many of Ozanam's guests, particularly to avoid police attention.

I will probably squat in a vacant house in Nightcliff. I came by the house when I was visiting a friend and noticed it was vacant. It has some beds with mattresses and no windows, but has running water. I worry the neighbours might see me so I won't go there until after dark and I'll leave early in the morning...The property is surrounded by a high fence and I have to scale it to get in and out. I use candles for light and went outside to check that they would not be seen from the neighbours...I don't think you get arrested for it [squatting], I think they just move you on...I have a sheet and put it on the bed and I carry two other bags with me always; one with kitchen stuff and the other with clothes. It is difficult to squat at this place because you have to wander around all day before you return and the days become very long...One of the best things about Vinnies is that you do not get kicked out in the morning and can rest when you are genuinely sick, not just with a hangover.

The above example mirrors the experience of many homeless people in this study. Living daily life in a public domain with nothing to do was boring and tiring. Some guests reported the ongoing need to survey their surroundings for dangers, including the police and the 'normal' public. A homeless person who employs mobility or the appearance of having something valid to do as stigma management dis-identifiers is often reactive to the presence of others. In turn, others interpret this behaviour as suspicious, reinforcing the deviant stigma.

"The individual's world is divided up spatially by his social identity..." (Goffman, 1963; p.82). According to Goffman (1963), stigmatised individuals oscillate between three types of places. These include: forbidden places where exposure leads to expulsion; civil places where people are treated as if they are permitted access, when in fact they are

generally not; and back places, where the stigmatised person stands exposed and where they do not need to hide their stigma. Back places often 'herd' people based on common stigmas, such as Ozanam House and its homeless people. Goffman (1963) maintained that in these back places, individuals can be at ease. Ozanam's guests spent most of their time on edge in civil places, or at relative ease in back places, when they were accessible:

It is always a good day when you are at Vinnies. There is always something to do down there, you're never bored, that is one thing, and you always see different people come in and never seen them before. All the different people are starting to rock up to Vinnies now that never came before. A lot of them at Vinnies...now they know me by my first name and I see them up the street and they say, 'g'day Zac, how are you going?' ...

It is no surprise then, in an urban milieu where institutions such as Ozanam House are located, territorial bases for homeless stigmatised individuals are established.

The 'normals' perception of homeless people

At the beginning of this chapter I described three interrelated notions of stigma coming from the data of this study. The first, homeless perceptions of the self, has been presented in the above paragraphs. This section now elaborates on the second feature of stigma at play in this research: - how the 'normals' understood homelessness in Darwin and their subsequent treatment of homeless people. The first part of the section will describe community attitudes toward homeless people. I will then explain the dichotomy that existed at Ozanam House stemming from the Vincentian ethos and philosophy surrounding the service delivery and the tensions involved in doing this where judgments are continuously made around stigma and deviance.

Community perceptions

As discussed earlier, both Indigenous and non-Indigenous (usually long term) homeless people often described themselves as Long Grassers when they were living in Darwin. For non-Indigenous homeless people, this self identity was unlikely to be used outside of homeless circles and institutions as it could potentially discredit the individual in 'normal' settings through sharing the stigma, but also because most 'normals' believed you have to be Aboriginal to be a Long Grasser. There were (and continue to be) many

misconceptions about homelessness and homeless people in Darwin. For instance, there was an overwhelming perception by Darwin's homed that chronic homelessness was an Aboriginal problem, despite half of this population being non-Indigenous (Chamberlain & MacKenzie, 2003). The conceptions held about Long Grassers and homelessness were (and continue to be) perpetuated by local media reports, letters to the newspaper editor and on talk back radio. Homeless people were understood within a framework of anti-social behaviour, and discussed in terms of their homeless symptoms, rather than the complex underlying causes of their homelessness.

The following excerpts are from a transcript of an ABC local radio show. The segment was entitled '*Program to Tackle Anti-Social Behaviour in Darwin*', and although it explained why some Aboriginal people end up in the Long Grass in Darwin, it also captured how the 'problem' of homelessness is constructed in public forums. These constructions have a profound influence on public opinion and contributed to the misconceptions and limited understanding of homelessness by 'normals' in Darwin.

For years, one of Darwin's most pressing social problems has been the hundreds of itinerants, mainly from remote Aboriginal communities, who come into the city and live in the open or the "long grass". Some return home, but those who don't often enter a cycle of drinking, substance abuse and anti-social behaviour in many of the Top End capital's public places.

Well, now the Northern Territory Government is entering a new phase of a program to tackle the problem. Sarah Hawkes' report begins with a community patrol approaching itinerants in Darwin's long grass...

SARAH: Are most people that come in here from some of the remote communities?

LES: Yeah. See, Roper River mob, 'cause they're all my family, we're, they're all linked up with me. It's the ceremony out there has kicked them out, they've done something wrong and they won't go back there. They reckon it will kill them if they go back there.

SARAH: So in essence there will be long grassers here for quite a number of years?

LES: Yep, probably until they die.

The message is clear that we are not going to continue to accept people

conducting themselves in an anti-social behaviour and manner that is not good for the Northern Territory and especially not good for Darwin and Palmerston.

(Transcript, *The World Today*, ABC Local Radio, Mon 2nd Feb, 2005, <http://www.abc.net.au/worldtoday/content/2004/s1036496.htm>)

As Langton (1993) has observed:

Of all the different constructs of 'the Aborigine', or ways of imagining the native in Australia, the most vocal is the 'drunken Aborigine'. In cities and provincial towns there are regular public debates about the 'drunken Aborigines' (p.195).

In short, most normal homed people in Darwin regarded homelessness as a chosen lifestyle by Aboriginal people who would rather live in the Long Grass and drink, living off welfare. As discussed earlier under the heading of 'employment', homeless Long Grassers were perceived to be without pride, work ethic and ambition, and did not exhibit any sense of responsibility.

The institutional perception

At Ozanam House, there were numerous examples of homeless people (usually guest volunteers) who were no longer welcome. The shift from being a 'normal' in this setting, welcomed as an individual participating in a social dynamic, to being no longer welcome had a profound affect on the self and social identity of homeless people. This was more evident among individuals who became active guest volunteers. With the organisation espousing the worth of all their volunteers (guests and 'normal'), paradoxically, there appeared to be a systematic exclusion of guest volunteers when they became too involved or 'dependent'. Guest volunteers and staff were acutely aware when someone had become 'too involved', as illustrated by the comments made about one guest volunteer: "*Kim thinks he owns the place...I'm running the show, don't you worry, you leave it to me*". In this instance, a lack of clarity around staff and guest volunteer roles led to this tension.

The exclusion of guest volunteers typically resulted from tensions emerging with other guest volunteers or through conflict with staff or the organisation. The following

examples illustrate the nature and process of such exclusions, and the consequences to personal and social identity of individuals.

For several months Steve and Kim were key guest volunteers. They prepared, cooked and served meals daily. They both stayed at the premises as recognition of their service, to act as night watchmen and also for the practicality of the breakfast service. Both men expressed various frustrations with their work, shared views on the organisation's decisions and practices, but were largely committed to their voluntary work. Staff had responded with warmth and appreciation and Steve and Kim were part of a social network that also included non-homeless individuals.

Organisational changes at Ozanam resulted in another staff member excluding both Steve and Kim from the service. Neither Steve nor Kim had broken any rules and continued to work hard. According to the volunteers, they felt the staff member had treated them with disrespect, placed no value on their contribution to the service and actively and overtly exerted his authority over others. The staff member confiscated their keys for the office and refrigeration unit and implemented a security blitz to prevent theft, targeting guest volunteers. Volunteer response to the changed organisation was effectively captured by Kim's outburst one morning. He had worked continuously for several weeks. Eventually he took a day off and returned the next morning to find:

...he [the staff member] burned the food on the trays and did not even wash them. The bins are overflowing and now there are hundreds of flies in the kitchen. The kitchen benches and floor are dirty and the dining tables have not been cleaned. He did not even put the garbage out...he is rude to guests and does not help... we are happy to volunteer and work for people we like, but him, we don't like.

A few days later, Kim and Steve were on the street. Kim's statement also echoed the view that many guest volunteers would forego the importance of their Vinnies role to their identity, and discontinue their service, if personal recognition for their contribution appeared to be absent or mistreated.

The new staffing body maintained the exclusion of guest volunteers from participating in the service by threatening to call the police. As one volunteer said, "*the police will*

believe him over me". The staff also manipulated another guest volunteer to facilitate these exclusionary processes, which was easily achieved, as the guest volunteer believed his voluntary position would be more secure if he acted in accordance with the demands of the staff member.

Both Steve and Kim found themselves sleeping in the Long Grass, humiliated and angry. Kim lost all his possessions, including a mobile phone where important contact numbers had been recorded. Within a few weeks the staff members involved in these incidents were instructed not to return to the service by the Management Committee. Steve and Kim resumed their voluntary roles soon after for a period. This sense of social justice felt by guest volunteers was discussed for many months; so too was their contempt for the staff members involved, as illustrated by the following quote:

They have been fired...we have won. You see, they got found out and that Committee, they believed us...that staff were no good...

Another example of the exclusion of a guest volunteer, Adam, occurred following altercations with another guest volunteer. Adam had been relied on heavily by the organisation. He maintained food supplies, cooked, cleaned and conducted a range of other duties. Unlike Kim and Steve, Adam did not sleep on the premises. With a shortage of staff, Adam was appointed temporarily to oversee daily operations – a function typically conducted by paid staff. He explained a drunken guest had been threatening and violent towards another guest during a meal service. In response to this, he physically restrained and removed the drunken guest (without injuring him) off the premises, with the support of another 'normal' volunteer, in order to protect the safety and wellbeing of all other guests and volunteers. General consensus was that the situation had been handled well. The same guest returned the following day and there was no resentment or animosity directed toward Adam for his actions the previous day.

Adam then had an altercation with Simon, another guest volunteer. Simon was described by most who knew him as a 'pain in the neck', 'an old woman' and an 'incessant whiner'. Simon abused and attempted to offend guests regularly and as a small framed and short man, most guests laughed at the absurdity of his actions. Adam, along with

several other volunteers, was worried that one day a guest would strike out at Simon for his behaviour and cause some real damage.

Simon was carrying on in his usual way, while Adam was servicing Ozanam's homeless with little organisational support. He was under tremendous pressure. Completely frustrated with Simon, Adam picked him up and shook him. Adam, on the verge of a mental breakdown (according to people who knew him well) was excluded from Ozanam House by the organisation for this incident, reinforced by the earlier altercation with the drunken guest. (Later this ban was relaxed to allow Adam access to the laundry facilities to clean his clothes).

A further incident resulted as a consequence of Adam's altercation with Simon. Adam's parents were immigrants to Australia from the Middle East, and Adam had inherited their olive skin and dark eyes. Prior to Adam being excluded, he received a visit from several officials from the Commonwealth Department of Immigration in response to a telephone 'tip off' they had received. They were investigating whether Adam was an alleged 'Middle Eastern looking terrorist residing in Australia illegally'. They asked him about where he was born, whether he was an Australian citizen, and where he had family. Adam explained where his various siblings lived and then provided details on extended family members. After he revealed his familial relationship with a prominent Australian politician, the officials completed their investigation. They had concluded he was an Australian citizen and no longer a terrorist threat. Simon had made it known he had been responsible for this call; an attempt to place a question mark over an important part of Adam's identity, an attempt to discredit Adam.

Adam, Steve and Kim all developed many skills through taking on responsibilities associated with guest volunteering at Ozanam House. They were committed and hard working. Yet as soon as the opportunity came to demonstrate their prowess or defend their role and responsibilities, they no longer matched what the organisation had constructed as what a homeless person ought to be, i.e. they no longer fit within the

socially-prescribed homeless system. The organisation deemed them deviant, and acted to exclude them. This finding is supported by Venness (1993) who found that:

...society is more willing to give assistance and approval to poor people who become part of the system. Poor people who accept their homeless categorization may receive help (p.331).

Police interactions

...there are important stigmas, such as the ones that prostitutes, thieves, homosexuals, beggars, and drug addicts have, which require the individual to be carefully secret about his failings to one class of persons, the police, while systematically exposing himself to other classes of persons namely, clients, fellow-members, connections, fences, and the like. Thus, no matter what role tramps assume in the presence of police, they often have to declare themselves to housewives in order to obtain a free meal, and may even have to expose their status to passers-by because of being served on back porches what they understandably call 'exhibition meals' (Goffman, 1963; p.73).

This study observed and documented a number of interactions between homeless guests and the police. Some of these occurred at Ozanam House. This was problematic, as all homeless guests ran the risk of being discredited when a police officer (as a normal) entered this 'back place', marking previously unmarked individuals in their eyes, with ongoing consequences to the homeless individual when occupying 'civil places' (Goffman, 1963). Staff worked very hard to restrict police from accessing the inside areas of Ozanam House to ensure their ongoing comfort or ease and discretely responded to inquiries in the office or front entry area.

Ozanam's homeless, however, were repeatedly pursued outside the service, forcing localised mobility (see also **Chapter Three** and **Chapter Seven**). Individuals were questioned about what they were doing, where they had been, whether they had seen a particular person, the circumstances surrounding the death of someone, and of course, instructed to move on. (Their very presence could constitute an offence). Their 'deviant' identity was reinforced by the law enforcers, reminding individuals of their lowly position on the social ladder.

In response, the homeless people appeared to adopt a ‘suspicious’ manner. They were illusive, evasive, secretive and constantly surveying their surroundings for anything out of order. The deviant identity cycle continued and those who became known to the police remained discredited individuals, and were treated accordingly. For some, being treated like a deviant only served to encourage illegal activities, rather than prevent them from occurring. Homeless people were more easily caught, when it was probable a non-stigmatised individual under the same circumstances, would not have been. During my study, many guests were locked up for being drunk and anti-social, which would not have happened had they been occupying private spaces. They were arrested for having ganga (marijuana) in their pocket and for unpaid fines. These incidents provided confirmation to the ‘normals’ that they are right to be fearful of this deviant group.

I recall walking down the highway one day and bumping into Aaron, the man who gave me tips on toothpaste and deodorant. We were standing on the footpath outside a car yard catching up. After about 30 minutes, a police car travelling on the opposite side of the road did a sudden U-turn and flew up the footpath next to where we were standing. The police officer questioned me about whether I was OK. I said I was fine and was catching up with a friend. But the officer continued to ask the same question. Eventually I insisted, “*I am fine*”, and turned to Aaron and asked, “*what about you Aaron? How are you? Are you OK?*” Aaron politely said that he was fine too. The police eventually left, but not without further reassurances from me. Aaron indicated that he was always hassled by them and for him it was ‘water off a duck’s back’.

Not all interactions were initiated by the police. On one occasion, the police were contacted and attended an attempted suicide (See Steve, **Chapter Eight**). They fulfilled their duties by waiting with Steve until the ambulance officers arrived, and provided assistance moving Steve down a staircase. I recalled the unexpected satisfaction Steve had as the police ‘reluctantly’ (according to Steve) provided this assistance. Steve had felt like he had some control over the event, even empowered, if only for a moment, and in the context of feeling miserable. Hopper (1988) commented that one of the most intriguing aspects about the social response to homelessness lay with the ongoing

“tension between providing sanctuary for the helpless and disciplining the unruly”
(p.163). Steve’s experience may describe such a tension felt by the attending police officers.

Polly (see also **Chapter Eight**) also had numerous interactions with the police – mostly initiated by her. She was desperately trying to maintain private housing tenure and had to manage the tensions between her family and the conditions (and perceived conditions) of her lease. On one occasion, her brother smashed a window when Polly refused him entry to her flat. She had reported the property damage and break in to the police as she had wanted her brother to be held accountable. The police were annoyed by Polly as they believed that because she was not forthcoming with the name of the person who had damaged and then entered her flat, she was trying to protect them. In fact, Polly was trying to protect herself from retaliation. She had wanted the police to discover the individuals who were causing problems in order to ease the family tensions she had to negotiate on a daily basis, not fuel them. At the police station the officer would yell at Polly, *“we can’t help you unless you tell us their names”*. Polly was frustrated, and over time, she became increasingly disillusioned with the police and believed they would do nothing to help her.

This final example of the experience of a homeless person with the police was a common one, and also a trigger for unplanned mobility. The guest explained:

...There was a church in Surfers and we go there to have a cup of coffee and a sandwich and that, shower, and they would wash your clothes for you, give you a food parcel, and then, say 11.00am come lunch, like Vinnies here - but you are actually in a church - and just up the road from the church was a used car place. I was walking down to the church one day and this bloke goes, ‘you’re the bloke who stole that green Ford the other day. I seen you driving it’. I turned around and said ‘you don’t know what you’re on about you fuckin idiot, fuck off.’ I didn’t know he was a copper. John says, ‘Don’t worry, that dude does it all the time to the homeless. A car gets knocked off, of course they blame the homeless. They won’t blame anyone else’. After that me and John were thinking about coming to Darwin anyway.

Implications for interaction in society

In this Darwin study, stigma has emerged as a key dimension to the experience of homelessness; a dimension which has a significant influence on health and health seeking behaviours. The first section of this chapter teased out the complexities associated with homeless perceptions of the self. The second section discussed the research findings which related to the ways in which the normal members of society understood homelessness and treated homeless people. The final section of this chapter on stigma examines the research findings which shaped the implications for interactions in societal functions.

Becoming discreditable: relationships and interactions with the ‘normals’

Don't forget your friends in the Long Grass...

As my relationship with individuals deepened, greater emphasis was placed on rejecting the assigned stigma and defining their own 'non-deviant' identities within our relationship. This was possibly supported by my role as a researcher as I was making a conscious effort to suspend judgement and at the same time understand the life world from the perspective of the individual. This same process, however, was observed between other homeless and non-homeless individuals in the study setting where a newly constructed social reality was transformed, supported by non-homeless, non-stigmatised individuals. As Davis (1961, as cited in Anderson *et al*, 2003) observed, these reprieves from stigmatisation were not always problem-free despite experiencing a degree of personalised recognition, social validation and normalisation of interactions.

I have pointed to the fact that an individual presenting at Ozanam House arrived marked with the stigma of homelessness or poverty. For many individuals, relationships were built between the service staff and guest volunteers and homeless people. Indeed, most service staff viewed relationship building as the singularly most important dimension of their work, to overcome barriers and to address and respond to the complex needs of their client group. In order for such relationships to develop, staff worked at personal

recognition of individuals, providing social functions through mechanisms such as volunteering and through normalisation processes during interactions.

Personal recognition was achieved often through introductions that emphasised the strengths or skills an individual had or their 'normal' experiences. For example, "*this is Tom, Tom is one of the Territory's most acclaimed artists. He has travelled all over*". And a further example, "*have you met Ben? Our friend Ben works very hard here, nearly every day...I tell him he should take a day off and rest*". This second example highlights how an individuals' interaction with the homeless institution and staff can be normalised *within* the setting. The phrases 'our friend', 'Ben works' and 'take a day off' illustrate the use of dis-identifiers by staff that temporarily shift the homeless individual from having an identity that is stigmatised to a 'normal' identity.

The reprieve from being regarded as a homeless individual came at a cost for both the homeless person and the institution. While for some time each day the homeless individual felt a sense of belonging and his self worth appeared to be propped up, this was in stark contrast to how he was regarded when he left the premises and moved about among the public sphere. This contrast saw many of Ozanam's guests, particularly guest volunteers with more established roles and relationships within the institutional environment, return daily. A paradox was created and the desire to essentially feel 'good' resulted in what was deemed as an unfavourable outcome; dependency. Staff were painfully aware of this and validated their actions by limiting the working definition of 'dependency' to apply to accommodation. As one staff member commented:

...some guests can become too dependant on us. This place is a temporary shelter only and not long term residential accommodation. We need to support the people in securing their own places.

As Blunden (2004) has commented, "*The welfare State is under sentence of death, and the charge is supporting a culture of 'dependency'*" (p.31).

At the time of this study, a struggle of ideology and power between the Management Committee and the organisation was burgeoning. The committee had been relieved of

most of their responsibilities at Ozanam House by the organisation, with the exception of recruitment and coordination of volunteers. Committee members, unlike organisational members, had developed 'trusting' relationships with guest volunteers and guests that recognised individuality. In these relationships Adam, and others, had felt 'normal'. As Misztal (2001) explained, definitions of trust typically include notions of vulnerability, uncertainty and risk; a confidence that neither party will exploit vulnerability:

Social trust is seen as a stabilizer of social order because it reduces social complexity (Luhmann, 1988) and as a lubricant for cooperation because it mutually reinforces expectations about reciprocity (Scott, 1999)... 'Normality' seems to refer to both an aspiration for the future and a factual situation of a lack of "immediate external or internal threats to society's stability" (Berger 1998:352) (Misztal, 2001; p.313).

In their relationship with Committee members and staff, Adam and other guest volunteers, were what Goffman (1963) referred to as 'discreditable'. And like other examples presented here, relationships in this politically unstable institutional environment had consequences for homeless individuals as they negotiated shifting identities.

Conversely, and to re-state the above point, Ozanam's guest volunteers did not consider they shared relationships with organisational members which generated a sense of 'normality'. Like Adam, many guest volunteers felt they were discredited individuals in the eyes of the organisational members. (This is in part due to the inability of individuals to conceal their stigma, but also due to the fact that organisational members rarely visited Ozanam House for such relationships to develop). However, guest volunteers and organisational members participated in the occasional meeting and these had a profound impact on volunteers. Meetings were an exercise in managing tensions stemming from discredited identities. In Adam's case, his identity was marked by both homelessness and mental illness, which increased the tensions that required management under such circumstances. In Goffman's (1963) words, these situations became "*tense, uncertain, and ambiguous for all participants, especially the stigmatized one*" (p.42). Guest volunteers expressed their frustration with meetings and felt disempowered, disenfranchised and that their contributions had no worth.

Organisation members began to refer to Adam and other homeless volunteers as ‘client helpers’, rather than as guest ‘volunteers’. This use of language further persuaded Adam he was a discredited individual within this context, with ‘volunteer’ status reserved for homed, non-stigmatised individuals. Adam felt stripped of his worthwhile public identity and excluded from meaningful established social networks. He commented, “*I know they [the organisation] think I, and the rest of us, are just a piece of worthless shit...but we do care*”. This changing discourse around ‘volunteer’ and ‘client helper’ may have emerged as an unconscious strategy to manage dependency. Dependency, however, understood in terms of de-stigmatisation and social inclusion processes has dangerous consequences when the pendulum swings. As a result, volunteers such as Adam, underwent an identity crisis, which was experienced as yet another traumatic event. This often led to increased mobility and loneliness as social networks were severed and the individual retreated. This effectively hampered the ability for social trust to be re-established, destabilizing the social order, an observation also made by Misztal (2001) in her own research.

Socialising with the ‘normals’ from Ozanam

Surveillance and consequent attempts by homeless people at being invisible as responses to societal rejection and alienation are well documented. More than 30 years ago in the USA, Spradley (1970) described the process of societal alienation starting with friends and kinsmen due to excessive drinking or an inability to maintain employment. He described the process as one whereby the gap widens dramatically when the individual is jailed or homeless, and then labelled accordingly, and commented, “*An identity vacuum is created within as items of personal property, symbols of their identity, disappear*” (p.255). This alienation leads to a loss of a respectable identity as the disconnection with family, friends and jobs occurs. Spradley (1970) observed that as society rejected these men, institutions transformed their identities and provided ‘a right of passage’ for their entry into an alternative social network - the homeless.

Ozanam House is one such institution which facilitated a transformation of identity and entry into a homeless social network. Ozanam House staff and/or committee arranged

various social functions both within the premises and at alternative venues. The significance to homeless people of participating in these events was profound and was often the topic of conversation for several months to follow. The following example describes Christmas celebrations held at Ozanam House.

An enormous effort was made by staff and Committee members to provide a Christmas celebration wherein guests experienced what Davis (1961) described as, a degree of personalised recognition, social validation and normalisation of interactions. A menu was carefully developed which included turkey, ham, pudding and other traditional Australian Christmas foods. There were gifts for children and guests were encouraged to stay and socialise. The service of food differed from the norm in that guests collected an empty plate and passed by tables where non-homeless waiters served up portions of selected dishes. The food was well received with many guests requesting seconds and takeaway containers. However, guests were reluctant to approach the service area themselves and make requests as they had often done under normal circumstances. The resources required to pull off such an event had resulted in many new or unknown volunteers arriving to help out on Christmas Day for the first time. Serving food was a task that could be more readily delegated to someone unfamiliar with the place and people. While staff, committee and regular volunteers worked behind the scenes and socialised with guests to bring about degrees of personalised recognition, social validation and normalisation of interactions (Davis, 1961), these actions were offset by the presence of unknown volunteers serving food. There was a sentiment among some Committee members and volunteers that the unknown volunteers gained more through their token day of Christian charity, than did the intended recipients of this event.

Ozanam House, like many homeless services, can only survive with the support of volunteer labour. The management and function of volunteers in homeless settings are critical elements to an institutions philosophy and ideology around service delivery. This Christmas example highlights some of the issues around volunteers as they inadvertently affect stigma management in such settings.

The next example describes social events organised by Committee members and/or staff in appreciation of regular volunteers (including guest and 'normal' volunteers). During my fieldwork I attended three of these events in which St Vincent de Paul covered the bill for a dinner out at a city restaurant. The first was held at a popular buffet lunch at the Casino very early on in my fieldwork. I recall meeting many staff and their partners from the head office and other people connected with the organisation in various capacities. The only people I had been previously acquainted with were the staff, regular guest volunteers at the time and a few Committee members. I observed the discomfort of the guest volunteers as introductions were made and their hesitance at choosing food. Much of the table discussion where I sat involved senior St Vincent de Paul members, and centred on their negotiations and the moral implications of obtaining funding derived from poker machines. I learned later that none of the people from head office were known to the guest volunteers. The nature of the conversation was alienating and confronting and probably unexpected by volunteers. Again, this was not the desired intention of the event and the reprieve from stigma generally existed only briefly before and after the event.

The second and third social events of this nature were held in a restaurant in town, and were well attended by guest volunteers (about 12) and a few Committee members. No one from 'head office' attended/was invited. Despite some uncertainty around what constituted appropriate 'normal' behaviour, these two evening events were thoroughly enjoyed by all the homeless volunteers. Reference was often made to how much food was consumed, particularly seafood. Their stigmatised homeless identity had been successfully managed with the support of Committee members, and the events were recounted in a positive light for a long time to follow.

In addition to the strategies used for stigma management outlined so far, individuals also employed multiple other dis-identifying strategies. My own experience with developing relationships with individuals at Ozanam House further illustrates the use of dis-identifier while in pursuit of a normalised relationship. For example, a couple of guests would regularly discuss their use of the public library located at Parliament House and engage

me in discussions on recent articles in political journals. Another would talk about his study, and another his ability to complete forms. Many literate guests read the local paper and provided a passionate political commentary. One guest quoted poetry and attempted to philosophise on life. And the majority provided tips on raising children. These conversations were quite deliberate. After all, everyone knew I was a student who used the library, presumably read, was doing a doctorate in philosophy (hence the philosopher) and had children. The flip side of this, of course, was as we found common ground and developed a sense of trust between one another. I initiated conversations with guests about their life experiences, inadvertently reminding individuals of their stigma. Although this jeopardised the potential for a normal and trusting relationship, guests apparently did not *feel* stigmatised as a consequence of discussing their stigmas.

Summary

The stigma experienced by guests at Ozanam House impacted on many aspects of daily life. This chapter has explored the management strategies employed by individuals to deal with their stigma. As evidenced, homeless people tried not to look homeless, and paid attention to their appearance. This study found that many valued personal belongings and they were important in constructing a non-stigmatised identity. However, being homeless increased the risk of losing possessions and also jeopardised those occasions when an individual could pass off as a 'normal' individual.

This study has revealed the information management strategies used by this homeless population to conceal their homeless identity during social interactions within and beyond the institutional environment and make attempts to 'pass off' as a 'discreditable', with a non-stigmatised public identity. Individuals managed stigma both within the institutional environment and beyond it, employing avoidance of stigma symbols or identifiers.

Despite the awareness of homeless individuals of their differences, the findings of this study reveal Darwin's homeless demonstrated resilience in spite of the multiple traumatic experiences they endured. They rejected some of the assigned stigma thrust upon them,

and participated to varying degrees in society. This research has found that many of Ozanam's guests had a vision or ideas about how they ought to be regarded, raising the question whether the ability to see oneself as a 'normal' contributed to a higher degree of resilience in individuals.

Several guests wanted their intelligence recognised, and others their literacy, trade skills or general knowledge. Others wanted to be regarded as creative, expert, informed or responsible. Nearly all key informants in this study were authoritative about child rearing and expressed deep empathy for the challenges confronting the contemporary family. On occasion, guests felt confident to own these attributes in the Ozanam House setting, reinforced by staff and other non-homeless individuals. Yet staff and other non-homeless individuals also saw guests in multiple ways. Other guests were sometimes: vulnerable; unstable; lacking in self confidence and self worth; secretive; racist or homophobic; poverty stricken; drug and/or alcohol dependent; attracting trouble; highly fearful; and pathetic or helpless.

This study also found that the interactions of homeless individuals with the 'normals' at and beyond the institution, and the many double edged swords that were created, potentially damaged identity. There are important considerations here for service providers, particularly as they consider the notion of dependency within this context. Further, there are implications for services that are dependent on volunteers for their ongoing survival. The evidence points to the need for services to reflect on the tensions created through service provision driven by a particular philosophy of non-judgement and the stigmatisation processes that are at work which generate judgement about people.

Whether discredited and/or discreditable, guests at Ozanam House were provided with a social setting in which temporal escape from the stigma attached to their homelessness could be found to varying degrees. According to Anderson, Snow and Cress (2003), 'social resources', such as Ozanam House, permit individuals to be identified by "*distinct personalities, relationships and biographies*" (p.286). For a few, however, who were new to homelessness, being at Ozanam House generated a sense of shame.

The homeless people in this study often expressed their sense of social exclusion or rejection. The evidence clearly indicates they felt stigmatised by their homelessness, and moved between being both discredited and discreditable, depending with whom the individual was interacting and the nature of their relationship. Presentation at Ozanam House as 'homeless' or 'very poor' was, by default, a clear example of an individual's inability to conceal stigma. From an etic viewpoint, being Aboriginal added an additional layer to managing stigma as Aboriginal guests were likely to be being discredited on account of both their homelessness and ethnicity. As Anderson *et al* (2003) observed, "...the anonymous black male is usually an ambiguous figure who arouses the utmost caution and is generally considered dangerous until he proves he is not..." (p.183).

Stigma shaped both individual and public identities and was further complicated by the interaction of different cultural norms, beliefs and expectations in a shared environment, for part or all of the time. This influenced the process of stigmatisation from the 'normals' to the stigmatised and determined how the stigmatised individual perceived his or her own stigma. In turn, the way in which individuals experienced and negotiated their stigmatised identity helped them to define what constituted 'normal'.

Stigma, however, was negotiated along with a host of other hardships such as unemployment, inadequate shelter, poor health and nourishment, the effects of trauma and limited financial resources. Phelan *et al* (1997) stated:

Stigma is not only likely to have negative consequences for their [homeless people] self-esteem and psychological wellbeing; it also suggests the possibility that they will face discrimination in social relations, employment, and housing, which will contribute to the perpetuation of their homeless condition, and that the public may not support policies that would improve their situation (p.335).

Goffman's theory on stigma has resonance with this study into Darwin's homeless. His stigma theory has been effective in explaining the findings in this study. Applying his theory, this chapter has described the interaction between Darwin's homeless and the 'normals', the experience of stigma and stigmatising processes.

Although Goffman (1963) has provided a useful theoretical framework for explaining the processes that take place among this population around stigma and deviance and their implications for identity, the theory had one minor limitation for this study. Goffman described stigmatised individuals as being either ‘discredited’ or as ‘discreditable’. This study has illustrated that the process of stigmatisation is a highly complex one with many players and stigmatised individuals were both discredited and discreditable at the same time, depending on the social dynamics and context of the situation. Consequently, the stigmatised individual has an identity that remains fluid, which creates the possibility for an individual to move towards normality. This study has demonstrated, however, that normality is unlikely due to the trauma endured by this population and because of the extent to which individuals were entrenched in a homeless lifestyle. Chronically homeless individuals may attain a relatively normal lifestyle, but society is unlikely to regard them as ‘normal’ or allow ‘normal’ participation in society.

The following chapter is the last of five chapters in this thesis to discuss the research findings. It brings together the key dimensions of the homeless experience which had the most significant influence on the health of Ozanam’s guests, and describes the health seeking behaviours in which homeless people engaged in within a Long Grassier context.

Chapter Ten

Health in a homeless culture dominated by trauma and stigma

Homeless people have significantly poorer health than the general community - mental health problems are particularly prevalent. They face substantial barriers to accessing health services, including lack of transport, lack of money, unhelpful reactions from people within the health system and lack of information about health services. They are also less likely to recognise that they have health-care needs and less equipped to follow through with medication and self-care regimes (Commonwealth Advisory Committee on Homelessness, 2001; p.34).

In **Chapter Eight**, I discussed the role of trauma in the daily lives of Ozanam's homeless guests. I pointed to the high prevalence of significant traumatic events, and the probability that many suffer from Post Traumatic Stress Disorder. As a key dimension of the homeless experience emerging through this study, much of daily life processes can be explained as a response to, or symptomatic of, trauma, or as an attempt to avoid trauma. Interwoven in this fabric of daily life is the matter of stigma. In **Chapter Nine**, I examined the processes by which Ozanam's guests experienced stigma, also a key dimension of the homeless experience, and the subsequent effects on individual and social identities and wellbeing. Both of these chapters were in fact about health; mental and physical health, wellbeing, social and spiritual health. Yet together with **Chapter Six** (Ozanam House: the study site) and **Chapter Seven** (homeless knowledge and the institutional landscape), they were also about painting a socio-cultural portrait in which daily life was experienced and meaning was negotiated.

In this chapter, I turn to a pointed discussion on the ‘health’ of Ozanam’s homeless from the premise that health must be understood from within this social and cultural context of daily life. In short, health for Ozanam’s homeless people must be considered within a framework of compounded trauma interacting with the ongoing processes and outcomes of stigmatisation. Further, as a key dimension of the homeless experience, the stories in this study illustrate the importance of the ways in which homeless knowledge was accumulated and the ways in which homeless institutions became important resources to homeless people in managing their daily life and their health.

The consequences stemming from trauma and stigma endured by all of this population had a profound influence on notions of health. Health seeking behaviours were significantly influenced by the way in which knowledge was accumulated by the homeless population under study. This key dimension to the homeless experience was found to have played a pivotal role in health care management and in accessing health care services, as evidenced in this study by the role of Ozanam House in this aspect of life.

Most commonly participants conceptualised their health in terms of wellbeing. Thus, good and bad health lay at the intersection between wellbeing, stigma and trauma. Through discussions with Ozanam House guests, it was evident that wellbeing was affected by many factors, the key ones being: physical health; diet; mental health; sexual health; assaults to identity including disconnection from place and events that invoked a sense of shame; alcohol and drugs; sorcery; loneliness and social disconnectedness. Social disconnectedness and loneliness emerged as powerful determinants of wellbeing and influenced decision making on a daily basis. These complex interactions were also affected by other factors, for example, an individual’s character or resilience.

This chapter will describe how each of these key factors identified in the data (listed above) influenced wellbeing and affected life quality. The circumstances which led to individuals seeking treatment from health care providers are also explored. In doing so,

the stigmatising experiences of homeless individuals as they interacted with the health care system are highlighted. Some of the health concerns of homeless individuals which did not result in treatment by health care professionals, or which were unavailable to this population, are also explored.

I examine the matter of social connectedness and loneliness and raise critical questions for housing authorities and other agencies involved in the delivery of services to homeless populations. Housing is consistently regarded by health professionals, governments and international organisations, such as the World Health Organization and the Office of United Nations High Commissioner for Human Rights (OHCHR), as a precursor to achieving good health and life quality. The OHCHR (2006) stated:

Having a secure place to live, is one of the fundamental elements for human dignity, physical and mental health and overall quality of life, which enables one's development (p.i).

Despite this generally agreed upon position, this Darwin-based study found that for many individuals, housing created a tension around social connectedness and was generative of profound loneliness, adversely affecting some aspects of affecting wellbeing and life quality. Individuals weighed up 'being housed' against the social and cultural consequences of being disenfranchised from the only social group where their stigma was tolerated and the rules of life properly understood. A confounding factor of being housed was being sober, as will be expanded on later.

Housing chronically homeless people did not always reverse the effects of stigma, but rather there was evidence to show it sometimes enhanced them. For some people who moved into housing during this study, the loneliness and isolation was potentially crippling. This situation served to reinforce individuals' stigma, as living in a house did not secure them as a 'normal'. Rather, it tended to place a stigmatised individual under closer examination by the 'normals'. In such cases, difference was more obvious. Housing increased the two-way surveillance and amplified the reactive 'suspicious' behaviour of the stigmatised homeless person. Although there is much evidence to support that a lack of housing seriously compromises an individual's 'health', this study

showed that the mental health and wellbeing for several chronically homeless individuals was in fact impaired by returning them to contemporary housing structures.

The nexus of stigma and identity, trauma and health were central to the life quality of homeless people in this study. Stigma and trauma affected life decisions and, for many, seriously undermined individuals' capacity to increase the resource pool available to meet their own health needs. This influenced homeless persons' attitudes towards the management of their health and health seeking behaviours and affected their interactions with health care providers. Homeless individuals in this study generally felt they had low level of control over their health when the issue was being 'fixed' or 'treated' by health care providers. Rarely did such experiences engender a sense of control over life, although when a problem was fixed, individuals were delighted.

The Role of Ozanam House in Long Grass Health

Accessing care with a 'normal'

With the support of a 'normal', Ozanam's guests and guest volunteers were more inclined to engage with health and medical services, believing they would receive proper treatment and be regarded as a deserving patient. During my field work there were many instances when I observed Ozanam House staff, as 'normals', brokering relationships between guests and various health services. I was also urged by guests on several occasions to take on this role. For example, on one occasion an older Aboriginal man was fitting in the park next door to Ozanam. Billy, his friend, explained that the fitting man had left his medication where he had been camping when he went off in search of food. He had epilepsy; the result of a head trauma. Billy asked if I would call for an ambulance. While we waited for the service, Billy comforted the man by gently rubbing his back and reassuring him with words like, 'don't worry mate, you just rest'. Billy appeared to have everything under control, so I began my exit. When this was apparent, Billy urged me to stay. He argued, "*no, you must tell them, they will listen to you*". I responded by saying, "*but it is you who knows what is going on here*". Billy persisted, and I stayed and repeated Billy's words, almost verbatim, to the paramedics.

Billy was bright, articulate, educated and compassionate. But this was not enough for Billy to feel confident his friend would be treated and cared for properly, nor that his knowledge and observations would be believed and regarded as credible. After all, Billy and his friend were homeless, alcoholic and Aboriginal.

This scenario illustrates how past experiences, as a homeless person with medical and health services (and other institutions in society), informed individual behaviour with such services. The power imbalance that exists between lay people and the medical profession is compounded here for homeless people, particularly Aboriginal homeless people. Their experiences have dictated the methods which are construed as effective in obtaining care and in which accountability is constructed. Billy, and many other homeless people in this study, believed that proper treatment could only be achieved if a 'normal' was involved in the interaction. Consequently, Ozanam House staff members were often called upon to facilitate access for guests to a range of health care services. Ozanam's staff were also often the only 'normals' guests interacted with on a daily basis.

It was the view of several staff, however, that without the involvement of a 'normal', Ozanam's homeless would not have access to health care services at all; a view supported by countless examples. One such example which clearly illustrated why staff had this belief related to the situation experienced when a staff member arrived at work on a Monday morning after having had the weekend off. A guest had been in the park since Friday, unable to move due to a suspected broken leg. The staff member asked why he was still in the park and had not arranged for an ambulance. A relative of the guest had in fact called for an ambulance, and more than once. The staff member then called and an ambulance soon arrived. The guest had spent three nights there, the first night of which he was violently assaulted for money as it had been a welfare payment week. He had sat in his own waste, in pain, and dependant on the capacity and willingness of other Long Grassers to care for him. Four months later, this guest died as a result of an

infection stemming from untreated chronic Osteomyelitis²³. Experiences such as this one were key motivating factors for staff in their taking on of the ‘normal’ role during interactions with health care services.

Paradoxically, while staff were often the ‘normal’ in interactions with health care services, some staff reported feeling disempowered and discredited during such engagements. They believed the health care services did not value or accept what they were saying, citing numerous examples to illustrate their claims. For instance, there were instances where ‘proper’ treatment for the guest ceased once the staff member was no longer physically present. According to Goffman (1963), this type of process stems from the ‘normal’ person being assigned a ‘courtesy’ stigma. This occurs when the ‘normal’, related through social connections to the stigmatised person, leads society to treat both individuals as one. The normal is “*obliged to share some of the discredit of the stigmatized person to whom they are related*” (p.30). There were implications of this process in the interactions that occurred between guests and health care providers when Ozanam’s staff acted as intermediaries and were assigned with a courtesy stigma. Goffman (1963) observed, “*The person with a courtesy stigma can make both the stigmatized and normal uncomfortable: by always being ready to carry the burden that is not ‘really’ theirs, they can confront everyone else with too much morality...*” (p.31).

Although I can not comment on whether guests felt discomfort associated with staff courtesy stigmas, staff did employ strategies to overcome the consequences of their ascribed stigma. One staff member described taking a Long Grass woman who had been raped to a trusted and credible local doctor in order to obtain ‘proper’ medical and police services. (Although the police responded, they argued the woman would not cope with the additional trauma of a rape identi-kit and physical examination at the hospital, leaving a business card and instruction to call in the morning if she wanted to pursue the matter).

²³ Osteomyelitis is an infection in the bone. Risk factors for this condition include recent trauma. Treatment usually involves an extended course (six weeks) of antibiotics (Medline Plus, 2006).

Ozanam's guests typically accessed health care institutions and the shelter at Ozanam House when they were at crisis point. This usually occurred when the discomfort or pain experienced elsewhere became too great to continue to negotiate the demands of daily life in the Long Grass. In short, guests were rarely proactive with health, but rather reactive to serious illness. As such, guests tended to conceptualise health care institutions as places to deal with illnesses or as places to die.

For some guests, their involvement in the health care system was passive, initiated by police or ambulance services, following a telephone call from a concerned person. A few guests initiated their own visits to health care providers, but for many guests, Ozanam House played a pivotal role in providing and/or facilitating access to health services. Staff supported guests in accessing health care services through several ways. They facilitated appointments with clinics, general practitioners and an array of specialists and other allied health services. The level of support provided varied and depended on individual needs. As such, facilitation of these appointments could mean anything from making phone calls to booking taxis or accompanying individuals to appointments.

Practical support following appointments was also provided, including the provision of a place to rest and recover, obtaining medication and explaining dose requirements, support with related or follow-up appointments and providing relevant information or explanations about the individual's problems. In addition, Ozanam staff routinely administered first aid, including cleaning and dressing wounds, and encouraging guests to stay in the shelter, rest and build their strength. For some, refuge with recovery was sought to avoid engagement with the health services, and for others refuge and recovery followed a period of engagement with the health service, such as hospitalisation.

Working to overcome the real and imagined barriers to health care services, Ozanam staff provided accurate, local and relevant information to guests on how to negotiate their way through the services. For example, information on the X-ray process, what bulk billing meant and *triage* at the hospital's accident and emergency department was given.

Information sharing was often undertaken in an informal manner through one-on-one interactions or via group processes.

Generating wellbeing through creating home

Ozanam House staff members were able to facilitate access to health care services because they concentrated on enhancing individual's wellbeing through building trusting and supportive relationships with guests. Shelter guests described forming a relationship with the service during their stay which was profound and lasting. Guests looked to the service for comfort, to gain a sense of responsibility, to make a contribution or to participate in social interactions. For some former and regular shelter guests, the people (guests, volunteers, staff etc) at Ozanam House became a family of sorts. For all guests, participation in Ozanam House activities and/or services was important for wellbeing.

Ozanam House was seen by many homeless guests as a place where they could belong and return to, as evidenced by the numerous comments made, such as, “...*my home in the Long Grass*” and “...*a home away from home*”. As a ‘home’, a guest would take time to mend, recover and interact with people who had a shared knowledge about their daily life and social connections. For example, one guest commented:

I had been living in a share flat arrangement. It was not working out. My flat mate was inviting people over and the dynamics were not good. Bits and pieces would also go missing. It was no good for my health so I came to Vinnies to work out what I would do...lots of people come to here because it helps them become well emotionally and that the people become a family. It is like a home to return to.

Those people with a greater level of involvement with Ozanam House consistently made statements such as this one below, initially presented in **Chapter Nine**:

It is always a good day when you are at Vinnies. There is always something to do down there, you're never bored, that is one thing and you always see different people come in and never seen them before. All the different people are starting to rock up to Vinnies now that never came before. A lot of them at Vinnies, now they know me by my first name and I see them up the street and they say, g'day Zac, how are you going?

There were expressions of dignity and mutual care between people within the setting. Ozanam House was a relatively safe place with few apparent external pressures, and where disharmony was mostly effectively managed by the rules, staff and Committee members. Guests and volunteers acted to protect their place as one of non-violence (although there were a few episodes of physical violence and verbal abuse during my field work), and one that was private. This was clearly expressed on the few occasions local media visited Ozanam in an effort to advocate for the plight of the poor. Being on television was discrediting and publicly shamed homeless people. Guests managed this situation by hiding, leaving and asking specifically not to be filmed. One guest commented, “*they should go away and leave us in peace to eat our lunch*”.

Ozanam House played a pivotal role in health care and in linking individuals to other health care providers in Darwin. Staff became aware of health concerns through ongoing interactions with guests. Some guests would divulge their problems freely (or their problems were obvious) and others required more encouragement by staff to share their concerns. It was common for other guests to report on the poor wellbeing and illness experienced by other homeless individuals, prompting some action to locate the individual and get them to Ozanam House. Both staff and guests initiated these discussions, as they were aware when someone was absent from the service or had fallen ill in the Long Grass.

The role that Ozanam House played in health care was consistent with the findings of other studies. For example, the Commonwealth Advisory Committee on Homelessness (2001) observed that research concluded:

...that the homeless find specialist homelessness services more responsive to their health needs than generalist health services, including hospitals and emergency departments (p.36).

Health concerns and beliefs of guests

Reported health complaints

Ozanam's guests presented with a myriad of physical and mental health problems. Some problems were acute and some were chronic. Specific diagnosed diseases reported included kidney failure, cirrhosis of the liver, dementia, psychiatric conditions, hepatitis C, Human Immunodeficiency Virus (HIV), other sexually transmitted infections (including Chlamydia, gonorrhoea and syphilis) and drug (usually marijuana) and alcohol addictions. Alcohol addictions were commonplace, and had a severe impact on physical and mental health status²⁴. One guest reported having a morphine addiction, and he was also the only guest to have been formally diagnosed with Post Traumatic Stress Disorder although received no treatment for his disorder. Some guests took medication, from time to time, for high blood pressure.

Guests, in general, reported other temporary conditions, including physical injuries resulting from fighting or accidents (such as broken bones, dental problems, bruising and tenderness, cuts and abrasions), detoxification from drugs and/or alcohol, being under weight, periods of mental illness (such as depression, confusion and psychotic episodes), body and head lice, boils, scabies and other skin infections. Some guests appeared to have intellectual deficits and often included those who had a long history of petrol sniffing or heavy drinking of cask wine. A few regular guests had acquired brain injuries and several would probably be regarded as legally blind. Another guest had Hodgkinson's disease, another Cerebral palsy and another had a physical disability which severely impaired his mobility.

Many of the complaints discussed here affected wellbeing and can be linked to individuals' trauma, their homelessness and the experience of being stigmatised.

²⁴ As discussed in chapter eight, alcohol addiction is likely to be connected to trauma, and used as a management device.

‘Crazy people’

Ozanam’s homeless were vulnerable to mental health problems, with many reporting feeling depressed or feeling constantly unhappy. Often the feelings of depression and unhappiness were directly linked to a traumatic event or events that had occurred in the individuals’ lives (as discussed in **Chapter Eight**). While some believed craziness was caused by substance abuse, other guests attributed their depression to poor physical health:

My hip is sore, and my eye and ear make me unhappy as I get older. I feel sad....
But I think it is not good to be happy all of the time...people need time to think.

There was a varying acceptance of mental illness amongst Ozanam’s guests. Some guests were disgusted by those with obvious mental deficits, particularly if the individual was seen to have contributed to their mental status through practices such as long term petrol sniffing. Tolerance was increased if the individual was born that way or involved in an accident. Tolerance was also increased when the illness was depression related, particularly when individuals could empathise with the cause of another’s depression (when the cause of this condition was known, empathy was commonly expressed probably because all of Ozanam’s guests, as discussed in **Chapter Eight**, had endured a/multiple significant traumatic event/s). And finally, tolerance was increased if the individual was a volunteer at Ozanam House and was well known and reliable. As one guest said about a guest volunteer, *“he is as crazy as they come, but he’s a decent bloke”*. Despite the fact that some circumstances increased tolerance, individuals with mental illnesses were stigmatised by other homeless people and usually avoided, tending to be loners at Ozanam, as they departed from the rules constituting normality within this setting.

During my fieldwork, I met at least five homeless individuals at Ozanam who had diagnosed psychiatric conditions. Each individual fervently rejected the diagnoses, usually because of distrust for the doctor and/or the medical system in which the doctor operated. Individuals conceded they were different, and should be allowed to be, and that did not justify the label or the need for prescribed medication.

...I had a breakdown and soon the doctor diagnosed me with manic depressive delusional psychosis. I dispute this diagnoses and label and because of the doctor, I am now expected to behave in a certain way. I am not delusional and my actions are completely logical. I think my problem is due to thinking too fast...a superior mind, intellect. I am no different from the next person except I act out my thoughts.

As loners excluded from participating in informal homeless social networks, the guests with diagnosed psychiatric conditions craved social interaction with Ozanam's staff. Being treated with respect and as different, rather than as sick, allowed some individuals to feel relatively normal, even if only for a short period now and again.

There is profound stigma associated with mental illness and as noted above, guests at Ozanam demonstrated a lower tolerance towards those with such illnesses. This led to further social exclusion and loneliness, possibly exacerbating the illness. As homeless people do not necessarily have access to the resources that can diminish or protect them from the social consequences of mental illness, it is no surprise then that Ozanam's guests did not actively explore whether they had mental illness associated with trauma, yet they shared detailed accounts of traumatic events. (In fact, only one homeless person in this study, Edwin, declared being diagnosed with PTSD). To obtain a diagnosis and engage in treatment was declaration of yet another stigmatising condition which was deeply discrediting.

In any case, as discussed in **Chapter Three** and **Chapter Eight**, preferred psychologically-based treatment options discussed in the literature are incompatible with the reality of Long Grass living and an individual's homelessness. According to the NCPTSD (2006b), an individual's homelessness must be resolved prior to the commencement of any treatment for PTSD. Treatment while homeless was problematic for several reasons. One reason relates to hyper-vigilance, a common behaviour among people who have been traumatised. Challenging hyper-vigilance is often a first step in treatment programs, in order to overcome heightened arousal. This was problematic for Ozanam's homeless people because vigilance was essential if people are to adequately protect themselves, with heightened arousal being normal under such circumstances.

Treatment with Cognitive Behavioural Therapy (CBT) typically follows and includes group sessions along with homework. Based on the incorrect assumption that Ozanam's homeless individuals did not have a preoccupation with daily survival, CBT unpacks an individual's anxieties in order to ascertain the likelihood of an event associated with the anxiety from occurring. In the case of Ozanam's homeless, the likelihood was actually high, reinforcing the appropriateness of anxiety and the need for hyper-vigilance among homeless people. Therefore, a diagnosis of a mental illness such as PTSD may render homeless individuals with a perpetual stigma that can not be overcome with treatment.

The poor physical and mental health of homeless populations has been well documented (see **Chapter Two** and **Three**). It is already well established that poor physical and particularly poor mental health feature as key causes of homelessness. This study has illustrated that homeless individuals tended to perceive their physical and mental health and wellbeing as also deteriorating during their homelessness.

Diet, food safety and volunteering

The food provided by Ozanam House provided a valid entry point for guests to access the service. The food was also a legitimising factor for an ongoing association between guests and the service. Food supply (security) was an ongoing concern or preoccupation for most guests, some planning their entire day around accessing a meal while drinking. The nutritional benefits derived from the food were important to many people, with weight gaining foods and improved diets critical to others. The awareness of the nutritional benefits of food, however, were secondary to obtaining sustenance and alleviating hunger.

Many of Ozanam's guests appeared under weight. Weight was likely to have been influenced by a high level of daily physical activity, alcohol addictions, insufficient food, stress, anxiety and other health problems and/or illnesses. Homeless individuals would often comment on their size and weight or the weight of others. 'Getting fat' was celebrated as a sign of recovery from poor health associated with 'living rough' or 'doing it tough' in the Long Grass, or, as a sign of wellness. This sentiment was illustrated by

one guest remarking on his wife's appearance following a brief period away from Darwin:

She is well now she has been away...she is eating and is bigger [pointing to her stomach]...when she was here she only ate little bits, not enough.

Another guest also commented on his wife's wellness as she consumed a steak. He commented:

...she is doing really well and is 40 kilograms now. That piece of meat would have taken her a week to eat before...

One woman recounted her happiness about her father returning, albeit temporarily, to their country. She explained:

In Darwin they do not care for him, he drinks moselle and does not eat...they do not look after him. At home he only can drink beer and can not get too drunk. He eats lots of meat – fish, kangaroo...they fish every day, and eat vegetables.

The following guest described his own physique:

Before I ended up here I was real strong. My shoulders and arms had muscles...all from workin' on the farm. Now, cause of the drugs an all and livin' rough, I'm only half the size I used to be. I'm skinny as...see the way me clothes hang? I'm like a coat hanger.

For many of Ozanam's homeless, the only food source accessed with regularity was the daily meal service. With restricted storage and carrying capacity, limited cooking equipment and few opportunities to prepare fresh food, Long grassers had very restricted diets. The significance of the food security offered by Ozanam was emphasised when the organisation underwent changes, leaving guests to feel vulnerable. Many guests raised concerns about the impact of the organisational changes to their relationship with staff, and also about food supplies.

...This [Vinnies] is my family, they [the staff] are my family. They care for me and clothe me all the time. I eat food from here so I do not go hungry.

One morning Billy inquired, "*Who is going to run the place? Who will do the cooking?*" Staff spent considerable time allaying his, and others', fears by giving assurances that meals would continue to be served. Despite this, for several days to follow, Billy and

several other guests asked if I would keep coming to Vinnies, and if so, would I do the cooking. For many guests, there was a strong association between meals, social connectedness and belonging. Accessing food at Ozanam was a daily ritual that satisfied hunger and at the same time provided individuals with a social network and identity (as explored in **Chapter Nine**).

Hunger was a daily experience for Ozanam's homeless. The lunch meal service started at 11.00am and guests would often not have food again until breakfast or lunch the following day. As such, it was not unusual for guests to have second serves, or depending on the meal, discretely take food away. Ozanam provided bags of donated bread to anyone who wanted them and some guests supplemented their Ozanam food with this between meals. A few guests mentioned having soup for dinner or occasionally buying a meal from another service, although those with money to buy food tended to prefer fast food from a shop. Occasionally, I would be contacted by guests that I knew well and I would start the conversation with 'hello, how are you?' to which would receive a reply of, 'Oh, I'm very hungry'. Going without food, eating bread or buying food from a shop allowed for greater flexibility in daily movements. Food accessibility was also affected by where an individual planned to sleep.

Guest volunteers and staff within the Ozanam House setting were generally responsive and compassionate towards people who were hungry and wanted food, even if it meant bending or breaking the rules. At the same time, there were a few occasions when guest volunteers who had worked at Vinnies for an extended period were perhaps the most critical of meal guests receiving food. For example, Vinnies received a donation of tinned foods and other specialty goods which were of little use to the meal service due to the quantity and the 'special' nature of the goods. One guest volunteer was invited to take some of the goods, which he accepted and filled a couple of shopping bags. At the same time, a staff member asked me if there were any salad items that needed to be picked up before the next meal service. I indicated that the tomatoes had run out. The guest volunteer interjected:

You must never pay more than \$2.50 a kilo for tomatoes. Anyway, what is wrong with porridge? We used to live on it, didn't we, why can't they. You see, if they are hungry they can eat porridge. It is simple, it is economics. You have to be able to afford it.

Another guest volunteer who had experienced prolonged and extreme trauma and poverty, and who also used alcohol and marijuana regularly, reflected on the issue of hunger as a broader matter linked to government policy, services and work.

...nobody in this country goes hungry...in my country if we had Vinnies nobody would work, but in Australia we have Centrelink so everyone has money and food. The people in the Long Grass they would rather not pay rent and drink and stay in the Long Grass. That is what they prefer...to drink.

With past training in public health and food safety, I found observing the processes and behaviour around food to be second nature, and unavoidable. I noted that alleviating hunger and consuming weight-gaining foods were often cited by guests as important, yet food safety was not identified as a problem, nor was it associated with weight loss among guests. However there was evidence to suggest that episodes of diarrhoea were common through complaints, multiple visits to the toilet over a short period (such as a lunch service) and soiled clothing. It is likely that a combination of factors rendered some guests dehydrated and malnourished, including: food and water borne diarrhoeal diseases emerging from reduced levels of hygiene and sanitation; unsafe food sources (such as bins); unsuitable storage of perishable foods available to homeless individuals; the diuretic effects of alcohol and the replacement of food with alcohol; and the hot and humid climatic conditions in Darwin. Diet was regarded by many homeless individuals as contributing to poor physical health status, as illustrated by the following quotes.

...he has big boils on his head, and his arms are one big infected mess...He says the arm is because he does not eat vegetables...

...I get boils when I stay in the Long Grass. It is because I do not sleep and I don't eat properly. I don't get to eat enough green stuff, so I try to eat a lot of salad here. The boils are worse in the build up...I get hot and sweaty, and they get infected. I hate it.

Many food safety risks stemmed from the inherent conditions associated with homelessness. Ozanam House itself exposed guests to potential food safety hazards.

Large quantities of food were prepared in advance for guests. Hot food was frequently stored for long periods at room temperature, often for more than two hours, in an environment where food could readily be contaminated, particularly by people and flies. There was no apparent system to prevent cross contamination of cooked food from uncooked food in food preparation or storage.

The safety of the food at Ozanam was compromised further by the food handlers themselves. Most were homeless guest volunteers and had not received training in food handling and hygiene. Furthermore, the facilities and resources necessary to attend to personal hygiene were not available all of the time. This situation was exacerbated by the fact that guest volunteers continued to handle food at Ozanam when they were unwell. For example, there were many occasions when food was prepared by people who had the flu or skin infections and open wounds on their hands. Now and again, a guest volunteer would declare their former experience in a kitchen and would assert their knowledge, and tell another guest volunteer, for example to ‘wear gloves because of your Hep C’. The strategies discussed by guest volunteers among one another and their kitchen practices, however, revealed a limited understanding of basic food safety measures. Declaring a knowledge of food safety based former experience fit more in the pattern of an individual saying ‘I’ve not always been homeless and before I had a credible identity’.

The safety of the food at Ozanam probably presented a higher risk to homeless individuals than food from other settings, such as a domestic or commercial kitchen, yet it remained safer than some of the alternatives available to this population. In an attempt to reduce the risks to unsafe food, staff routinely acted to promote hygienic practices in informal ways to both guests and guest volunteers. For instance, staff would model good practice and explain why they were doing certain tasks. Hence, they used an informative and demonstrative approach rather than an instructive one, particularly where new guest volunteers were concerned.

One good example of this related to the sterilisation of cutlery. Typically this involved soaking cutlery in water with bleach for several minutes, followed by rinsing, draining

and then air drying once it had already been washed in warm water with detergent. After staff explained and demonstrated this process, through their own initiative, guest volunteers enthusiastically performed the task themselves. This process quickly became routine, following the washing up process. Once staff became redundant, this changed and for a period 'sterilisation' replaced washing altogether and involved submerging cutlery for less than a minute in a solution of bleach and water.

Other examples of staff modelling good hygienic practices included regular hand washing and cleaning and sterilising dining and food preparation tables. Staff also discretely excluded guests who were not volunteers from the kitchen area, and occasionally (and very gently) encouraged guest volunteers to wash hands. Once relationships had been well established between a guest volunteer and a staff member, there was an increased use of a more instructional approach, although this remained low key.

The involvement of guest volunteers in food services at Ozanam House continued to contribute to the tenuous food safety situation for several reasons. Firstly, the service needed volunteers to operate and guest volunteers could participate by helping with meals (among other things). In this way an unspoken mutual obligation was achieved, whereby the individual could see themselves, and be seen, as deserving. Secondly, the service also wanted guest volunteers to become involved in order to develop trust so some of the more complex issues in their lives could be explored in a safe environment. Thirdly, there was an imperative for Ozanam to provide a place for homeless individuals to belong and have a social context.

Volunteering at Ozanam was a healthful choice for homeless guests. It was also empowering because in most instances volunteering was a choice rather than an expectation, where individuals were able to exercise control over part of their life. Yet the process of recruiting and maintaining homeless volunteers was a delicate one for staff. Essentially, the service did not want to interfere too much with the tasks being undertaken by any one volunteer for fear of scaring the volunteer off. Suggesting

individuals would need to undergo food handling and hygiene training before working in the kitchen would be overwhelming for many of Ozanam's new homeless volunteers. This approach had the potential to contribute to an increased sense of worthlessness. Perhaps most importantly, staff were aware of the stigma felt by homeless individuals around being 'dirty' both physically and morally (see **Chapter Nine**) and dealt with matters of hygiene with increased sensitivity.

Despite this situation, staff generally agreed that several of the more seasoned guest volunteers would have been excited and proud to participate in a food safety course. Such an endeavour would have had logistical challenges, such as negotiating the mobility patterns of this population. Furthermore, skills development of this kind could only have been achieved if a level of 'dependency' were attained by the guest volunteer in the first place; a notion that was discouraged by the service, yet at the same time promoted through their practice of embracing volunteers. As such, patterns of guest participation and associated behaviour at Ozanam which may have been construed as dependency forming in some contexts were often found to be fundamental to the wellbeing and health of guest volunteers. Accordingly, social inclusion, along with food sustenance and hunger abatement, were pivotal aspects to service delivery at Ozanam House, even when these functions appeared to be at odds with discouraging dependency on the service.

Sexual health

The 'Western Australian Aboriginal Sexual Health Strategy 2005-2008', referring to Sexually Transmitted Infections (STIs), stated "*STI incidence is usually higher in communities where there is ongoing social disadvantage, including unemployment and poverty*" (WA Health Department, 2005; p.5). According to the Australian Government Department of Health and Ageing (2005), the rates of STIs among the Aboriginal and Torres Strait Islander populations of Western Australia, South Australia, Victoria and the Northern Territory were significantly higher for some infections when compared to the non-Indigenous populations. In 2003, for example, in these States and Territories, gonorrhoea occurred among Indigenous peoples at a rate of 40 times higher than in the non-Indigenous population and syphilis at a rate of more than 250 times the non-

Indigenous population (Australian Government Department of Health & Ageing, 2005). By 2006, in the Northern Territory the rate of chlamydial, gonococcal and syphilis infections were significantly higher than the rates for these infections in any other State or Territory (Australian Government Department of Health and Aging, 2006).

With the incidence of STIs already higher in the NT than anywhere else and affecting Indigenous people disproportionately when compared to non-Indigenous people, the incidence of STIs among Darwin's Aboriginal homeless populations, facing the greatest level of social disadvantage, is also likely to be high. Highlighting the link between socio-economic disadvantage and sexual health in some Aboriginal communities, one Aboriginal guest explained:

These are big problems, especially young children sniffing. They are maybe 5 or 6 years old, girls too. Their parents are drinking and the kids think they do not care, so I will sniff. The girls will have sex more and have babies or get diseases...

In this study STIs were reported by some guests, although it was clear in our discussions that this topic, and the condition, brought them great shame, embarrassment and on occasion, humiliation. Some guests had multiple sexual partners and did not use condoms. Other guests did not necessarily disclose their infection status, however initiated conversations about STI, suggesting an interest in infection control or prevention.

It was apparent that a few guests were aware they had contracted infections through the sharing of needles. Some guests, however, attributed the source of their infection to individuals they believed to have a questionable moral character, for example, individuals who exchanged food, shelter, alcohol or marijuana for sex. Infection sources were also attributed to individuals who were physically blemished with boils or other skin conditions or infections. For example, one woman had consensual and non-consensual sex with four different men during an afternoon and contracted syphilis. She was ashamed of having acquired the infection and acknowledged her role in transmission, but believed she had contracted it from one particular individual:

...He fucks with any woman...I will not follow any more men. No more, that is it. I don't want to get diseases.

This woman's determination to avoid shame and further infections was also motivated by her strong desire to become pregnant, believing an STI would compromise her potential for a successful pregnancy. She had become aware that multiple untreated infections over the past 20 years or more, in particular chlamydia and gonorrhoea, had left her with fertility problems. (Kildea and Bowden (2000) found that among Aboriginal women in a Northern Territory community more than 26% had fertility problems associated with STIs and Pelvic Inflammatory Diseases). Becoming a mother was not only important to constructing a credible individual and social identity, it was critical to her notions of the future and her ongoing survival. This woman regarded having a child as being responsible and taking responsibility for herself, as the child would be obliged to care for her in her old age, in much the same way she was charged with the care of older members of her family. In this example, good sexual health became important to the individual's desired identity which was embedded in her cultural beliefs and responsibilities.

The most powerful consequence of contracting an STI related to the attached stigma and shame. For example, one couple became aware they both had an STI and promptly visited a clinic and received treatment. For several hours they agonized over whether or not to inform recent sexual partners. Ultimately they decided to tell only those individuals who did not obtain meals from Ozanam House. They explained that previously Damien, the ex-partner of the woman, had shamed and humiliated them many times publicly at Ozanam over matters relating to sexual health. Damien would mimic this woman in an animated fashion, raise an imaginary skirt to reveal genitals, then shout repeatedly 'I'm clean, look at me, I'm clean'. He would then shout at the woman claiming she had given him 'the clap', claiming she was not clean, but rather a filthy whore. This was despite Damien himself having a history of multiple sexual partners.

In short, having an STI was widely regarded as being 'dirty', blemishing an individual's moral character. Having an STI not only created the usual barriers all people experience in relation to accessing treatment, but also created barriers to accessing the Ozanam

House services, as individuals avoided the setting to manage shame and stigma. This, together with the demands of daily life for Ozanam's guests, made it difficult to employ preventative measures in the transmission of infections. Many guests, however, were willing to overcome the barriers to treatment in order to manage this shame, have a 'clean' identity, and maintain access to Ozanam's services.

The majority of homeless people in this study felt vulnerable to physical and sexual assault, and there was considerable physical evidence to support a high incidence of violence. This situation impinged on individuals' already reduced capacity to manage their sexual health. Coupled with the number of people who did indicate they had an STI, the prevalence of this condition among Ozanam's homeless population was likely to be much higher than in the general population. Accordingly, the context of daily life predisposed individuals to a greater risk of STIs when compared to the rest of the population, and was influenced by the:

- availability of condoms;
- individuals not necessarily being aware of their infection status;
- level of education and English literacy;
- limited exposure to meaningful and relevant health promotion and education initiatives;
- vulnerability to physical and sexual abuse and rape;
- need to combat loneliness;
- need to feel desirable and in control;
- desire to feel good, relaxed and intimate with, and accepted by, another individual and do 'normal' things;
- unplanned need to exchange sex for other goods, such as food, shelter or alcohol;
- high prevalence of drug and alcohol misuse and abuse;
- held beliefs about disease transmission; and
- the management of shame.

The people in this study were interested to learn about sexual health and reduce the risk of contracting an STI. Many saw STIs as having a direct impact on their wellbeing and

identity. The sexual health of this homeless population, however, is unlikely to improve due to the limitations of existing sexual health promotion and education programs, along with the context in which daily life is experienced and decisions are made.

Morbidity and mortality involving sorcery

Unexplained behaviour or events associated with alcohol were occasionally understood to involve sorcery or evil by some Aboriginal guests. This generated fear along with suspicion. One such example was presented in **Chapter Eight** and related to the circumstances surrounding the drowning of Polly's sister as punishment for Polly not staying with a man to whom she was promised. A further example related to convulsions experienced by a meal guest at Ozanam.

Following his seizure, the guest stayed for a couple of hours to rest. The next day he discretely got my attention. I could tell he was frightened and he wanted me to describe exactly what had happened to him. He was worried someone had tampered with his drink, and by his own admission, had been drinking too much. He asked if I thought something was wrong with his brain. After I explained that I did not know, he asked if I would take him to the hospital. When we arrived he indicated he wanted me to stay with him and insisted I explain to the hospital staff why he was there. After a while, he seemed to relax so I left. A few days later he told me he was drinking less and that his brain was OK. He had been relieved to learn his problem stemmed from too much alcohol and not malevolent others. He was also relieved that his brain was not permanently damaged rendering him, to any degree, as crazy.

A final example in this section describes how one man in his mid thirties was found dead in a car. A long term Long Grasser, the man was well known and liked. In the last year of his life he spent nearly five months in a residential rehabilitation program for alcohol addiction. When he left the program he visited Ozanam. He was overtly excited about sharing his success and expressing his love for the service staff and had been drinking to celebrate his achievements. He quickly and happily became immersed in the normal daily life of the Long Grasser which mostly involved drinking.

Within a few months he had died. There was some talk of the death being related to heart failure or maybe an infection and initially the death was not regarded as suspicious by anyone. A few months later a meal guest, Samuel, arrived at Ozanam after being absent for a period. He explained he had been 'lying low', in a state of fear, and needed to carry a metal bar for protection. Samuel claimed there was a mob who held him responsible for the death of the man due to a dispute over a cigarette. The dead man had requested a cigarette. Samuel had denied his request and a minor physical dispute resulted. According to Samuel, some members of the dead man's family believed this altercation contributed to the death and wanted retribution, referred to as 'pay back'. Samuel was infuriated by being blamed as the conflict had been minor. He appeared to have no knowledge that family members may have considered sorcery to have played a part. Samuel complained to the police and alerted them to the fact he was carrying a bar for self defence against 'the cowards'.

Sorcery as a common reason for Aboriginal people leaving their homes has been well documented (see Memmott & Fantin, 2001; Maypilama, 2004). The findings of this study showed that sorcery continued to generate fear among Ozanam's Aboriginal and non-Aboriginal guests during their homelessness, which in turn had an ongoing impact on both wellbeing and life quality. Sorcery, although just one of the many sources of fear found among this group, reinforced hyper-vigilant behaviour often associated with Post Traumatic Stress Disorder.

Children and place

Many of Ozanam's guests had children (under 18 years of age). Few guests, however, had the responsibility of caring for them. The topic of children was a sensitive one, particularly where individuals were not permitted by a parent, family or the law to have access to their children. Some children had been removed by government agencies from the care of both Indigenous and non-Indigenous guests and other children had died under tragic circumstances. As discussed in **Chapter Eight**, often traumatic events left

Ozanam's guests unable to remain homed, ultimately disconnecting them from the associated social ties, including their children.

As the demands of daily life became embedded in a homeless culture, individuals experienced increased levels of stigma. This inhibited contact with their children (and family) and was a very painful process for many of Ozanam's guests. While some guests managed their pain by frequently talking about their loved ones, others were unable to do so without feeling overwhelmed with emotion. "*They are better off without me*" or "*it is better to let them go*" were common concluding or subject-changing remarks during such conversations. Only a few guests who were informants in this study shared nothing of their past family life.

Despite the pain associated with their own family circumstances, Ozanam's guests often expressed an interest in other families and children growing up in a 'normal' environment. During my fieldwork, many guests routinely inquired after my family and offered advice and shared their strong views on child rearing. This interest has continued, made possible by Darwin being a relatively small city.

Engaging in discussions about my family, for example, was normalising and therefore healthful in itself. They also provided important opportunities for individuals to reflect on their own circumstances in a semi-detached way while maintaining control of their emotions. The construction of a social reality, even if tenuous at times, was important to the wellbeing of these individuals.

The experience of social exclusion from family and loved ones was coupled with a physical separation from important places and had a profound affect on wellbeing of most guests. For Aboriginal guests, as discussed in **Chapter Two** and **Nine**, the physical and social separation from country incorporated a spiritual exclusion. This spiritual exclusion was tantamount to an identity crisis, rendering individuals imbalanced and with poor health. While social death was experienced by both Indigenous and non-Indigenous

guests, this study has found that the shame associated with Aboriginal homelessness caused enduring pain.

Responsibility for Health: Accepting poor health, fatalism and perceptions of services

I have mentioned Ozanam's homeless tended to access health and medical services only when they reached a crisis point, and were unable to survive from day to day in the Long Grass. This chapter discusses many factors that contributed to this situation. Together these factors indicate that Long Grassers generally accepted a poor level of health - a level that simply permitted survival.

Some guests became more active in attending to health care needs when they had established a relationship with Ozanam House. As discussed, the evidence points to this improved wellbeing being gained through social, emotional and physical support and also through the involvement of a 'normal' facilitating access to health care providers.

Health promotion and education programs which bombard the general population, who have relatively better levels of health, seem largely inaccessible and ineffectual among this homeless population. Most do not have television or radio and some have low levels of English literacy. Further, the homeless people in this study felt excluded from the institutions where such information was available. Accessing health information in public places was also discrediting, reinforcing stigma and shame. This too led to reduced vigilance around meeting health care needs. For example, Ozanam House – a relatively safe environment with individuals who share the same stigma - had various health promotional materials available to guests. During my field work I did not observe any individual look at, or take, any of this material.

Meeting the basic needs of day to day life in an environment where individuals remained under constant public scrutiny and had to manage their stigma was a full-time vocation. In the context of a homeless culture the idea of maintaining 'good' health and eating five

serves of vegetable and two serves of fruit, for example, was unachievable and had little relevance to Ozanam's guests. As such, the belief that there was very little individuals could do to prevent poor physical health became a barrier to accepting responsibility in health care. This fatalistic position rendered individuals unlikely to alter health maintenance habits. This is well illustrated by one man, who provided a common response to questions about smoking cigarettes:

...Smoking...I'm not gonna live long enough to get lung cancer!

These views, coupled with the belief that guests would receive inferior service and treatment (reinforced during interactions with so many of society's institutions) also affected the decision to take responsibility for health. Occasionally, individuals formed unrealistic expectations of the health services. There are several examples at Ozanam where individuals believed they had constructed a social relationship with medical professionals. As such, they had expectations they would be remembered by the professional. In reality, the individuals became part of a nameless crowd.

That Doctor Margaret, she knows me. Yes, she knows me. I saw her when I had a sore stomach...

Compliance

The issue of compliance with medical regimes is an important consideration to the health of homeless populations. During this study several factors were identified which affected an individual's ability to comply with medicinal regimes. Firstly, the cost of medicine was a deterrent, even when purchased at a government subsidised price with a health care card. Some guests also reported feeling very uncomfortable going inside a chemist to have scripts filled and/or to purchase pharmaceutical items. (This may have been due to entering the 'clean' chemist environment as a 'dirty' individual). There was also difficulty expressed in maintaining required regimes, including an inability to store medicines in the prescribed manner. Further, individuals carrying medicine often had it stolen.

For some individuals, the need to be vigilant against sorcery and malevolent others affected medicinal use. For example, an Aboriginal Long Grasser had been assaulted and

hospitalised with a broken jaw. He was later discharged with more than eight 200ml bottles of children's Neurophen for pain relief. (I assumed this child strength medication was supplied to prevent accidental overdose). Carrying the bottles was inconvenient and so he hid them, but because he was uncertain whether they had been tampered with, he was only able to take a swig out of each newly opened bottle. After eight or so swigs, the bottles were no longer safe, and the individual resorted to alcohol as an alternative and reliable medicine for pain relief. (Alternative medicines are discussed further in the following section).

The cultural dimension to medical non-compliance among Aboriginal patients has been documented by Humphrey, Weermanthri and Fitz (2001). They noted that health professionals often see cultural influences as the most important explanation for non-compliance among this population. According to McConnel (2003), treatment failure among Indigenous Australians has been attributed to poor compliance. He suggested that compliance is not the problem but rather a dissonance between belief systems and he calls for "*the development of a shared knowledge which includes Indigenous health beliefs and practices*" (p.1). Senior (2002), however, questioned the cultural basis for non-compliance and alerts us to the fact that non-compliance with medication is a widespread problem among both Indigenous and non-Indigenous people. She argued that it is important to develop an understanding of the barriers that prevent compliance in a population. The evidence presented in this thesis shows that the reasons for non-compliance of Darwin's Long Grassers outlined here were embedded in a cultural context of homelessness.

Ozanam House had management strategies to respond to some of these factors. On occasion, these included paying for and having scripts filled for guests. The staff at Ozanam also brokered a relationship between some Long Grassers and a local chemist to address some of the barriers to access. Guests staying in the shelter were encouraged to leave medicine with staff to prevent theft, although some were reluctant to do this. And a few guests were dispensed medicine daily by staff or visiting community nurses.

Marijuana, alcohol, bush and other medicines

A few guests were obviously confused and had a very different idea of reality to other guests, volunteers and staff. Some guests attributed the cause of the confusion experienced by other guests to excessive drinking of alcohol and smoking of marijuana, which was considered to make some people crazy and do crazy things. This view was often expressed through comments such as:

...he smokes ganja. He smokes too much...it makes him mad

...too much of that moselle is no good for his brain. It makes him do crazy things...

To the outsider, it may seem contradictory that Ozanam's homeless guests could attribute marijuana and alcohol use in the cause of 'craziness', yet at the same time regard marijuana and alcohol as useful and effective medicines. Alcohol and marijuana were deemed beneficial (and often necessary) to maintaining an individuals' wellbeing.

I got me medicine...a 2 gram stick of good quality hydro for 30 bucks....I only like to smoke the best.

...he hit me over the head with a Johnnie Walker bottle and I fell back and hit the back of me head on the pavement. I remember being airlifted by helicopter to hospital...There were two areas on me brain scan that may be tumours, but I'm not sure. After that they told me I had to take Dilantin...I don't take them now, I use marijuana as my medicine.

A further example of the perceived medicinal benefits of marijuana is illustrated through a discussion recounted by one guest with his step daughter. The daughter had asked why he believed sniffing paint was so bad, and concluded her argument with: "*well mum and you are always smoking marijuana*". The guest explained to his daughter, "*...the paint will kill your brain whereas the marijuana is medicine*".

Alcohol, as a medicine to enhance wellbeing, was central to some guests' coping strategies (see also **Chapter Eight** for a discussion on the relationship of trauma to alcohol use). A very common sentiment was expressed by one guest: "*I felt very sad and drank more to feel better*". Further, guests who were alcohol dependent considered a

regular supply necessary to ensure they did not get sick and remained well. Guests feared detoxification, particularly when it was not a choice.

On one occasion, a guest was unable to attend the meal service and called to me from the adjoining park and asked if I could take some food to him. His leg was plastered from his ankle to his hip. He explained to me he had been hit by a car because he was drunk, but was relieved he was drunk at the time. Drinking wine out of an old juice bottle, he said:

...when it gets really painful I take the pain killer tablets, but I try not to and just drink this, it helps with it.

Another guest, Martin, had been in considerable pain and eventually saw a doctor who arranged a biopsy of his kidneys. Martin had the option of having the procedure with the assistance of local anaesthetic or morphine. He explained:

I opted for the 'local' because if I had the morphine I would have had to stay in the hospital. After the procedure they gave me a couple of Panadeine Forte and sent me back to Vinnies. If the pain gets as bad as it was a few nights ago, I'll check myself into the hospital for the morphine.

In addition to alcohol, marijuana and the other medicines discussed above, some Aboriginal guests in Darwin's Long Grass talked about using bush medicines. In Darwin, however, they were hard to source and therefore they were not as convenient as alternatives. As one woman explained:

...Some bush medicine is better than the clinic, but some clinic medicine is better. People don't use bush medicine anymore because they do not know how. The young people have not learned this. I know some but the clinic is easier even if bush medicine is better. Most people use the clinic now.

This response is consistent with the findings of Senior (2002) and Scarlett, White and Reid (1982). Senior (2002) described the tension between the pragmatics of using clinic medicine versus the social desirability of using bush medicine among residents of Ngukurr in the NT. Further, Scarlett *et al* (1982) observed that despite a decline in the

use of bush medicine and an increase in preference for clinic medications among the Yolnu²⁵, bush medicines were regarded as important and were well known by adults.

Ozanam's homeless people generally did not want to take prescription drugs, due in part to the challenges associated with compliance discussed above, preferring to self medicate and manage their own problems in their own way, for as long as possible. While many may have visited clinics or even the hospital emergency department for illnesses and injuries, they were less inclined to do so if it meant staying overnight. The reasons for this included:

- (i) Staying overnight under the care of the hospital staff affected individuals' capacity to make decisions about their own health;
- (ii) Guests were generally unable to make the life style changes usually demanded by hospital staff to effectively manage their illness. Through this process, they felt blamed for their illness and helpless. This situation reinforced a sense of worthlessness and irresponsibility, and in turn generated hostility and resentment towards medical staff. For example, one man had been profoundly affected by the death of his guardian more than 20 years ago. He talked about his experience in hospital during the time of the death, and regarded the doctors as largely incompetent and inadequately qualified and trained. I asked him if he would go to a hospital if he became very ill. He exclaimed:

What do doctors know, they do not know me, I know me and what my needs are, not them, they are mostly useless...we have not had a doctor graduate in this country for more than 25 years....Maybe if I broke my leg or arm I might go to the hospital, but that would be it.

Under such circumstances, self medicating was construed as a responsible approach to the management of illness and avoidance of hospital stays.

- (iii) Guests felt stigmatised for their homelessness in the hospital setting. When their homelessness was known, staff responded in a way which increased the stigmatising processes.

²⁵ Yolnu (or Yolngu) refer to the Aboriginal people of northeast Arnhem Land.

- (iv) Staying in the public hospital ward with other ‘normals’ was also a reminder of their stigma. Physically removed from their social networks, guests received no visitors or phone calls, unlike other people in the ward. This was deeply discrediting. As an essentially lonely place, the hospital generated self loathing feelings, with guests taking increasing responsibility for their shortcomings.
- (v) The hospital controlled and restricted individuals’ freedom. The individual’s choice of medicine was not tolerated and a stay in hospital was very difficult for those with addictions to alcohol and other drugs.

Alternative medicines for wellbeing and pain management, as discussed, were sought by Ozanam’s homeless for complex reasons. The self management of health and illness was understood as taking control and responsibility for one self. These health management strategies evolved as a result of the lived experience of homelessness, including those experiences homeless individuals had with medical services, particularly hospitals, where they felt responsible and blamed for their illnesses and subsequent presentation at hospital. In this way, they became less deserving than other patients.

Sobriety, housing and social death

For the vast majority of Ozanam’s guests, alcohol played a role in everyday life and in the management of trauma. As discussed above, it was used for medicinal purposes and to feel better. Consequently, becoming sober presented a range of new challenges for those few individuals who attempted it during my study.

Based on the supposition (from **Chapter Eight**) that Post Traumatic Stress Disorder was an almost universal condition among this homeless population, an early challenge then for sober alcoholics was to negotiate the symptoms of profound trauma without alcohol, while at the same time fighting the addictive properties of the substance. Although further research is necessary to gain a better understanding of responses under such circumstances, keeping busy appeared to be the most common approach for the few who attempted sobriety in this study. Individuals volunteered, went fishing, watched movies,

slept and interacted with other sober people in order to keep their minds focussed on matters unrelated to alcohol and their traumas.

After a period, guests tried to interact with friends and family they had previously spent time with. However, the social dynamics had changed, raising uncertainty around their social cohesion and connectedness. As Goffman (1963) pointed out, if a stigmatised individual “*turns to his group, he is loyal and authentic; if he turns away, he is craven and a fool. Here, surely, is a clear illustration of a basic sociological theme: the nature of an individual, as he himself and we impute it to him, is generated by the nature of his group affiliations*” (p.113).

Guests learned quickly that sobriety was one important characteristic that identified individuals as different from many of the Long Grassers they had known or called family. It was a condition that broke the rules of normality within Long Grass culture. No longer would the sober individual be assumed to participate in daily business of gathering money to buy alcohol. They no longer had a need to. Indeed the sober individual became a potential source of funds, which was often met with resentment. The sober person had different priorities and found it difficult to spend time with heavily intoxicated people. No longer could sober individuals cope with the pressures found in Long Grass living and remain sober. The few people who experienced this predicament found tentative accommodation in shelters, boarding houses and private flats. Yet they were in ‘limbo’, rejected by the ‘normal’ society and now treated differently, sometimes suspiciously, by other Long Grassers. They were excluded or excluded themselves from participating in a daily life with patterns and rules that were well understood. Consequently, the most profound initial affect of sobriety was social dislocation, exclusion and resultant loneliness.

Now I do not drink I miss my family, someone to talk with in my own lingo...I don't like it when they are drunk because they fight and humbug.

In **Chapter Eight** I highlighted the trauma for one guest, Polly, as she attempted to maintain private rental accommodation and the fear she experienced when threatened with the loss of her flat and burgeoning new identity. While Polly was confronted with

extraordinary pressures from family to exploit her resources and use her flat, she found it difficult to resist the pressure all of the time largely because she wanted to be socially connected and included, as this was also important to her identity.

Loneliness was both a powerful cause and a symptom of stigma. The desire to combat loneliness was consuming and during my study many guests left accommodation and returned to the Long Grass because of it, although it usually took a bit of probing to ascertain the underlying cause. Some guests broke establishment rules in order to be thrown out so they could offer a reason for loss of shelter which was not loneliness. This behaviour is consistent with what has been written about loneliness as a highly stigmatised condition in a western context and one that has a significant detrimental affect on quality of life and health (Demakakos, 2006). Loneliness equates to the absence of supports and dependencies. This has serious implications for wellbeing of homeless persons, for contemporary housing policies and the types of support available in the community.

Loneliness is also an important factor affecting sexual health. The World Health Organization (WHO) (2000) noted that street children may feel a sense of power or control by engaging in sexual activities which they do not usually experience. They contended that street children combat feelings of loneliness or rejection by having sex, or have sex to feel desired or accepted. The WHO (2000) argued that these children use sex to forget their worries and to relax and feel good. This explanation has applicability to Ozanam's homeless, and while sex worked to combat loneliness, it increased the risk of deeply stigmatising diseases.

Sobriety was one avenue that led to accommodation beyond the Long Grass but, as demonstrated, sobriety was also a potentially stigmatising and lonely choice. In juxtaposition, homeless individuals understood that the 'normals' saw both sobriety and conventional housing as desired conditions; perhaps even as milestones worthy of recognition, deeming the homeless individual as deserving of support. One guest, however, who became sober and housed and negotiated loneliness, found enormous

resistance from the 'normals' when she attempted to obtain more secure housing, and recounted her experience.

This Aboriginal woman explained that a housing officer placed her lower on the waiting list for public housing as she was no longer a priority, as other people had more complex problems than she did. She was instructed to return after a period with references confirming her successful private rental experience to determine eligibility for housing.²⁶ Some time later she returned to the housing authority sporting the required references. It was the officer's contention the references were meaningless as anyone could have written them. The woman insisted they check the references, but to no avail, before being turned away. The housing officer explained to this woman she would be better off in supported accommodation and that if she was to ever live in public housing, she would need to live like the Europeans. This woman explained she felt very confused, frustrated, angry and punished. As a consequence, she stopped communicating with the housing officer who then interpreted her behaviour as further evidence and confirmation of her beliefs about the need for supported accommodation, and reiterated the point: 'You just don't understand what I am saying to you. You could not possibly cope with living in public housing successfully'.

Although this detailed account is of only one woman's experience, other guests at Ozanam shared similar experiences with housing authorities in Darwin and other jurisdictions. This particular incident further illustrates the point made in **Chapter Nine**, in that institutions delivering services to homeless people may construct ideas around what a homeless person ought to be. When an individual no longer fit within this idea because they developed new skills or achievements, for example, and attempted to use them, their deviant stigma was reinforced by the service department official and they were excluded and/or punished until they reverted to type.

²⁶ The references had to state that the woman had been in private rental for a period of not less than three months, and caused no problems and had no complaints made against her, even if she was not responsible.

Goffman (1963) explained that while a stigmatised person should never attempt to completely pass off as a 'normal', he maintained they should also not fully accept the negative attitudes attributed to them as their own. He warns the stigmatised against acting out all the bad qualities assigned to his or her kind in front of the 'normals', a process he described as 'minstrelization'. Goffman (1963) illustrated this point, citing the work of Carling (1962):

I also learned that the cripple must be careful not to act differently from what people expect him to do. Above all they expect the cripple to be crippled; to be disabled and helpless: to be inferior to themselves, and they will become suspicious and insecure if the cripple falls short of these expectations. It is rather strange, but the cripple has to play the part of the cripple, just as many women have to be what men expect them to be, just women; and the Negroes often have to act like clowns in front of the "superior" white race, so the white man shall not be frightened by his black brother (Carling, 1962, as cited in Goffman 1963; p.110).

Consistent with Carling's (1962) observations, homeless people *are* expected to behave like homeless people to prevent fear, suspicion and insecurity swelling among the 'normals' in society and our institutions. This expectation and pressure not only stems from the 'normals', but also from the individual's own or 'real' group, being those who share the same deprivations and stigma (Goffman, 1963).

Summary

In **Chapter Six** and in this chapter, the evidence confirmed that homeless people accessing a homeless service not only experienced, but accepted, poor health. This acceptance of their own poor health in turn created challenges for individuals in taking responsibility for improving their own health. This situation has tended to drive individuals to negotiate many aspects of their life from a fatalistic position.

The first part of this chapter discussed the ways in which Ozanam House provided health care, and how they facilitated access to other health care providers. This study has revealed the important function homeless services have, in this case Ozanam House, in improving the health of homeless individuals; a finding which is echoed through anecdotal evidence provided by numerous homeless services. Of significance, however,

is the insight into the complex processes which enabled Ozanam to be successful in this role. They took on a position of the 'normal' homed person when negotiating with these services on behalf of the homeless individual. In most instances, this approach worked to neutralise the inherent power imbalance between individuals and the health services, increasing their confidence in the services they received.

Ozanam's homeless people generally viewed health as wellbeing. Ozanam House was able to instil a sense of wellbeing in individuals, even if only for a short time, through the building of trusting relationships. In this setting both the sense of stigma and the actual stigma did not need to be managed to the usual degree. The trusting relationships formed through social interaction at Ozanam between the homeless and the 'normals' enabled homeless people to address their health concerns. These findings demonstrate the complex social processes at Ozanam House which underpin homeless individuals' capacity to access health care services and improve their wellbeing. An understanding of these social processes is essential for effective health care delivery to homeless populations.

Consistent with the published findings on the health of Australia's homeless, this study has found Ozanam's guests had a myriad of acute and chronic health concerns. This study, however, has uncovered the significance of an adequate and satisfactory diet to Ozanam's homeless people as being fundamental to achieving an acceptable level of health.

The association of mental illness with homelessness in Australia is not new. Little has been documented, however, about the social processes that take place within homeless populations when an individual has a mental illness, and the implications of these processes for the wellbeing of that individual. The evidence generated through this study suggests that individuals with mental illness were stigmatised by other homeless people as they departed from the rules of normality within the homeless context. While the treatment of mental illness during homelessness was often problematic for reasons such as the difficulty in achieving medical compliance or the lack of treatment options (such as

PTSD), a diagnosis or label of mental illness meant individuals could be marked with a permanent stigma that they could not shake. This research has found that mental illness adversely affected the health of homeless individuals as the increased level of stigma and social exclusion they experienced led to ill-being.

This research also found that: the deterioration of physical and mental health during homelessness; sexual health problems; peoples' belief in sorcery and the associated fear and anxiety, all influenced wellbeing. Individuals also managed their wellbeing by counteracting feelings of ill-being through linking themselves to a family, home and normal identity.

The evidence presented has illustrated the many barriers homeless people face in complying with the requirements of the health care system. People used alternative medicines, influenced by their homeless experience and limited resources. This was seen as taking responsibility and charge of one's life. This sense of responsibility was in contrast to the lack of control felt when people used health services, particularly the hospital.

A further issue of compliance related to alcohol use. Within a homeless context alcohol consumption was generally perceived as negative, anti-social and damaging by mainstream society. This study has shown that the use of alcohol by homeless people is far more complex than often assumed, such as its use in the management of mental illness and physical pain. Further, of the few Long Grassers who became sober during my research, they had to cope with the subsequent loss of place and identity in the Long Grass. They had become alienated from the one social group to which they had a sense of belonging. As such, sobriety in this context led to ill-being through increased loneliness.

The following chapter draws together my key research findings from this and previous chapters and highlights the implications of these findings for mainstream society, government and non-government agencies working with homeless people and issues.

Chapter Eleven

Conclusion: Challenges and implications

Homeless people are very visible. Their lives are played out in the street, the shopping mall and public parks. They are easily blamed for social problems and easily blamed for their own homeless predicament. The solution, theoretically, is an easy one: find these people houses and paid work and they will become normal and acceptable members of society. The evidence presented in this thesis confirms that despite their visibility (or perhaps as a result of their visibility and people's desire to shun deviancy) the social worlds of homeless people are poorly known and the barriers to achieving normalcy and health are complex and multilayered.

This study set out to learn about homelessness from the perspective of homeless people themselves. Specifically, it asked the question:

'What is the experience of homelessness in Darwin?'

This question led to a further question, being:

'What are the key dimensions of that experience that influence the health homeless people?'

To answer these questions, this study aimed to explore future possibilities for:

- (i) healthful environments for a homeless population that reflect the experiences and hopes of the homeless themselves; and
- (ii) how such environments can be constructed so that they are supportive of health and a better quality of life.

This multi-method inquiry was undertaken through St Vincent de Paul's Ozanam House meal and shelter service, located in Darwin, Australia. The life worlds and experiences of Ozanam's guests were documented through participant observation, informal interviews and individual narratives between June, 2004, and June, 2005. In this concluding chapter, I will reiterate the main findings that were generated through this study and presented in this thesis. Stemming from these findings, I will identify the challenges to: governments; service providers (in particular St Vincent de Paul's Ozanam House) and those in society at large who have an interest in, or responsibility for, the health of homeless people in Darwin.

Key findings, challenges and implications

Trauma

This study found that trauma was a primary threat to the health of homeless people in Darwin. The evidence presented in this thesis clearly illustrated homeless people had endured multiple and significant traumas. This high prevalence of trauma suggests the incidence of the psychiatric illness, Post Traumatic Stress Disorder (PTSD), is likely to be very high among the homeless population (NCPTSD, 2006a). There is a distinct lack of literature published on the impact or prevalence of trauma to any dimension of homelessness in this country. This research has firmly placed trauma and its associated behaviours as integral to the homeless experience.

The first challenge for government and non-government agencies involved in policy formulation or service delivery to homeless populations will be the need to be cognizant of the high prevalence of trauma related illnesses among this population. This recognition should be the first step towards improved health outcomes for homeless people. These agencies will benefit by being informed about, and able to identify, behaviours and symptoms associated with such conditions. The challenge will be to recognise the role trauma plays in the everyday life of homeless individuals if effective and appropriate responses are to materialise.

Trauma-related behaviour and treatment

This study found that the behaviour of the homeless people in the Long Grass and other public places was influenced by trauma. The research also found that the need to stay on high alert, for example, was necessary for survival in an often inhospitable environment with many threats to safety. It was also necessary to be alert to avoid trouble from police and council officers. Homeless people, consequently, were kept on the move. This movement was often interpreted as suspicious by mainstream society. However, a state of high alert was also found to be a symptom of trauma related illness. Therefore, homeless people in Darwin were suffering from the symptoms of trauma, yet these same symptoms were necessary for survival.

The body of literature on homelessness tends to define alcohol use/abuse as a cause of homelessness. However, the NCPTSD (2006a) maintained that excessive alcohol use is a common approach to the management of the symptoms of trauma related illness. This study supports this theory, and found that homeless people in Darwin's Long Grass used alcohol to manage the symptoms of trauma.

The literature also tells us that that trauma related illness is untreatable with contemporary approaches. The theory indicated that homelessness must be resolved before treatment can commence (NCTPTSD, 2006b). Homeless people in Darwin endured significant and ongoing trauma in their homeless experience and probably had trauma-related mental illness (discussed above). Thus managing and surviving with illness had become a way of life. Because trauma-related illness was a way of life, excessive alcohol use as an accessible and affordable management strategy would most likely continue to be favoured in the absence of more conventional or orthodox treatments.

Perhaps the greatest challenge stemming from these finding relates to the development of a treatment for PTSD among homeless individuals. A cross sector and collaborative approach will be essential if this is to eventuate. Housing, planning, health and social welfare departments for instance, at all levels of government, will need to work together

to explore, develop and deliver creative responses. These responses must take into consideration the lived experience of homelessness, moving beyond the structural dimensions of housing, and consider how, for example, stability could be provided to homeless people during their homelessness to facilitate treatment of PTSD.

Stigma

Homelessness in Darwin is conceptualised by mainstream society as an anti-social Aboriginal problem, where people choose to live in the Long Grass and drink alcohol. There has been strong mainstream support for punitive measures against those exhibiting anti-social behaviour. A high level of police surveillance has been regarded as both acceptable and necessary. It is reasonable to conclude that homeless people are understood by mainstream society as dangerous, deviants and undesirable, and that people in houses need to be protected from them. This socio-political context was found to underpin the reasons why homeless people in this study felt discarded and excluded by mainstream society.

This study found that homelessness was poorly conceived by mainstream society. For example, it was not the case that only Aboriginal people lived in the Long Grass. While they may be over-represented, the census data informed us that around half of the primary homeless (living rough, in the Long Grass) were constituted by non-Aboriginal people. This was confirmed through my own investigations at Ozanam House. The limited understanding of the homeless experience held by mainstream society extended to the use of alcohol, seen as an anti-social choice, rather than a trauma management strategy or addiction. The poor conception of homelessness in Darwin reinforced the negative experiences associated with homelessness and the wellbeing of the individuals concerned.

The socio-political context in which homelessness was experienced in Darwin provided fertile ground for stigmatising processes and the assignment of a deviant identity to homeless people. This dimension of the homeless experience, stigma, emerged as a primary threat to the health of homeless people in this study. This inquiry documented

multiple strategies employed by homeless people to manage their stigma, with personal appearance and the ownership of belongings being of particular importance. The evidence also revealed the intricate nature of information management, the avoidance of stigma symbols and the use of dis-identifiers by homeless individuals in a bid to pass off as a non-stigmatised person. Further, findings revealed that the social interactions between homeless people and normal members of society were tenuous and had potentially damaging consequences for the former.

The literature on homelessness often described homeless people as socially excluded or marginalised. However, it has been largely silent on the direct and significant influence of stigmatising processes on the health of this population. This study has found that the contemporary popular conceptions held by mainstream society about homelessness in Darwin, together with the consequences of stigma, reinforced homelessness and contributed to ill-being among homeless individuals.

The challenge stemming from this finding is the need to reduce the negative consequences to homeless people that result from powerful stigmatising processes. At an extreme level, this may well require the deconstruction and reconstruction of all the institutions and ideologies that govern contemporary Australian lifestyle. A first step on this long journey should be to challenge society on the many ways of 'being'. This research has found that homeless people will continue to live in unconventional ways among mainstream society and some will never return to conventional lifestyles.

Challenging stigmatising processes is a broad social issue which must be driven by governments and non-government agencies in the first instance. Mainstream society needs to begin to understand that they play a pivotal role in stigmatising homeless people and that this role has a detrimental effect on their health. Through carefully considered and well informed educational programs, people may begin to question their assumptions about homeless people, as well as the ways in which society establishes social rules and effectively reinforces 'undesirable' behaviours in marginal groups.

Addressing stigma, like all the dimensions of the homeless experience which influence health, will necessitate mainstream society rethinking the notion that creating stronger supports for this population breeds dependency. The perception that homeless people are hopeless and have no desire to work needs to be challenged. This is supported by these research findings wherein Ozanam's guests expressed a strong desire to be employed, as evident by their keenness to undertake voluntary work.

Homeless people form a significant part of the social landscape in Darwin. This study has shown they are poorly understood, perceived in negative terms, categorised as a nuisance and severely stigmatised. They are often visible as a group, but invisible as individuals and denied a personal identity in most spheres. Positive contact with members of mainstream society is often limited to those interactions with service providers, for instance the staff at Ozanam House. This has implications for service providers who need to realise that their own behaviour and relationship with homeless people can inadvertently adversely affect this population's health and reinforce the consequences of stigma.

The relationship between service availability and service need

The negative experiences of homelessness, such as those periods an individual was in crisis within his or her homeless context, were exacerbated by a lack of resources and services. My review of the homeless services in Darwin highlighted that not only were there many gaps in service provision, but also a significant shortage of services given the high homeless population. This study has also found that as an individual's needs became more complex, services were less able to respond in a meaningful and effective way due to financial constraints, inadequate resources and the need to manage their responsibilities within a legal framework.

In addition to the problems surrounding access to, and availability of, homeless services, homeless people experienced many barriers to accessing health services. This study found that while the lack of services was of major concern, other factors of the homeless

experience, such as stigma and trauma, hindered these peoples' ability to achieve wellbeing.

The obvious implication of this finding relates to the need to increase funding and resources in order to provide sufficient and appropriate services to this population. This will require governments recognising their responsibilities toward these people, and challenging their propensity to write homeless people off as 'a lost cause' simply because they can not re-integrate as members of mainstream society. This is not just a matter of increasing funding, but committing time to rethink and challenge the assumptions made about homeless people. By investigating the lived experience of homeless people, this study has given insight into some of the assumptions that need to be challenged in Darwin if homeless peoples' health is to be improved.

Home in the Long Grass

My findings revealed that homeless people constructed positive notions of home situated within their homeless context and that this contributed to improved wellbeing. An examination of the literature on homelessness concluded that little was known about the lived experience of homeless people in Australia from the perspective of the homeless people themselves. Even less was known about their quality of life and how homeless individuals understood and then managed their own health during homelessness. The loss of home itself, as a multifaceted and constructed concept, did not account for the lived experience of being homeless. This study has shown that being homeless placed individuals in a precarious position in society, as the powerful stigmatising processes acted to reinforce mainstream notions of their deviance and undesirability. Yet the literature on home provided an important insight into the many forms of loss experienced by homeless people. This literature also provided an insight into the many forms of home individuals create/retain during their homelessness.

Memmott *et al* (2003) stated:

For those who have abandoned mainstream housing options and connected themselves and their daily activities to certain public spaces, the condition of being homelessness is about having no control over, or legitimacy in, the places

they have chosen to call home. Approaches, which fail to recognise that these public place dwellers do not want to be readily reintegrated into the mainstream, can have little real success in improving their quality of life (Memmott *et al*, 2003, p.iii).

It was found that being able to construct aspects of home and normalcy in the Long Grass went a long way to improving the life quality and health of homeless people, through achieving wellbeing. Further, study participants were not entirely devoid of positive dimensions of home. This thesis has presented numerous examples of these home experiences, including Ozanam House as home being: a familiar social and spatial experience; a haven to escape the dangerous outside; a place of social connectedness; a place to recover, feel cared for and care for others; a place to feel social acceptance and normalcy; and as a place to recall memories of significant places, events and people. Homeless people in this study also experienced many negative aspects of home during homelessness, such as home in the Long Grass as a place of fear, violence and exploitation.

This study concludes that the use of the word 'homeless' does not capture the lived experience of homelessness. As such, the challenge will be to find methods of communicating homelessness in ways which have resonance with the experience. My inquiry suggests that an alternative way of conceptualising homelessness is to shift from a house orientated perspective of home and work to create healthy environments in multiple habitats.

My research has demonstrated that creating a more favourable social environment is pivotal to the wellbeing of homeless individuals, and this, in part, may be achieved through addressing the physical environment in which people live out their daily life in the Long Grass. The focus on housing people, however still continues to be one important response to some forms of homelessness. Yet for the primary or chronically homeless, the transition from the Long Grass to a housed lifestyle will require appropriate and ongoing support if sustained health and life quality outcomes are to be achieved.

Such support must recognise the lived experience of homelessness and the cultural and social challenges that emanate from this way of life.

A homeless knowledge base

In addition to the identified key dimensions of trauma and stigma in the homeless experience, this study has found that health seeking behaviours were significantly influenced by the way in which knowledge was accumulated by the homeless population under study. This key dimension to the homeless experience was found to have played a pivotal role in health care management and in accessing health care services. This homeless knowledge base was also found to facilitate planned movement in order to meet desired needs. Further, this knowledge contributed to the shaping of a homeless identity which involved relationships with other homeless people and the institutions set up to provide for them. Becoming more knowledgeable within this world, e.g. knowing about meal services and how Vinnies or jail constituted respite care, was an important strategy for daily survival and improved wellbeing among the study population.

This study has revealed that homeless knowledge was formed through three critical areas: individuals' own experiences; shared experiences with other homeless people; and through the information provided by other services. The implications of this finding for service providers will be to make the most of understanding the pathways in which knowledge is gained by homeless populations in order to bring about desired change and provide more relevant, efficient and effective services.

Homeless people and health

The theoretical debates on health suggest it is socially and culturally constructed, and generally accept wellbeing as an integral component of lay persons' holistic conceptions. The evidence presented in this study indicates health for Ozanam's homeless population should therefore be considered within a framework of compounded trauma interacting with the ongoing processes and outcomes of stigmatisation.

Within this framework, participants in this study conceptualised their health in terms of a type of wellbeing and this wellbeing was affected by many factors. These factors included: physical health; diet; mental health; sexual health; assaults to identity including disconnection from place and events that invoked a sense of shame; alcohol and drugs; sorcery; and loneliness and social disconnectedness. The latter two factors had a powerful influence on daily decision making and were strong determinants of wellbeing. This finding is at odds with the common perception held by members of mainstream society and with conclusions found in the literature which subscribe to the notion that homelessness can be resolved through addressing the structural factors alone; in particular through the provision of housing. This study has illustrated that those few individuals who experienced being housed also experienced ill-being stemming from loneliness.

The findings presented in this thesis confirm that wellbeing was inhibited by the circumstances of the life worlds of homeless individuals and individuals behaved in ways which were detrimental to health from a western biomedical perspective. Individuals had a pragmatic approach to their own healthcare and would put up with most conditions until they were no longer able to meet the demands of daily survival. Alternative treatments for illnesses were used as important coping mechanisms and their homeless knowledge in this area was often privileged. People were resourceful and made sound decisions about their health based on the limited range of options available to them. The lack of confidence in dealing with the medical profession reduced these options as the power disparity was compounded by homelessness itself.

The implications stemming from the findings of this thesis suggest it is important to accept that there will always be homeless people. It is unhelpful to construct homelessness as a problem to be solved through housing, as it masks the issues that most affect the health of homeless people. As illustrated in this study, homeless people are not fundamentally deviant. By understanding their life worlds, the opportunities to develop more creative responses for improved health and life quality, in a socially and culturally sensitive manner, are more likely to emerge. From this standpoint, my research has

implications for mainstream society, governments and non-government agencies involved in policy development and service delivery to homeless populations, and for homeless people themselves. The challenges emerging through this Darwin study are consistent with the findings of Davis (1996) who argued that, “*by developing cultural sensitivity and using a cultural perspective in program planning, health and human service providers can empower the homeless to achieve lifestyles that are less stressful, less dangerous, and more productive, and that, most importantly, provide for human dignity and basic human rights*” p.182. This study found that homeless people want to behave like ‘normal’ people but are excluded and forced into a role of deviance that they do not generally embrace themselves.

This thesis raises the challenge of involving homeless people in meaningful ways in the development of policies and services which have a direct impact on their lives, in particular, at the local level where the public places constitute the physical environments in which homeless people live. Engaging homeless people in these processes can only occur through the gradual building of trust and this will be a challenge. Homeless people need a voice for this process to advance. This study has found that recognition should be given to the fact that homeless people do not wish to be defenceless. However, pressing priorities around basic survival compete with the desire to have a voice and improve life quality. This needs to be taken into consideration when attempting to engage this population.

While there are challenges and barriers to the meaningful engagement of homeless people in discussions around health, this study points to the need for homeless people to be supported in having increased input to local planning and policies. This Darwin study has found that there is a propensity for mainstream society to build homeless people out, and concludes that in order to improve the health of this population, society must look for ways to build this population in. Such measures could include:

- (i) the creation of private spaces in public places;
- (ii) the planning for security which protects public spaces used by homeless people;

- (iii) the construction of healthy shelters/housing, regardless of the form and permanency;
- (iv) the identification of suitable locations for alternative and safe shelters for transient populations;
- (v) the adaptation of existing facilities to be used by homeless people, such as public benches; and
- (vi) the provision of secure and accessible lockers for the storage of personal items and important documents.

These measures aim to counteract the consequences to health which stem from stigma and trauma.

The implications emerging from my study also suggest the need for both government and non-government agencies to challenge existing policies that adversely affect the health of homeless people, or which are discriminatory or have the potential to criminalise poverty. In ensuring this population have access to the same safeguards experienced by the mainstream populations, my inquiry suggests it is necessary to provide the basic public and environmental health measures that protect human health. Such measures could include:

- (i) improved access to clean water and sanitation;
- (ii) access to facilities for the maintenance of basic hygiene standards;
- (iii) access to safe and nutritious food;
- (iv) access to facilities that enable the maintenance of personal appearance, such as haircuts and dentistry;
- (v) maintenance of sanitation facilities (toilet and shower) with the provision of sanitary goods, such as soap, toilet paper, sharps bins, waste bins, mirrors etc;
- (vi) public kitchens for self catering or all-weather BBQ facilities;
- (vii) access to laundry, clothes and blankets; and
- (viii) the strategic delivery of contextually relevant primary health care, health promotion and education programs to homeless people.

Homeless populations are inherently difficult when it comes to health promotion messages. These behavioural messages have little meaning to or resonance with people who live day by day. In this context, mainstream health promoting messages are not relevant. The challenges emerging from this study point to the need for approaches to public health which understand the ways in which homeless people accumulate knowledge (and experience their homelessness) in order for the effective delivery of programs.

A final comment...

The key dimensions to the homeless experience and the health of homeless individuals are not adequately addressed in the Australian literature. While making its contribution to knowledge in this area, this research has highlighted the value of a continuing research focus on the lived experience of homeless people. It is only through such explorations that the wellbeing of homeless populations may be addressed.

Homelessness is conceived of as an undesirable way of being by mainstream society. But for many people there is no alternative. Currently there are few opportunities to avoid the consequences of stigmatising and traumatising processes. Homelessness should be addressed creatively and collaboratively, across multiple disciplines and across all levels and sectors of government, particularly at the local level. Importantly, if improved health and life quality outcomes are to eventuate, responses to homelessness must find ways to include the voices of homeless people themselves and must ensure the responses have social and cultural relevance to the lived experience of this population. It is not until the life worlds, aspirations and understandings of homeless people are better known and appreciated that governments and other agencies will be in any position to offer appropriate services and care.

By addressing the key dimensions of the homeless experience which have the greatest influence on health, the agencies concerned can begin to create living environments which reflect the experiences and the hopes of homeless people and which are supportive of their health and a better quality of life.

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Appendix 1

SAAP Funded services in the Darwin area

Each table presents background information sourced from service providers, generally managers, and includes: demographics of the usual clients; the core services provided by the service; and specific aspects that impact on client access to the service and that shape service delivery. It should be emphasised that this information was based on what *usually* occurred in the service, which may differ from time to time. For example, while Service 1 will cater to the needs of youth between the age of 15 and 19, it was more usual for clients to be 15 – 17 years of age. Further, at Ozanam House, meals were available to all children and adults, both Indigenous and non-Indigenous. It was not usual, however, for children or non-Indigenous adult women to access this service.

The name of each service had no relevance to this study and as such has been excluded, with the exception of Ozanam House. By providing a summary of each SAAP service in this way, this section aims to highlight the gaps in service provision.

SAAP service	Usual clients	Core services	Comments
Service 1	12 youth, majority 15-17yrs, accommodated. 58% single, 70% female, 44% Indigenous. 30 youth case managed through outreach.	Semi-supported accommodation in 6 x 2 bedroom units, share facilities. No food. Outreach services. Usual stay 6 months.	No alcohol and drugs on premises. Can be intoxicated. Must have income and pay 30% in rent plus \$15 utilities per wk & \$200 bond.
Service 2	3 youth, 15-19yrs, accommodated. 50% males, 35% Indigenous. Outreach for 12-20 youth at any one time.	Semi-supported accommodation in a 3 bedroom townhouse, share facilities. No food. Average stay approx. 5 weeks. Outreach services.	No alcohol and drugs on premises. Can be intoxicated. Rent depends on income status – will assist to secure income then must pay rent and utilities.
Service 3	6-7 youth, usual age 15 - 16. More males than female. Singles only. 50% Indigenous.	Accommodation – usually approx. 4 wks – in 4 x 2 bedroom, same sex blocks, share facilities. Food provided. Case management and accommodation brokerage.	High need clients (e.g. drug dependency or suicidal) referred or moved on. No alcohol or drugs on premises. Must not be intoxicated and cause a problem. 7.00pm curfew. Nominal charge of \$40 per week if you have income.
Service 4	3 youth, age 15-24, usually male with an average age of 17-18. 50% of clients are Indigenous. Clients are often asked to leave the family home by parents. Clients are often students.	Accommodation in a 3 bedroom community based house with medium level support for 3-6 months with good access to public facilities. Usual stay is 2 months. Clients have own room and share facilities. Responsible for own food, cooking and property maintenance. Employment assistance, referral, independent living skills and counselling.	Fees are \$100 for 2 weeks for rent and electricity. Will accept clients with addictions where referral agency provides support. No alcohol, drugs or pets on premises. No curfew for clients, 10.00pm for visitors. On-call worker visits regularly to monitor and support clients. Eviction is common, usually for drugs, alcohol

			or damage to property.
Service 5	3 female youth. Approximately 50% of the clients are victims of domestic violence.	Usual stay 2-3 months.	As above
Service 6	5 females either pregnant or with a baby under 12 months. The average age of clients is 20-21 and they are mostly Indigenous. Most clients are victims of domestic. Clients are not usually students.	5 bedroom house with a pool. Usual stay 2-3 months.	Clients take the opportunity to save towards white goods while waiting for public housing. Territory Housing responsive to the needs of this client group. This client group less likely to return to the service.

Table 1: SAAP funded services in the Darwin area for youth (personal communication with each service, 2005).

SAAP service	Usual clients	Core services	Comments
Service 7	18 male adults. Usually 4 Indigenous and 14 non-Indigenous. Therapeutic community.	Accommodation – approx. 9 in long term stay (years), own room. 9 in dorm style room. Share facilities, own food and cooking. Daily activities and transport available Tue/Wed.	Must abstain from drugs and alcohol – random and routine breath and urine testing. Rent is \$100/wk. Rural setting limits temptation for alcohol.
Service 8	20 single adult males. Majority of clients are non-Indigenous with the majority between 30-45 years old. 50% of clients are from interstate.	25 single rooms with fan and share facilities. Average stay is 80 days. A few clients have stayed for more than 20 years. Semi supported living, with meals, cleaning equipment and linen provided. Counselling and referral services. 10-20% expected to return.	No pets, alcohol or drugs permitted on-site. Off-site OK provided consistent with individuals case plan. Clients are expected to work towards goals as a condition of stay. About 50% of clients are goal oriented. Rent is \$120/wk. Visiting hours are 8.00am-6.00pm. Access restricted to residential area.
Service 9	5 adult male Vietnam War veterans and non-veterans. Usually 60% veterans, with 1 in 10 clients Indigenous. Clients often have mental health problems.	Accommodation - stay varies, usually 3 months. Semi supported living, own food, cooking and daily maintenance. Formal and informal welfare counselling on-site. Transport for medical and employment appointments.	No alcohol, women, drugs, weapons or pets on premises. No curfew with free access. Drinking off premises allowed. There is a financial imperative for beds to be filled. Fees are \$10 per night. Return clients are often based in remote locations and stay while in town.
Service 10	20 single males age 18-75, usually 20-40 years old. Usually not more than 2 Indigenous clients	Accommodation in own room with share bathroom.	No alcohol, drugs or implements women or pets. Breath testing with no access for people with blood alcohol level of

	<p>per night.</p> <p>Number of clients with mental health issues is notable.</p>	<p>Maximum stay is 3 months; usual length of stay is 6 weeks.</p> <p>Free soup and bread and \$4.00 meals for anyone.</p> <p>In 2004/5 there were 3483 paid bed nights, 2604 free bed nights, 2022 meals for room guests, 3143 x \$4.00 meals and 8475 free soup meals served.</p>	<p>more than 0.2 - referred to spin dry.</p> <p>Up to 12 free nights. \$12/day or \$80/wk bed and breakfast.</p> <p>With dinner \$16/day or \$100/wk.</p> <p>Must vacate premises by 7.30am and not return until 3.30pm, with a 10.30pm curfew.</p> <p>Turning up to 10 away per week.</p>
<p>Ozanam House, St Vincent de Paul Society</p> <p>This service is discussed in detail in Chapter Six.</p>	<p>Up to 14 single adult males, both Indigenous and non-Indigenous in the Shelter²⁷.</p> <p>Usually between 45-65 Indigenous adults and non-Indigenous male adults at each breakfast and lunch service.</p> <p>35%-45% of all clients are Indigenous.</p> <p>Alcoholism, mental and physical health problems are common among clients.</p>	<p>Over night shelter for 10 male adults in dormitory style. Usual stay 1-2 weeks. Not unusual for 2-3 to be longer term with return clients not uncommon. 2 clients are long term residents, 1 being the night watchman.</p> <p>Common facilities.</p> <p>Free meal service for breakfast and lunch.</p> <p>Referral, counselling, in-services, respite, shower, laundry.</p>	<p>No alcohol or drugs onsite. Clients often intoxicated and are permitted access to services provided do not cause problem. Shelter guests expected to help out. Can stay all day. Must book in by 3.30pm and can not leave premises in the evening or across the night. Nominal fee of \$10/night.</p>

Table 2: SAAP funded services in the Darwin area for single adult males (personal communication with each service, 2005).

²⁷ The shelter component of this service had closed by December 2004, during the fieldwork phase of this study. The data presented here is based on the period when the service operated a shelter.

SAAP Service	Usual clients	Core services	Comments
Service 12	<p>10 single adult women, no children. Usual age 25 - 40 yrs. Refuge for 6 women, 57% Indigenous.</p> <p>Overnight shelter for 4 Indigenous Long Grass women who are not victims of violence.</p>	<p>Accommodation in refuge and shelter. Share rooms and facilities. In refuge food provided with usual stay 2 wks. In shelter usual stay 1-2 nights.</p> <p>2 semi supported houses in the community for share housing.</p>	<p>No drugs and alcohol in refuge. Do not test women. Will take intoxicated women in shelter if known and/or cause no trouble.</p> <p>Rent is nominal and set at \$50/wk in the refuge. Shelter has no charge.</p>
Service 13	<p>6 Indigenous women with around 16 children escaping violence and homelessness.</p> <p>Usually women from remote locations aged 30-40 years.</p>	<p>Shelter for women and children in flexible share arrangement.</p> <p>Usual stay is 1-2 nights.</p> <p>Case management, outreach, referral, transport and advocacy.</p> <p>Semi supported living – clients clean, look after kids and self.</p>	<p>No drugs, alcohol or pets permitted. Not allowed to be intoxicated.</p> <p>Fees are \$20 per night and \$20/wk for children. Can stay initially with no money.</p> <p>All food provided</p> <p>Free access with a curfew at 10.30pm.</p>
Service 14	<p>7 women with approx. 15 children who are escaping violence.</p> <p>Average of 45% Indigenous and 15% non-English speaking background clients over a year. Community housing usually non-Indigenous.</p> <p>A notable number of interstate clients.</p>	<p>Shelter accommodation in 3 houses with 2 families per house. Usual stay is 8 wks</p> <p>Halfway accommodation in a house and a unit. Usual stay is 6 months.</p> <p>Community housing in 3 houses with usual stay of 18 months.</p> <p>Semi-supported living – buy own food and do own cooking.</p>	<p>Violent free zone. Women with boys over 13 years stay in halfway house, not shelter. Indigenous people respect the concept of a women's only space.</p> <p>Can stay with no money or belongings. Nominal fee of \$40/wk for utilities.</p> <p>No curfew, regulated access. No alcohol, drug or pets onsite. Off-site controlled drinking permitted.</p>
Service 16	Victims of sexual assault	Counselling	Information unavailable

Table 3: SAAP funded services in the Darwin area for adult women (personal communication with each service, 2005).

SAAP Service	Usual clients	Core services	Comments
Service 17	<p>60-80 clients in family groups or single adult women.</p> <p>A further 25-30 Indigenous clients in the crisis care facility.</p> <p>99% of clients are Indigenous</p>	<p>Accommodation in share rooms with up to 8 beds in bunk style.</p> <p>Crisis and acute care for Indigenous clients Darwin.</p> <p>All meals, cleaning and maintenance provided.</p> <p>Length of stay varies and is usually 2 weeks, 3 months or for life.</p>	<p>Access to crisis care is by referral from the Harmony office. No alcohol permitted.</p> <p>Fees for all accommodation are \$140/wk for a single, \$200/wk couple and \$20/wk for each child. The Centre does not expect or want clients to volunteer in any capacity.</p>
Service 18	Information unavailable	Information unavailable	Information unavailable
Service 19	<p>Singles or families, men and women over 16 with or without children.</p> <p>The average age of clients is around 26 with children between 6-10 years.</p> <p>55%-60 % of clients are Indigenous.</p> <p>Clients often require a high level of support.</p>	<p>Accommodation in 2 self contained 3 bedroom units. Self sufficient living. Each unit can take 6 or more. Usually between 6-8 people in both units.</p> <p>Usual stay is 3-4 months.</p> <p>Alternative housing, referral, information with strong counselling focus.</p>	<p>Rent is \$95/wk, including utilities. Access determined via committee decision.</p> <p>No pets, drugs or alcohol on premises. Can drink off premises. Clients may be evicted after 2nd complaint.</p> <p>On departure may get a no interest loan for a fridge or washing machine.</p>
Service 20	<p>Families escaping domestic violence with children.</p> <p>Around 50% of clients are male and 50% female.</p> <p>Age of client varies but typically around 30 years old.</p> <p>50% of clients are Indigenous.</p>	<p>Crisis accommodation in safe houses. Self supported living. Always at full capacity. Usually 1 family per house or sometimes 2 small families.</p> <p>Usual stay is between 3-6 months.</p> <p>Counselling for children.</p> <p>Advocacy, legal</p>	<p>Rent is on a sliding scale according to income and includes utilities.</p> <p>No adult counselling. No alcohol or drugs on site. Alcohol accepted off-site. No testing.</p> <p>Client assessment at shop front then moved to safe house.</p> <p>Male clients often non-</p>

		processes, referral, alternative housing.	Indigenous with Indigenous partner, drugs and alcohol often involved.
Service 21	<p>Drug and alcohol rehabilitation - Up to 30 clients in total usually comprised of family groupings. Families encouraged to participate. Adults usually in mid 30's and Indigenous. More men than women. Rare for client to be alone.</p> <p>Returning home program – 1 client/wk staying for usually 2 weeks. Directly from Long Grass via referral. The most clients at one time have been 4.</p>	<p>Drug and alcohol rehabilitation program lasting 8 wks. 50-60% stay 8 wks with highest drop out rate in 1st wk.</p> <p>Accommodation in self contained duplexes with kitchenette.</p> <p>Registered training organisation providing courses in alcohol and other drugs.</p> <p>Post program support in housing, bond assistance, utilities, ongoing counselling etc.</p> <p>Returning home program is a new initiative. Alcohol and drug withdrawal for 12 adults in newly constructed self contained buildings.</p>	<p>Rehabilitation program is \$95/wk rent plus \$55/wk food and weekend outings paid direct from Centrelink pay. Clients must stay on-site except for medical and organised outing. On-site education for children. Breath and urine testing is random and targeted.</p> <p>Service purchases and allocates food for clients to cook.</p> <p>Returning home program – pay for food and accommodation</p>

Table 4: SAAP funded services in the Darwin area for families and others (personal communication with each service, 2005).