Making the link between mental health and youth homelessness

A pan-London study

There’s no-one here supporting me mentally, it’s so lonely and isolated, I had nobody to turn to. My mental health problems definitely got worse but the experience has made me more resilient. I just want to do something with my life, I can make a difference now!
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ABSTRACT

The transitional years from childhood to adulthood are a significant milestone in a young person’s life. There are a number of factors that hinder a successful transition including a reported increase in the risk of homelessness. This study examines this phenomenon among 16-25 year olds. Quantitative and qualitative data were collected from services involved with young people experiencing homelessness across London (n=123) and from the young people who accessed these services (n=59).

Key findings from service sector data included a lack of integration between services attending to housing and mental health needs simultaneously and a lack of mental health awareness, including low confidence across service sector staff to provide basic emotional support for young people within the generic housing and homelessness sector. However, promising practice examples were identified reflecting innovative approaches delivering more comprehensive care and these are presented in the findings. The key findings from young people support current literature within the field of youth homelessness and mental health specifically highlighting the association between these characteristics. Mental health problems commonly precipitated and were exacerbated by homelessness and typically present within socially disadvantaged groups. These findings have implications for policy, commissioning, service practice development, and a training agenda and identify the need for further research within this field. These implications are discussed and recommendations have been made.
SECTION I: BACKGROUND

1.1 Introduction
The period of transition from childhood to adulthood is a rite of passage that presents both opportunities and risks. Over the past 20 years traditional pathways to adulthood have been replaced with less certain routes. Family and community ties are more fluid, ‘job for life’ securities are rare, and jobs are increasingly only available for those with the pre-requisite qualifications (Policy Action Team [PAT] 2000). Young people now have more intense exposure to high-risk behaviours including alcohol and drug use, availability of financial credit and sexual activity. On top of this is the seemingly ever-present encouragement from the media toward increasing maturity at an earlier age. Whilst most young people harness these freedoms and opportunities constructively, for others this period of transition is difficult and risky. Furthermore, disadvantage at this transitional point can have devastating consequences throughout a person’s life (Social Exclusion Unit [SEU] 2005).

Two factors associated with these shifting sands are an increasing proportion of young people who report being homeless and an ongoing rise in the incidence of mental health problems among the young. The Mental Health Foundation and Centerpoint have each conducted work into the mental health of young people experiencing homelessness (MHF 2002, Centrepoint 2005). This report reflects a partnership between the two organisations and describes the background, methods and findings of a pan-London study into homelessness and mental health among 16-25 year olds.

1.2 Homelessness among young people
It is difficult to provide accurate data on the number of young people experiencing homelessness. Estimates depend on the definitions of the populations that are used and the ability of research staff to access members of that population to form representative samples (Warnes et al 2003).

Please and Fitzpatrick (2004) conducted work on behalf of Centrepoint to develop a baseline estimate of the number of young people between the ages of 16 and 24 who experienced homelessness in England over the course of 2003. A young person was defined as being ‘homeless’ if they didn’t have, or were imminently going to lose accommodation that they could reasonably be expected to occupy. Between 36,000 and 52,000 young people were estimated to have been ‘found homeless’ by local authorities. Of these, between 4,700 and 6,700 individuals (13%) were thought to have had recent experience of sleeping rough. However, the researchers commented on the paucity of reliable data with which to determine whether youth homelessness was increasing or decreasing in England year on year.
More recent evidence produced through the Office of the Deputy Prime Minister (OPDM) does point to an increasing trend. In 2004-05 nearly one in ten of all those accepted as homeless were young people, and their proportion of the total rose by 6 per cent between the years 1997 and 2005 (SEU 2005). Although this increase is partly due to a widening of the statutory definition of priority need in 2002, statutory returns are likely to underestimate true prevalence since not all young people who experience homelessness come to the attention of the authorities.

Hidden populations of people experiencing homelessness include those who live in overcrowded conditions, those who stay with friends and relatives or in night shelters and hostels, and those who opt to sleep rough away from the outreach services of care providers. Crisis (2004) has estimated there may be as many as 380,000 hidden people who are experiencing homelessness in Britain, which is equivalent to the population of Manchester. Pplease and Fitzpatrick (2004) suggest there may be several thousand young people who experience homelessness each year without having any contact with local authorities. The gravity of the situation is evident in the results of a 2004 survey of the reasons why young people access health and/or social services. More than one third did so because they were homeless (Social Exclusion Unit [SEU] 2005a).

1.2.1 Young people’s risk of being homeless

The risk of becoming homeless is greatest for those who have experienced multiple disadvantage including disrupted family background, institutional history, poor socio-economic status and poor health (SEU 2004a). Among those who appear to carry this increased risk are black and minority ethnic communities, care leavers, drug and alcohol users, asylum seekers and refugees, and lesbian, gay, bisexual or transgender people.

Black and minority ethnic communities

In the 2001 census black and minority ethnic (BME) communities accounted for 7% of England’s population whilst for the year ending June 2004 they accounted for 20% of households (including single people) accepted as homeless by local authorities (Garvie 2004). Other data reveal a 34% increase in households accepted as homeless by English local authorities between 1977 and 2004 and this figure rises to 77% for BME groups over the same time period (OPDM 2004). African Caribbean communities appear to be the most over represented with an 89% increase in homeless households. The impact of these figures on young people cannot be under estimated. Minority ethnic groups in the UK have a younger age structure than the white population, with 48% being under the age of 24 (Cabinet Office 2000).
The reasons for these dramatic increases are poorly understood. It is thought that an underlying reason for the higher prevalence of homelessness among people from ethnic minority backgrounds is that they are more likely to experience the risk factors associated with homelessness and face multi-faceted deprivation than white people (ODPM; 2005). According to Sommerville et al (2001) emerging key factors that explain the increased likelihood of homelessness for BME people include the extended nature of many BME families, which can result in overcrowding in housing stock, experiences of social exclusion and racism, low incomes, unemployment, limited housing opportunities in the right location and a lack of cultural awareness among housing staff.

**Care leavers**

As of 31st March 2004, 61,100 children were in public care in England and over the preceding year 6,700 left care aged 16 or over (Department for Education and Skills [DfES] 2005). As well as making the transition from youth to adulthood these young people face the additional challenge of managing the transition from care to independence. The majority (62%) have a history of abuse or neglect and it is against this backdrop that they enter adulthood (DfES 2005). It has been widely acknowledged that care leavers are vulnerable to homelessness and reports suggest that up to one fifth of care leavers experience some kind of homelessness within 2 years of leaving care (DfES 2005, Broad 1998).

**Drug and alcohol users**

The relationship between substance use and homelessness is complex and can be reciprocal in nature. Thus, substance use may lead to a period of homelessness, which in turn may worsen the substance use behaviours. In a study of young people experiencing homelessness across England and Wales 73% were found to be current drug users, a majority of whom had left home because of family conflict (Wincup et al 2003). However, of those who were using heroin and/or cocaine more than half started only after becoming homeless. Similarly, in a pan-London study of homelessness among all age groups 83% were found to be substance users and their levels of dependency and the likelihood of them injecting drugs increased the longer they remained homeless (Fountain and Hawes 2002). This negative association between homelessness and substance use is further compounded by the pessimistic views held by some service providers. Wincup et al (2003) report a tendency for housing workers to feel insufficiently skilled to provide meaningful care to young substance users and to attribute negative feelings towards this specific group.
Asylum seekers and refugees

The number of asylum seekers entering the United Kingdom has fallen in recent years with 31% fewer asylum applications being received in 2004 compared with 2003 (National Statistics 2006). Some of the mechanisms put in place by Government to bring down these figures can increase the risk of homelessness for this group. For example, Section 55 of the Nationality, Immigration and Asylum Act (2002) provides opportunity for authorities to no longer have obligatory responsibilities if an application for asylum is not made as soon as reasonably practicable after entering the UK. In 2003, nine thousand individuals were refused support as a result of Section 55 and a common consequence of this action was homelessness (Refugee Council 2004). Government's support structures also impact on young asylum seekers such as the National Asylum Support Service (NASS), which supports waiting claimants from the age of 18 until a decision is made on their asylum application. A positive outcome, such as being granted refugee status means the young person becomes entitled to receive mainstream welfare benefits. The ending of NASS support (subsistence and temporary accommodation), which ends after 28 days, can itself precipitate a period of homelessness (Stanley 2001).

Lesbian, gay, bisexual, transgender people

Most local authorities and housing providers do not monitor the sexuality or gender orientation of their clients (Gold 2005). It is not known therefore how great a problem there may be for these groups, nor is it possible to determine how well services are responding to need. Nevertheless, there is evidence which gives cause for concern.

Sexuality and gender orientation can themselves cause some young people to become homeless. In a survey of 16-22 year olds who were lesbian, gay, bisexual or transgender (LGBT) one third became homeless because of non-acceptance by their family (Dunne et al 2002). Others experience verbal and physical harassment, which can lead some to leave their own home (Gold 2005). According to William & Molloy (2001) in most service settings, young lesbians and gay men are completely invisible, their particular needs are rarely assessed, and they can be reluctant to share their full stories in the expectation of intolerance from staff.

1.3 Mental health problems in young people

In recent years there has been an upsurge of scientific and media interest in the mental health of young people. In a recent study commissioned by the Nuffield Foundation, which examined
adolescent mental health in the UK over the past 25 years, emotional problems including anxiety and depression had increased for both girls and boys since the mid 1980s (Hagel 2004). This study took account of increasing tendencies among parents to rate teenagers as problematic, but real changes in problem levels remained. Other UK research has supported this trend not only for anxiety and depression but also for conduct disorders and self-harm behaviours (MHF 2005).

These findings are markers for the presence of common mental health problems rather than for more severe and enduring conditions such as schizophrenia, which appear more stable in their prevalence. However this also points to the importance of looking beyond psychiatric diagnoses for evidence of compromised mental health among young people. From a mental health perspective, emotional competence, connection to others, attitude to self, neighbourhood trust and autonomous expression (among other concepts) are important indicators of mental health and if frustrated can become the precursors for some common mental health problems (World Health Organisation [WHO] 2001). This perspective serves also to emphasise the value of interventions to strengthen young people’s resilience and thereby reduce their risk of encountering mental health problems.

Our understanding of the long-term consequences of child and adolescent mental health problems is at a relatively early stage. Nevertheless, it is true that the majority of adult mental health problems can be traced back to initial symptom identification between the ages of 11 and 15 years (Kim-Cohen et al 2003). Longitudinal research also demonstrates a negative correlation between childhood mental health problems and earnings, qualifications, employment, relationships and family formation, general health and disability later in life (MHF 2005). There is then an emerging body of evidence that points to the long-term costs of child and adolescent mental ill-health for individuals, their families and communities.

1.3.1 Associations between mental health and homelessness

It seems reasonable that in most cases the loss of one’s home will bring about stressors that can deplete an individual’s mental health. Thus, it is estimated that between 30% and 50% of single people experiencing homelessness have mental health problems compared with between 10% and 25% of the general population (Warnes et al 2003). More specifically in a London based study of young people experiencing homelessness in which psychiatric diagnostic criteria were used, two thirds met the threshold for a mental disorder (Craig et al 1996). In the same study 70% of those with a diagnosable mental illness had experienced their first symptoms before their first episode of homelessness.
It seems likely that as well as creating or exacerbating mental health problems, homelessness might itself be precipitated by a mental illness. There is also the possibility that other factors may put individuals at risk of both homelessness and mental health problems. Against this backdrop Centrepoint (2005) has reported a lack of adequate provision to manage the increase in mental health problems amongst young people, which if untreated can lead to far greater long-term problems. As long as there is homelessness there will be an associated burden of mental ill health above that which exists in the general population. People who live in bed and breakfast or hostels are 8 times more likely than the general population to experience mental health problems, and those who sleep rough are at 11 times the risk (Wright 2002).

1.4 Policy and practice context
Statutory responsibilities of local authorities to people experiencing homelessness are contained within the *Housing Act 1996 Part VII* and the *Homelessness Act 2002*. Young people have no automatic entitlement to social housing unless they can demonstrate their vulnerability against strict criteria. However, young people who have dependent children are considered to be in priority need and since 2002 16-17 year olds and 18–21 year old care leavers are also considered to be priorities.

Those young people not accepted by local authorities have to arrange their own accommodation for which they may need to claim housing benefit. However, this is administratively complex, difficult to claim and many entitlement calculations are incorrect, with the potential for overpayments to be recovered from landlords (Institute of Revenues Rating & Valuation [IRRV], 2001). This can make landlords reluctant to accept young people on housing benefit, pushing them toward poorer quality accommodation or rough sleeping.

Without private sector or social housing a young person may turn to the voluntary sector where they can access hostels and other temporary shelter. However, demand consistently outstrips supply and commentators have drawn attention to the psychologically challenging aspects of residing in hostels and shelters, as well as difficulties people encounter when wanting to move on (Warnes et al 2005).

Other policies and practices can impact on young people experiencing homelessness such as *Supporting People*, which replaced various funding streams from 1st April 2003. Supporting People places responsibility on local authorities to fund, plan and commission all housing-related support services and has brought significant changes, including more attention on issues of quality and "user involvement" (Audit Commission 2005). There have been concerns expressed that Supporting People has limited the referral routes available for people experiencing homelessness and in particular for those with mental health problems (Sainsbury Centre for Mental Health [SCMH] 2003).
The mental health policy and practice context for young people is beset with problems of integration. There are two National Service Frameworks relevant to the mental health needs of 16 – 25 year olds, although the adult framework has been criticised for not adequately addressing the needs of 18-25 year olds, and the children’s framework is not solely orientated to mental health (DH 1999, 2004). Thus, the mental health needs of young people as they journey from adolescence to adulthood are not clearly articulated in existing national policy.

In keeping with these different strands of policy specialist mental health provision is divided between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services. Until recently specialist CAMHS services across the country have employed different age cut off points resulting in some 16 and 17 year olds having to access adult services for support. From 2006 it is expected that all young people aged 16 and 17 will be entitled to support from CAMHS. However, entitlement does not guarantee receipt of service and there remain many practice gaps that young people can fall through as they mature from adolescence into early adulthood. As with the housing sector, the demand for psychological support or psychiatric intervention outweighs the current supply of services.

Any young person between 16 and 25 who seeks mental health support is likely to encounter access difficulties. These problems can be compounded if the young person is homeless. There is an increasing need to find ways to provide access for young people experiencing homelessness in contexts where they are comfortable, and to integrate provision so that it is relevant throughout a young person’s life.

1.4.1 The London context

The challenges of youth homelessness and mental health are as relevant to rural communities as they are to urban centres. However, there are characteristics specific to London, which warrant attention. The capital is relatively young in its age structure with nearly one quarter of its citizens being under 18 years old, and of those who live in inner London 48% reside in households with an income that is below the official poverty line (Greater London Authority [GLA] 2004). Despite London’s wealth young people continue to experience the highest levels of poverty and inequality of any region in the UK.

Although black and minority ethnic groups concentrate in various parts of the UK the highest proportion reside in London making up 23% of the local population (OPDM 2003). Over 40% of under 18 year olds in London are from Black, Asian or other minority ethnic groups (GLA 2004). London also
attracts other groups who may have experienced marginalisation elsewhere, such as lesbians and gay men, but who find communities of like-minded people in the city.

London has a higher proportion of people who experience mental health problems at some time in their lives than is found elsewhere in the country and the capital has a severe lack of good quality affordable housing (SCMH 2003). For these reasons the present study is confined to London, which will limit the degree to which its findings can be applied nationally. Nevertheless it is anticipated that some key lessons will emerge for the mental health and housing sectors across the UK.

1.5 Summary
On the available evidence there is a noticeable increase in the incidence of homelessness and in the presence of mental health problems among young people in the UK. For some there appears to be a mutually sustaining relationship between these two attributes so that one may lead to or exacerbate the other and vice versa. Research points also to the heterogeneity of these individuals. It is no longer possible to view homeless young people as one group with similar needs. We can now discern their differences and realise the array of skills and interventions that may be needed to provide appropriate care to such a diverse group. From this knowledge it is apparent that some young people are at greater risk of becoming homeless than others, and there is therefore opportunity to target public funds to support those in greatest need.

This backdrop presents many challenges to providers, which are under resourced, over subscribed and operating in a policy context that is complex and at times unhelpful. It can therefore be difficult to enable change and even harder to sustain it, particularly when this may mean reaching out to groups whose cultures and experiences seem alien, such as those with mental health problems or a mental illness diagnosis.

London provides a unique opportunity to explore these challenges from the perspectives of service staff and the young people who use those services. The research project presented here capitalises on those opportunities by surveying services to explore the mental health needs of young people experiencing homelessness and to identify examples of promising practice, which may inform future service developments.
SECTION II: METHODS

2.1 Aim and objectives
The aims of the study were to survey services involved with young people experiencing homelessness across London and to capture the experiences of the young people who use them. Specific objectives were as follows:

- To review the literature and policy documents relating to homelessness and mental health among the young.
- To explore responses by the service sector to homelessness and the mental health needs of young people.
- To document the experiences of young people who become homeless.
- To explore the association between mental health and homelessness among the young people.
- To describe examples of promising practice in terms of young people’s housing and mental health needs.
- To disseminate findings to practitioners and policy makers

2.2 Sampling
Two samples were generated for this research. The first included London services working in the field of housing and youth homelessness and the second included the young people who use those services.

2.2.1 Service sample
A census of services working in the field of housing and youth homelessness was generated from all 32 London boroughs plus the Corporation of the City of London. Inclusion criteria were that each service should be available to 16-25 year olds who are currently homeless, have previously been homeless or are now at risk of becoming homeless. Services that were available to wider age groups such as 18-65 year olds were included in the census as long as their service provision met the study’s inclusion criteria. Services dedicated to ex-offenders were excluded from the sample due in part to the specialist focus of their work but also because of the limited resources available to the research team.

Services were identified through various means including consultation with professionals in the field, use of housing directories, websites, literature and internet search engines. Identified services were then contacted by research staff and asked for other services in their area that worked in the field of housing and youth homelessness. This process continued until saturation was reached and resulted in a London wide database of 640 services. A constant sampling fraction of 0.5 was then applied to
each of the London boroughs to randomly select half of the services. To gain a representative sample of services within each borough 50% of services were randomly selected based on service sector, service type and target client group/s. The final sample therefore constituted 320 randomly selected services stratified according to the London borough in which they are based.

2.2.2 Young people experiencing homelessness
Young people were selected by staff from the services that took part in the study as suitable participants based on selection criteria, and of those who were identified by staff they then self-selected to take part in the study. Inclusion criteria were being aged between 16 and 25 years, being currently, previously or at risk of becoming homeless, and residing within a London Borough. Those with a current history of violence or drug and alcohol intoxication were not invited to interview. Due to limited resources those who were unable to communicate in English were also not included.

2.3 Instruments and data collection
2.3.1 Service sector questionnaire
The questionnaire was semi-structured containing both quantitative and qualitative items. It gathered information on service characteristics, target client groups, current barriers and constraints to effective service provision, proposed solutions to these challenges, and sought examples of promising practice.

All services on the database were contacted via telephone to gain the service manager’s name and contact details. Letters to service managers informing them of the study and inviting them to participate were sent out two weeks before service sector interviews began. Service managers were then contacted by ‘phone to secure their consent and to offer the option of completing the research instrument by ‘phone, e-mail or by post.

2.3.2 Young person’s interview schedule
Items in the young person interview schedule were mainly qualitative and open-ended. The schedule explored young people’s experiences of being homeless, how this had affected their mental health and the quality of support they’d received. The young people were also given an opportunity to suggest solutions for better service provision. Some basic demographic data were also gathered.

Services that participated in the study were asked for support to identify young people who may be willing to be interviewed. All interviews with young people were administered face-to-face and tape-
recorded at the service they were recruited from. In return for the young person’s contribution they were given a modest cash voucher.

2.4 Data analysis

2.4.1 Service data
Quantitative items from the service questionnaire were subject to simple descriptive statistical manipulation and are presented as frequencies, percentages and means. Qualitative data were analysed independently for each of the questions asked, and emergent themes are presented.

2.4.2 Young person’s data
Data from the young person interviews were subject to thematic content analysis using Nvivo software. An *a priori* framework was developed based on items in the interview schedule. All key data were coded and applied to the framework making adjustments to its form as the process progressed. This continued until thematic saturation was reached. A second researcher checked a random selection of the transcripts for coding errors. Demographic data underwent simple descriptive statistical manipulation.

2.5 Ethics
The study gained ethical approval from the Multi-site Research Ethics Committee based at University College, London. The study was also subject to external and internal peer review and was reviewed by a young person consultant. All individuals involved in the study were provided with a Participant Information Sheet which stated the purpose of the study, the need for their involvement, what their participation would entail and issues surrounding ethics and confidentiality. Informed written consent was obtained by all individuals participating in the young person interviews and from service workers who completed the service questionnaire by email or post. Informed verbal consent was obtained from all individuals who participated in the service sector questionnaire by ‘phone. Young people were debriefed and thanked for their participation at the end of the interviews and all service managers that took part in the study were sent letters thanking them for their contribution.

Anonymity codes were assigned to all participants to protect personal and organisational identity. All data obtained were kept under strict confidence, audio files were password protected and held on a secure server with hard copy transcripts, questionnaires and consent forms were stored in a locked cupboard.
SECTION III: FINDINGS

3.1 Introduction

Findings from the service sector questionnaire and the young person interviews are each presented in this section. The former includes two brief case studies as promising practice examples identified through the service sector questionnaire. Findings from the young people are presented together with verbatim quotes to emphasise or elaborate key themes. A case study of promising practice sourced from the interviews with young people is included. Discussion of the findings and examination of their implications for policy and practice are reserved for the final section of this report (Section IV).

3.2 Service sector findings

A total of 321 services were contacted of which 123 agreed to participate, giving a response rate of 38.3%. However, there were differences in response rates, for example 26% of statutory services responded compared to 40% of voluntary sector services and this difference was statistically significant at the 5% level. Table 3.1 presents characteristics of the sample.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of organisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory</td>
<td>19</td>
<td>15.4</td>
</tr>
<tr>
<td>Voluntary</td>
<td>92</td>
<td>74.8</td>
</tr>
<tr>
<td>Private</td>
<td>11</td>
<td>8.9</td>
</tr>
<tr>
<td>Missing data</td>
<td>1</td>
<td>0.8</td>
</tr>
<tr>
<td>Type of Service Provision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(some services offer more than one type of provision)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Centre</td>
<td>14</td>
<td>11.4</td>
</tr>
<tr>
<td>Drug/Alcohol Service</td>
<td>31</td>
<td>25.2</td>
</tr>
<tr>
<td>Floating Support</td>
<td>61</td>
<td>49.6</td>
</tr>
<tr>
<td>Foyer</td>
<td>12</td>
<td>9.8</td>
</tr>
<tr>
<td>Hostel</td>
<td>73</td>
<td>59.3</td>
</tr>
<tr>
<td>Information/Advice</td>
<td>99</td>
<td>80.5</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>37</td>
<td>30.1</td>
</tr>
<tr>
<td>Outreach</td>
<td>52</td>
<td>42.4</td>
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<tr>
<td>Resettlement</td>
<td>86</td>
<td>69.9</td>
</tr>
<tr>
<td>Supported Housing</td>
<td>82</td>
<td>66.7</td>
</tr>
<tr>
<td>Tenancy Sustainment</td>
<td>65</td>
<td>52.8</td>
</tr>
</tbody>
</table>

The majority of services operated an open access policy. However, 49 services targeted specific client groups, presented in Table 3.2 (over). In addition, one third of services worked specifically with couples and families, 16% with the parents, guardians or the family of under 18 year olds, and 37% with schools, colleges and universities.
### Table 3.2 Targeted client groups

<table>
<thead>
<tr>
<th>Client characteristics</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teenage/Young Single Mothers</td>
<td>11</td>
<td>13.3</td>
</tr>
<tr>
<td>Mental Health Issues</td>
<td>11</td>
<td>13.3</td>
</tr>
<tr>
<td>Rough sleepers</td>
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<td>6.2</td>
</tr>
<tr>
<td>Single Homeless</td>
<td>4</td>
<td>4.9</td>
</tr>
<tr>
<td>Minority Ethnic Groups</td>
<td>3</td>
<td>3.7</td>
</tr>
<tr>
<td>Homeless Women</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Big Issue Vendors</td>
<td>4</td>
<td>4.9</td>
</tr>
<tr>
<td>Lesbian/Gay/Bisexual/Transgender</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Male Transgender Sex Workers</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Asylum Seekers &amp; Refugee’s</td>
<td>3</td>
<td>3.7</td>
</tr>
<tr>
<td>Facing Violence</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>1</td>
<td>1.2</td>
</tr>
</tbody>
</table>

#### 3.2.1 Recording service user characteristics

Approximately one third of services routinely recorded service users’ ethnicity, religion, sexual orientation, asylum status, whether they were a care leaver, and their mental health and drug and alcohol use status.

Religion was the least recorded characteristic (n=50 services) primarily because it was considered ‘not relevant’ to an individual’s presenting circumstances. Others commented that it might be perceived by the service user as too intrusive. Forty-two services did not record an individual’s sexual orientation again because it was felt to be too intrusive, but also because of an assumption that it would not impact on housing needs. This perspective stood in contrast to the views of those services targeting young LGBT people who emphasised the importance of monitoring sexual orientation and its relevance to housing need.

“I think there’s only 3 organisations in London that provide LGBT-specific services…and that’s one of the challenges that there are, is that it’s even hard to say if there is a need out there because nobody records it…everyone comes back and says, well we couldn’t possibly ask that and our line is that well you ask them to identify their ethnicity, their disability, their gender, their age. Why is sexuality so different? If people don’t want to tell you then they won’t tell you”

(GLBT Supported Housing Manager)
A smaller number of services (n=36) did not record whether individuals had a history of being in care. There appeared to be an assumption among some voluntary sector services that care leavers would typically still receive Social Services support. Fewer services did not record the mental health status or drug and alcohol use patterns of new referrals, again because this was felt to be ‘too intrusive’.

More generally services expressed a reluctance to gather sensitive information during a period when they were developing trust with new service users, many of who were considered to be ‘too chaotic’ for this information to be gained reliably. Additionally, the characteristics to be recorded may be determined solely by the service’s funding criteria. For example, some statutory services reported that the Office for the Deputy Prime Minister (OPDM) did not require the recording of sexual orientation or religion.

### 3.2.2 Meeting the needs of service users

Table 3.2 reports the degree to which service workers felt they were meeting the needs of specific client groups, where 1 represents failed to meet the needs and 5 represents fully met the needs. The questionnaire relied on self-report thus, the ratings are not anchored to a standardised scale or evaluated against specific criteria by which to rate service performance.

<table>
<thead>
<tr>
<th>Client Group</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Leavers</td>
<td>3.75</td>
</tr>
<tr>
<td>Drug/Alcohol Users</td>
<td>3.57</td>
</tr>
<tr>
<td>Lesbian/Gay Bisexual Groups</td>
<td>3.34</td>
</tr>
<tr>
<td>Minority Ethnic Groups</td>
<td>4.12</td>
</tr>
<tr>
<td>Asylum Seekers &amp; Refugees</td>
<td>3.57</td>
</tr>
</tbody>
</table>

The majority of services felt they were not fully meeting the needs of these client groups. Minority ethnic client groups had the highest rating and LGB groups the lowest. On average service workers reported that they were partially meeting the needs of asylum seekers and refugee’s, care leavers and drug and alcohol users.
3.2.3 Barriers and constraints to general service provision

The challenges to general service provision expressed by service staff fell into three main themes; policy, funding and staff skills.

Policy

Respondents commented that the Homelessness Act does not define young refugees as vulnerable or in priority need. Services across all sectors reported that asylum seekers and refugees were at increased risk of becoming homeless, experiencing mental health problems and being subjected to prejudice. Significant problems were frequently encountered when these clients had to endure long periods of living in insecure and unsafe environments, and even when accommodation was available it was often not appropriate to their needs.

Respondents felt that policies often affected service integration. For example, inputs from different services may be required to meet the different needs of a service user. However, once a service was working with a client, some respondents reported it could be difficult to get an other service input. Some services also have age cut off points such as child and adolescent or adult mental health services. Service sector staff stated that service users frequently fell through these gaps as they matured through services.

Care leavers were reported to experience problems when moved on to independent living before they have the necessary skills. Many expressed how care leavers were not being successfully engaged by adult services. Difficulties in establishing which service has duty of care were expressed and many thought this a key reason for the lack of integration between children and adult services.

More general difficulties were reported in making successful referrals to other services. This seemed particularly true of some voluntary sector services (i.e. general housing and homelessness support services and youth resource services) wanting to refer to the statutory sector. Reasons for this included an assumption that Community Mental Health Teams were under resourced or that some statutory services were reluctant to accept referrals from the voluntary sector. Other referral problems related to particular client groups who had specialist needs such as those with a dual diagnosis of mental health and drug and alcohol problems. Services reported that the two specialisms operated to different policy and rarely worked together making it difficult to provide complete care packages.
“I think it’s not having the specialists within the teams and the contracts tend to be focused on either … running a Drug or Alcohol Service, Care Leavers service, or running a Mental Health Service… it’s going to cost a lot in terms of specialists for those with complex needs because most people present with drug, possibly some alcohol, plus care leaving; you know the mixture. These are the things that always seem to be the problem and always have done for years in this field”

(Project Manager, Supported Housing)

**Funding**

A key challenge reported by the field related to funding services for asylum seekers and refugees. Rigid guidelines and legislation caused problems with access to public funds unless an individual had been granted leave to remain. Lacking entitlement to mainstream statutory benefits and care left many vulnerable to homelessness. On top of the experiences that led a person to seek asylum, this additional life event was considered particularly damaging to a person’s already vulnerable mental health.

Both statutory and voluntary sector staff expressed frustration over difficulties arranging specialist assessments, diagnosis and treatments including drug and alcohol detoxification, residential rehabilitation and structured day care. This was mainly attributed to limited funds for these stages of the treatment and care process.

“Lack of resources and other agencies lack of resources because sometimes you want to signpost somebody to counselling or drug services or floating support or outreach services that could work with us to help them sustain their time here and those places…have waiting lists and don’t have enough people…we are not able to do it and sometimes it is very difficult to access somebody else that can fill the gap because it is just tight all round for resources.”

(Manager, Women’s Hostel)

A funding gap which has led to a lack of provision for young people with extreme, complex and forensic needs was identified. Supporting People though generally welcome were criticised for not fully meeting the needs of these clients. Additionally, services reported that Supporting People provided only restricted input into education, training, social activities and holidays. More immediately, a service dedicated to young LGB people reported that a shortage of funding meant only 49% of calls to their dedicated help line were getting through.
**Staff Skills**

A significant number of services in the voluntary sector were established as Christian faith based organisations and some reported difficulties adapting to the increasing cultural diversity in the capital. Some staff acknowledged their lack of skills and found it a challenge to keep up-to-date with cultural awareness. More widely, services reported difficulties recruiting staff from different cultural backgrounds. Without culturally representative staff services felt there were the risks of not fully understanding the needs of their service users.

Being able to recognise and respond to the signs and symptoms of mental health problems and drug and alcohol use were considered necessary skills. Increasingly service users presented with complex multiple needs, often accompanied by chaotic behaviour that requires a multi-skilled workforce. A need was expressed for specialist training in mental health and drug and alcohol use.

“… I think a lot of the staff working with the young people don't necessarily have the skilled background to recognise mental health problems… until something becomes a crisis because the beginnings of mental health problems aren't often recognised by people that work with them”

*(Homeless Housing Team Manager)*

Many staff did not feel confident or comfortable in monitoring sexual orientation and some expressed a lack of general familiarity with young people’s needs. A lack of knowledge of current legislation, particularly in relation to asylum seekers, refugees and care leavers was also reported as problematic.

**3.2.4 Solutions for better service provision**

Suggested solutions to enhance service provision invariably involve additional funding and this was a core theme of the data. However, respondents attached additional resources to specific service developments. For example, a key concern was access to services. Thus, more interpreter and translation services are needed. Equally, there was a call for more advocates to be employed to help young people through the health and social care systems. Dedicated services of this type were emphasised for asylum seekers and refugees, as was a call to speed up the asylum system.
“Under the Homelessness Act refugees are not a vulnerable group for priority need for housing and in actual fact we see high levels of vulnerability with the client group and high levels of mental health needs for example and also it certainly is a barrier to those people to access …they need to be a priority group”

(Service Manager, Temporary Housing)

Many respondents called for an increase in the number of staff from BME groups throughout the housing sector. Staff felt they were needed to respond appropriately to drug and alcohol problems among BME groups, to more effectively meet the needs of asylum seekers and refugee’s, and to provide culturally sensitive counselling services.

One suggested solution to the needs of young LGB homeless people was to harness the knowledge and support of the wider LGB community. Information about homelessness should be shared widely and grass roots responses to the prevention and management of homelessness nurtured. In contrast, some called for the sensitive integration of LGB needs within mainstream provision, thus avoiding association with a specialist LGB service for those who want their sexuality to remain anonymous. Nevertheless, within the service context, open and sensitive collection of a person’s sexual orientation was recommended.

Several services focused on preventative solutions requesting more support for families to provide stable homes for their dependents. Similarly, joined up policy that ensures a young person is assisted and appropriately moved on when they are ready for independent living was recommended. Overall, the need to develop a more preventative focus through careful policy and practice planning was a key theme of the data (see case study 1).
**Type of Service:** Local Homeless Forum

**Target Group:** Children & Young People with housing problems

**Aim of Service:** Their key role is in aiding the Local Authority to successfully engage with Children and Young People and provide family mediation. In addition they provided input into the development and implementation of the local homelessness and housing strategy.

**Why it was established:** The Local Authority recognized the challenges of communicating with young homeless people and were not fully meeting their needs.

**How it is run:** The Homeless Forum functions within the Local Authority - Homeless Persons Unit. The Forum has a steering group involving senior managers from all key-stake holders. The forum also closely liaises with Housing Associations, registered social landlords, the Police and Mental Health panels. A number of sub-fora run, one of which is the Children and Young Persons Homeless Forum led by the Head of Education. Voluntary sector staff act as advocates and represent the needs of young homeless people at the forum to ensure development of successful relations between the Local Authority and this client group. For example outreach workers accompanying young people to appointments at the Housing Department and monitoring their progress through the whole process, thus allowing them to assess whether the Authority are meeting their needs. Information is gathered from these procedures and is fed back to the Forum, strategies are then proposed to deal with any emerging challenges.

### 3.2.5 Mental health needs of service users

The stigma associated with mental health problems was reported to be a key challenge. Staff felt that many young people did not want to accept a referral for counselling, because of the stigma or the damage it would do to their credibility. Some young people were also reportedly uncertain about the benefits of counselling. Services described how young people equate mental health problems, with ‘long-term incarceration, strait jackets or padded cells’.

Struggles to access appropriate support for mental health, particularly for young people without a diagnosis, were raised. Delays in mental health assessment, support and diagnosis were commonly cited and many felt that this might be linked to the reluctance of the mental health teams to diagnose young people.
Dual diagnosis of mental health and drug/alcohol problems was again expressed as a major challenge in meeting the mental health needs of service users. Linked to this was a perception by some that mental health services could be poor communicators and reluctant to include housing workers or other non-clinical professionals in multi-disciplinary meetings.

There’s a huge lack of support for people with mental health issues. And we have been kind of bashing our heads against walls trying to sort that out. And sometimes people fall between the cracks…Like we’ve been in a quite serious situation at the moment where a young person has quite clearly got mental health issues, but also is involved quite heavily in drugs, so the mental health services are saying “well it’s a drugs issue”, and the drugs sort of services are saying “well it’s a mental health issue” and this young person is left in the middle. With like, “which way do I go?”

(Manager, Quick Access Hostel)

Delays with acute care and a lack of crisis intervention coverage across London were seen as a major problem and such interventions often came too late, thus service users frequently reached crisis point before they were seen by a mental health team. Finally, services described how some service users have a lack of insight owing to the nature of their mental health problems, which can make engagement very difficult.

Solutions

“On-going support face to face and making follow-up phone calls. If somebody is going through a difficult time, calling them a lot through the week. Giving them out of hour’s numbers, telling them what’s available in, in terms of local services. But it’s mainly sort of following them up and not, not just leaving them…seeing how they are on day to day. That seems to be helpful if people know that you actually care how they’re feeling.”

(Manager, Floating Support Services)

Efforts to de-stigmatise mental health emerged as a priority in the data and took different forms. More proactive work in schools and colleges was recommended as were mentors, particularly if a young person needs to have contact with the mental health system. One organisation had been able to bring the specialism into its service through funding sessions from a community psychiatric nurse. In
another example, a teenage mother and baby unit have introduced a weekly homeopathic service, which seems to facilitate informal counselling with an alternative therapist among the girls who attend.

The majority of service workers felt that training for staff in mental health issues should be easily accessible and free so that it would be possible for all workers to take it up. The call for better service integration across the mental health and housing sectors was a consistent request from the sector.

Some housing agencies have managed to foster excellent relations with Community Mental Health Teams with members of the team being invited for “induction” at the services they are to work in partnership with. One service was reported to have developed an effective integrated service (see case study 2). Central to both these examples was the agreement of clear care and treatment protocol.

Box 3.2 Case Study 2

<table>
<thead>
<tr>
<th>Type of Service:</th>
<th>START Team</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Group:</strong></td>
<td>Homeless people 18 years and over with severe and enduring mental health problems including schizophrenia, affective disorders and personality disorders and who are unwilling or unable to engage with mainstream services.</td>
</tr>
<tr>
<td><strong>Aims of service:</strong></td>
<td>To reintegrate clients back with local mainstream services.</td>
</tr>
<tr>
<td><strong>Why it was established:</strong></td>
<td>Research had indicated that there was a large pool of unserved and unsupported people with psychotic illnesses in the homeless population – up to 35% of traditional hostel users. Most of these had never used mental health services and most had not spent significant lengths of time in hospital. They were therefore nothing to do with the psychiatric deinstitutionalisation of the 50s, 60s and 70s.</td>
</tr>
</tbody>
</table>

A preliminary 3-year hostel service demonstrated that, compared with an assessment and referral service, providing a direct service to homeless people resulted in greater clinical improvement and an increased likelihood that they would still be engaged with mental health services after 1 year.

**How it is run:** This service runs an open referral system and conducts assessments and treatment within hostels, day centres, outpatient departments and on the streets. This incorporates a range of techniques such as assertive outreach, early intervention, family intervention, practical support, monitoring medication, and cognitive behavioural therapy. They work in partnership and liaise with services across the voluntary and statutory sector and have strong connections with Social Services, PCT, Secondary care, Inpatient Units, and the Judicial System. They also have quick access to 3 housing projects for referral of people with mental health needs. Along side their outreach work this service provides training in mental health issues to voluntary sector staff working in hostels, day centres and street outreach teams.
3.3 Young person findings

The study gained a moderate sample size of fifty-nine young people. The mean age of participants was 20 years and the range was from 16 to 25 years. Table 3.3 presents characteristics of the sample.

Table 3.4 Young person sample description

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
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<td></td>
</tr>
<tr>
<td>Male</td>
<td>40</td>
<td>67.8</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>32.2</td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
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<td></td>
</tr>
<tr>
<td>16 – 17</td>
<td>8</td>
<td>13.6</td>
</tr>
<tr>
<td>18 – 21</td>
<td>35</td>
<td>59.3</td>
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<tr>
<td>22 – 25</td>
<td>15</td>
<td>1.7</td>
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<td><strong>Marital Status</strong></td>
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<td><strong>Housing Status</strong></td>
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<tr>
<td>Hostel (low support)</td>
<td>21</td>
<td>35.6</td>
</tr>
<tr>
<td>Hostel (high support)</td>
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<td>11.9</td>
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<td>Quick Access Hostel</td>
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</tr>
<tr>
<td>Accommodation for risk offenders</td>
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<td>3.4</td>
</tr>
<tr>
<td>Supported housing (low support)</td>
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<td>10.2</td>
</tr>
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<td>Accommodation for single mothers</td>
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<td>6.8</td>
</tr>
<tr>
<td>Foyer</td>
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<td>10.2</td>
</tr>
<tr>
<td>Streets</td>
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<td>3.4</td>
</tr>
<tr>
<td>Staying with family/friend</td>
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<tr>
<td>Council Accommodation</td>
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<td><strong>Occupational Status</strong></td>
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<td>Student *</td>
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</tr>
<tr>
<td>Employed</td>
<td>5</td>
<td>8.5</td>
</tr>
<tr>
<td>Student &amp; Employed</td>
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<td>3.4</td>
</tr>
<tr>
<td>Neither employed or in education</td>
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<td>45.8</td>
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<tr>
<td><strong>Ethnicity</strong></td>
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<td>45.8</td>
</tr>
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<td>White Irish</td>
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<tr>
<td>White European</td>
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<td>Black African</td>
<td>13</td>
<td>22.0</td>
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<tr>
<td>Chinese</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>Mixed Ethnicity</td>
<td>3</td>
<td>5.1</td>
</tr>
</tbody>
</table>

* Short courses; GNVQ; HND
Among the sample 11.8% had children of which 42% were currently parenting a child. All parents were female. The majority of participants reported their sexuality to be heterosexual (91.5%) and 15% were asylum seekers or refugees.

Eleven young people (18.6%) had received a psychiatric diagnosis including attention deficit hyperactivity disorder, schizophrenia, clinical depression, bi-polar disorder, alcoholism and drug induced psychosis. In all cases, with the exception of drug-induced psychosis, these diagnoses were made before the young person became homeless. A further 29 individuals reported regular feelings of anxiety and low mood.

A higher proportion of young people with a mental health problem (36.4%) were living in high support hostels compared with those who had no reported mental health problem (18.8%). This relationship did not hold in the opposite direction with similar proportions living in low support hostels (27.3% versus 25.0%).

Interview data from young people (n = 59) were thematically analysed to describe their routes into homelessness, what it means to be homeless, the consequences of being homeless, experiences of services and their suggestions for better provision.

### 3.3.1 Routes into homelessness

Five different routes into homelessness represented the experiences of the young people. Graph 3.1 presents the routes into homelessness at the current episode of homelessness.
**Being forced to leave the family home**
Eviction from the family home due to relationship breakdown was a common theme. In the majority of cases this was a result of the young person’s behaviour such as illicit drug use, criminal activity, excessive teenage rebelling, mental health problems, gambling, pregnancy and issues surrounding sexuality. It was common for these young people to come from single parent families (89%), of which 83% were from a single mother.

**Choosing to leave the family home**
In other cases it was the parents’ behaviour that had led to relationship breakdown within the family. Behaviours included illicit drug use, excessive alcohol use and mental health problems. A number of young people felt they had no choice but to run away from these difficulties and establish their own independence.

“As long as I can remember there had been physical violence and mental abuse as well from my step-dad and that’s what kind of led to homelessness in a sense that I couldn’t take it anymore and it wasn’t a place that I would call home…”

*(Tanya, 17 year old)*

**Leaving own home**
Homophobic abuse had resulted in one young person being driven from his council flat and in another case the breakdown of a relationship with a ‘live in’ partner was a causal factor for becoming homelessness.

**Leaving care**
A small proportion of those interviewed had been placed into statutory care and moved on to independent living before they felt they’d developed the necessary life skills and coping strategies. For these individuals this was the precipitating factor for their homelessness.

**Seeking refuge & losing support network**
All asylum seekers and refugees had come to the UK to pursue a better and/or safer life and the majority of them had been sent by their parents/guardians. Those who have family and friends in London initially stayed with them but after some time they were asked to move on. Losing this support from their extended family and friends had resulted in a period of homelessness and others were not prepared for the ending of support from the National Asylum Support Service (NASS) and became homeless following a positive decision on their case.
3.3.2 What it means to be homeless

“Not having a stable place to live, not being able to call somewhere your home and somewhere to call your own place”

(Louise, 20 years old)

For these young people homelessness was described in both physical and psychological terms. Not having a permanent home of your own defined ‘homelessness’ regardless of whether they presently slept in a hostel, supported housing or other accommodation. In turn, not having a permanent home meant not being independent, ‘not having control of a situation’ and having to rely on others for basic needs.

Independence was reflected in material assets such as money to pay for accommodation, food, warmth and comfort. Being unable to meet these physical needs resulted in a lack of emotional security, stability and safety. A number of young people referred to an experience of being ‘excluded from society’, which resulted from the unmet physical and psychological needs associated with homelessness. For many becoming homeless was not a gradual process over a period of time, but a sudden de-stabilising change in their lives.

3.3.3 Consequences of being homeless

There were both negative and positive consequences of being homeless

**Negative consequences**

All the young people emphasised in different ways a loss of independence when they became homeless. This was expressed in terms of a lack of funds for accommodation, food and warmth, which left people feeling not in control of their situation and dependent on others. Being dependent on others requires good support networks but many also expressed the lack of trusted support in both their personal and professional relationships.

“I’d say that my drug use and mental health problems definitely got worse after I was homeless….Yet it’s the only thing that could give me comfort really, drugs. In such a situation I was thinking very irrationally, I had nobody to turn to, nothing to turn to except the comfort of heroin or methadone. So my problems did get a lot worse”

(Darren, 24 years old)
A common theme arising from these circumstances was a lack of life opportunities particularly in relation to employment or education. Many did not possess the relevant skills and qualifications and young people reported additional problems with time keeping and personal hygiene that compounded these difficulties. Many felt they were victims of stereotyping and said they felt the stigma of being homeless left them at a greater disadvantage than their peers. This affected their ability and confidence to build and engage in intimate relationships and had detrimental affects on their emotional well-being. Social exclusion was a resulting theme and was particularly characterised by a sense of vulnerability. Many experiences involving exploitation, physical and verbal abuse, and other criminal acts perpetrated against these young people were described.

“The way people react to you. The way they look at you. It’s not what they say if they say anything at all, but it’s the way they look at you and I just felt ashamed.”

(Christopher, 23 years old)

Environmental factors had an adverse impact on young people’s experiences of homelessness. Many referred to the lack of stability, safety and security encountered in temporary accommodation and when sleeping rough. In addition, poor standards of health and hygiene were reported with regard to hostels and the lack of privacy and freedom was also emphasised.

In some cases the young person’s own behaviour was a negative consequence of being homeless. Some engaged in abusive and violent behaviour due to their frustration with services and perceived lack of support. In one case this had resulted in police intervention and being barred from services. Others reported that they’d had to engage in criminal activity to fund their drug and alcohol habits or ‘simply to survive’. Nevertheless, these young people were aware of the detrimental effects these behaviours had on both their mental and physical health.

Positive consequences

“I say this teaches me to have my head screwed on and go about things the right way and to try to make something for myself, participate in as much things as I can and get myself somewhere.”

(Mark, 19 years old)
For some, homelessness can result in a period of personal growth and maturation. A few young people reported being more focused and goal orientated as a consequence. They had become more responsible, especially for their own actions and as a result felt ‘wiser’, no longer took things for granted and had learnt to ‘abide by society’s rules’.

Alongside this maturation was the development of life skills and coping strategies, thus enabling the individual to become more independent. Many had had to learn how to survive on very little and had become streetwise developing communication skills for interactions with services and for personal encounters. Those who had developed a sense of independence seemed to feel more confident in pursuing their personal goals.

Opportunities to re-build relationships were positive outcomes for some who had experienced homelessness. Some of those interviewed had managed to develop trusting relationships with support workers and through this process had learnt to accept support and advice and to use it effectively. This in turn equipped the young person with skills to build other types of relationships. Many stated that moving through the ‘social chain’ had allowed them to appreciate people from different walks of life and that this has been valuable in sharing experiences and learning from others.

A number of respondents learned of the importance of perseverance and hard work if they were to take control of their current situation and achieve their goals. Along with this realisation came an appreciation for personal resilience. Being vulnerable and naïve would potentially compromise their situation further and therefore some worked hard to become mentally and emotionally stronger. In particular, asylum seekers and refugees felt they had become stronger due to the experiences they had endured in their native country.

Those who had matured through homelessness, gaining more independence, developing supportive relationships and resilience, seemed more able to engage with employment and educational opportunities.

3.3.4 Young persons’ negative experiences of service provision

Benefits System

All interviewees had frustrating experiences to recount from their interactions with the benefits system. It was common to hear of a lack of understanding and sensitivity from staff, who were frequently cited as providing inaccurate information, particularly surrounding entitlements for 16-17 year olds. Many
complained that their claims had been processed inaccurately, especially when they entered part-time education or employment and this was attributed to a lack of communication within the system.

It was common for young people to report being in a ‘catch 22’ situation. Those who had been evicted from their family home were informed that to qualify for housing benefits or accommodation they would have to obtain a letter where by their parents serve them 28 days notice of eviction. Many were advised by staff to return home without any consideration of how unrealistic or unsafe this could be. Identification was also reported as an obstacle to gaining benefits. Many no longer had contact with family so were unable to obtain their original birth certificate and some had had their ID stolen. Delays in receiving benefits were common while young people struggled to obtain appropriate means of identification.

“I’ve been to the hostels but they want you to be backed by the council as well because I’ve got no money to pay for it. You’ve got to be in a house for a month first to get housing benefit…to get a flat you have to have a month’s rent, a deposit in advance…once you’ve got the flat I’ll be able to claim housing benefit…but to do that I’ve got to get money, which you don’t get.”

(Anthony, 21 years old)

Asylum seekers encountered long delays from the Home Office when applying for asylum. Only when granted leave to remain are they entitled to benefits and services reported being otherwise restricted in what they can provide to this group.

**Social Services**

“I’m fostered and when I turned 18 I did go to Social Services and ask them if they could help me get in a flat or something like that. They said that because I had turned 18 I am no longer on their records and they can’t help me, I’m on my own…not having help and having to do everything by myself and just being stressed, just nowhere to turn. You just think what’s the point?”

(Zahina, 19 years old)

Those who had been in the statutory care system felt that their progress during and after leaving care had not been monitored closely enough by social services, nor did they feel adequately supported when relationships with their carer broke down. They felt they were moved on before being ready for independent living and felt unsupported through that transitional phase. Those who had ongoing
support needs felt they were not successfully referred from adolescent services to adult services and that social services were reluctant to maintain duty of care if an individual was 17 or 18 and had broken ties with their carer.

**General service provision**

Among those accepted for housing by local authorities many reported staying in temporary accommodation for far longer periods of time than promised and in some cases this was at complete odds with the young person’s needs. For example, one young gay man received persistent homophobic abuse having been housed in a shared room with an intolerant heterosexual. In addition, those who stayed in bed and breakfast accommodation lacked adequate support mainly due to the isolating nature of those facilities.

“it was a B & B…they said it would just be temporary and the way he said it was like a couple of weeks and it ended up being 6 months, so every time I did call up he was like yeah, we are going to move you soon”

*(Adeola, 19 years old)*

There were also problems accessing some services that needed confirmation of an individual’s support needs. This confirmation might typically be secured through assessment by a statutory service, although some young people reported difficulty getting their needs assessed. Further, some had experience of an assessment made by a non-statutory service not being accepted by statutory sector staff. Problems finding a GP were reported by some, as were long waiting lists to gain a mental health assessment.

“I wish I was given more help with my depression because I felt that in that area I wasn’t really taken seriously…if I was given more help perhaps I wouldn’t be in the situation I am in now”

*(John, 24 years old)*
3.3.5 Young persons’ positive experiences of service provision

“Before I moved here, I didn’t go to anyone for help... when I did try to go to someone for help, they would turn me away, so I ended up drinking, cutting myself, finding myself in arguments. But since I’ve been here… my key worker, she’s brilliant, I love her to bits and I could go to her about anything.”

(Melissa, 22 years old)

Among the negative comments about service provision were some positive experiences. Connexions were reported to be one of the most promising and supportive statutory services. This service was specifically commended for providing excellent support and advice when applying for benefits, housing, employment and education as well as information about other services in the local area (see case study 3).

Box 3.3 Case Study 3

<table>
<thead>
<tr>
<th>Type of Service: Connexions Partnerships offering holistic information, advice, guidance and support to all young people.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Group: All 13 - 19 year olds in England, plus 20 - 24 year olds with learning difficulties and disabilities who are making the transition into adult services.</td>
</tr>
<tr>
<td>Aim of Service: To support young people through a successful transition into adulthood, encouraging them to stay in work and learning.</td>
</tr>
<tr>
<td>Why it was established: The Government launched the Connexions Strategy in 2000, the intention being to reduce the social costs of youth unemployment, and associated factors such as poor physical health and offending behaviour, through a single integrated youth support service involving a range of partners in the statutory and voluntary sector.</td>
</tr>
<tr>
<td>How the Connexions Service is run: There are 47 Connexions Partnerships across England, working in sub-regions. Each is managed and monitored by a Partnership Board; Connexions Partnerships offer a young-people centred service which has successfully engaged young people in the planning, development, evaluation and governance of local services. Connexions Personal Advisers work in schools and colleges, Connexions Centres, multi-agency ‘one stop shops’, youth centres, leaving care and youth offending teams. They provide impartial information, advice and guidance covering a wide range of issues, and additional support and advocacy for young people who need it. Each Partnership has its own website providing information and advice, and wide range of local resources including work and learning opportunities.</td>
</tr>
</tbody>
</table>
The voluntary sector was praised by many for their ability to meet emotional needs as well as support housing, benefit, education and employment needs. They were reported as responding more rapidly than statutory services and if they were unable to help with a specific need they would support the young person to find a suitable service. Many young people appreciated being managed by the same key worker within the voluntary sector, particularly those key workers who were empathic, supportive and consistently available to them.

The New Start Scheme was reported by some young people as being an excellent initiative provided by the Local Authority to support housing need. This scheme is for tenants or the homeless who are interested in moving to another part of the country where there is more council and private housing stock available. With this scheme an individual is more likely to be offered a home that better meets their needs and some young people were very keen to apply for this scheme as they had realised how difficult it could be to gain housing in London.

Finally one young woman stated that even though some of the council housing offered is not to the standard one would like, the Local Authority in some instances can provide a grant to re-decorate. This particular woman was awarded a grant to re-decorate her council flat and make it more suitable for her baby.

3.3.6 Service improvements proposed by young people

Benefits System

“It's not clear as to what benefits are available all the time. So maybe if help is given to people to understand what's out there and what's available, that would help... Like housing benefit, for example, I didn't even know that I would be entitled to housing benefit before”

(Lee, 20 years old)

All young people interviewed proposed in different ways that the Local Authority needs to be more consistent and organised in processing housing and benefit claims, in particular for those with high priority needs. Suggestions for developing a more efficient system were proposed, the most common being for a single key worker within the original benefits office to be allocated to each young person’s case and take responsibility for their claim. This key-worker should be specialised in claims for young individuals, be good a communicator, have awareness of their situation and be sensitive to their needs.
Many felt that the Local Authority should develop rent deposit guarantee schemes to offer the opportunity for young people to obtain a small loan for either a deposit for private rented accommodation, or few weeks rent for temporary accommodation. Once they have established a place of residence then they are able to make a claim for housing benefit and the loan can be deducted from the benefits received. Others felt they would benefit from the Local Authority helping them obtaining appropriate ID such as a birth certificate, national insurance number or passport.

**Employment and education**

Young people want services to do more to support them back into work and education and for this to be an essential part of an individual’s support plan. A Key-worker should be allocated for this purpose. Young people also want resources to be more widely accessible and services to develop further links with colleges and employers to offer work based learning programmes. In addition, it was proposed that a more appropriate scheme would allow an individual to work and earn for a specific period of time in order to save for a deposit, without losing the majority or all of their Housing Benefit.

Other suggestions included more washing facilities and clean clothes on offer at day centres for young people to look presentable when attending interviews. Travel bursaries were also requested to make educational opportunities more accessible to homeless people.

“The Job Centre…could probably have better facilities for homeless people. They should have a proper homeless service where there is free showers and hot water just so you can go and have a shower…. you’re not, you’re not always washed, you’re not always looking presentable which does affect a lot of things.”

*(Aaron, 21 years old)*

**General service provision**

There was a call for speedier access to suitable temporary accommodation when it was needed, such as in times of crisis. Solutions proposed included increasing the number of quick access hostels, services to accept referrals from a wider range of sources including self referral and the voluntary sector, and widening of inclusion criteria. In addition, it was felt crucial that there are more services exclusively for 16-25 year olds and some expressed a need for more single-sex hostels and designated mother and baby units.

Young people reported that the health and safety aspects of some existing temporary accommodation needed attention. This not only related to the physical features of a service but the client mix that might typically reside in a service. Thus, some young people felt that individuals with high support
needs are more likely to develop complex needs when placed with others who also have high support needs.

“if you put 27 people in a hostel, 8 of them have mental health problems, 10 of them have alcohol abuse and the remainder 9 people have drug addictions you have got all these people mixing together. They are all going to become hooked on other stuff, other people are going to start experiencing mental health problems because they have seen what’s going on around them and it’s affecting them. Some of the staff don’t realise this and the organisations don’t organise this. You need to stop putting too many people with too many problems in one place.”

(Martin, 23 years old)

**Emotional support**

Emotional support was an important need expressed by those interviewed. A common request was for access to services around the clock. Many proposed twenty-four hour drop in centres with readily available trained staff and counsellors. It was felt to be critical that those in their situation should have a readily available place to be listened to and talk through difficulties.

The opportunity to develop a rapport with a key worker was expressed as essential and that consistency in individual sessions for practical and emotional support is crucial. It was proposed that counselling and therapy should be offered at the first point of contact when a young person is experiencing any mental health problem. Services need to take a ‘young person’ friendly approach and ensuring the environment is non-intimidating to encourage young people to attend. It was felt that services should employ staff and mentors who have been through similar experiences so young people can be understood and their circumstances appreciated. In particular, it was felt that GP’s should be more proactive particularly during the earlier stages of a mental health problem. Referring young people to relevant agencies such as counselling services rather than prescribing medication was a preferred response.

An increase in early intervention services, especially those that work in the family setting were proposed. Similarly, there was a call for ready access to information on services that support young people experiencing problems at home. A more general need for people to be equipped at a younger age with information on homelessness and mental health was also highlighted.
“Young people, especially, that are vulnerable from a very young age, that nine times out of ten it is because of family problems and things like that and I think there should be more maybe counselling sessions or something like that to actually get people talking and help communicate with their parents and even if the parents are against it that at least the young person has someone there to talk to and explain their feelings”

(Sophie, 17 years old)

Those with specialist support needs felt that more services were needed, particularly to manage the combination of mental health and drug and alcohol problems. The employment of specialist staff was recommended in this respect along with more efficient liaison with mental health and drug and alcohol services. Fast track referral systems, and more detoxification and rehabilitation programmes were seen as necessary. The young people also felt that life skills and coping strategies should be more widely taught in schools.
SECTION IV: DISCUSSION

4.1 Introduction
This section of the report examines the representativeness of the samples before discussing the relationship between mental health and homelessness, how services currently respond to this challenge, and policy and practice developments to support the needs of young homeless people. Conclusions are drawn and recommendations for the field presented.

4.2 Representativeness of the sample
The voluntary sector was significantly more likely to respond to the research than the statutory sector perhaps because statutory sector work cultures require a large volume of paper work to be undertaken to audit and submit data on performance targets. This particular work culture may have prevented statutory sector staff from responding to the questionnaire. The voluntary sector is not always subjected to the same auditing pressures and appeared more enthusiastic to participate in the study.

There were difficulties in reaching specific corners of the homeless and housing sector (i.e. private landlords, friendly landladies) due to problems with access and confidentiality. A number of services felt they should not be included as they did not specifically provide mental health provision. Also, services appeared to lack awareness of mental health issues and many considered these to only be present when there was a clinical diagnosis. However, though skewed in terms of sector, the service sample was broadly representative of the types of housing and homelessness provision across London.

The young person sample is not necessarily representative of the types of clients that attended the services as the study had to rely on services to select suitable participants and then for those individuals to self-select. There was no systematic sampling strategy beyond this convenience method. In addition, individuals with a current history of violence or drug and alcohol use were excluded from the sample. Violence, drugs and alcohol use can sometimes be indicative of distress and symptomatic of the kind of emotional and physical trauma that people who are homeless experience. Thus, the sample could be under-represented in terms of young people with mental health problems. However, the young person sample appears representative of homeless young people in London in other respects. For example, individuals from BME groups are over represented in this sample, which also includes asylum seekers, care leavers, people with mental health problems and substance users. Current literature indicates this type of profile among young homeless people (Garvie 2004, Wincup et al 2003, Stanley 2001, Broad 1998).
4.3 Mental health and homelessness

There was evidence of compromised mental health and well-being amongst the young people interviewed. Breakdowns in family relationships were typical precursors to their homelessness. Whether it was the young person’s or other family member’s behaviour that led to the breakdown, the consequences were predominantly described in terms of loss (i.e. losing ‘independence’, ‘control’ and ‘emotional security and stability’). Experiences such as these can have a negative impact on an individual’s sense of emotional well-being. These experiences are also lost opportunities for earlier interventions that could have supported families to remain together. A point the young people made themselves.

Half of the respondents (n=29) acknowledged regular feelings of anxiety and low mood, which they associated with the experience of being homeless. In one case this led to self-harm behaviour and in others it resulted in increased drug and alcohol consumption. Other markers for mental health problems were cited. For example, experiencing stigma from being homeless, which some felt had prejudiced them in terms of education, training and employment. Others experienced a general sense of alienation and described feeling ‘excluded from society’.

4.4 Mental illness and homelessness

In addition to those who reported anxiety or low mood, 11 young people had received psychiatric diagnoses, 10 of which were made before their first period of homelessness. This tendency for diagnoses to precede homelessness in young people is supported by other work conducted in London (Craig et al 1996). In the present study a proportion of these young people (50%) reported being forced to leave the family home. This troubling finding lends weight to the growing recognition that mental illness in young people can be a major risk factor for homelessness. It also serves to re-emphasise the need for family interventions at an earlier stage.

It is not known what proportion of the young people who reported ‘psychiatric’ symptoms such as anxiety and low mood would have met diagnostic thresholds for the presence of an ‘illness’. However, if these reports are taken as evidence of a problem with mental health and those with a psychiatric diagnosis are also included in this category, then two thirds of the sample reported problems with their mental health (67%). Once again this is consistent with other research and points to a significant burden of mental ill health among this small group of young people (Warnes et al 2003, Craig et al 1996). Some of these problems arose through the course of being homeless, whilst others preceded
or precipitated it. This relationship between mental health problems and homelessness appears inextricable and is deserving of greater attention in policy and practice terms.

4.5 Resilience and homelessness

Although becoming homeless had been a major life event for all the young people it was not an inherently negative experience for everyone. A few young people seemed able to harness the freedoms and opportunities of leaving the family home, engage in trusting relationships with key staff and make the most of the resources available to them. These experiences are rarely evident in the literature but they may offer clues for how others can be supported to achieve similar gains. In the present study these individuals tended to view their homelessness as an opportunity to develop. This was particularly apparent in young people who had been forced to leave the family home as a result of their own behaviour. It was also noticeable that these young people had developed trusting relationships with professionals in the health or social care systems. Research that is designed to capture and understand these positive experiences would be valuable.

4.6 Service provision

In the main services struggled to respond to the mental health need of their clients. Some staff seemed unsure of its relevance or meaning, others acknowledged a need but also their lack of skills or confidence to deal with it, whilst some had grown frustrated with a specialist care system that struggled with capacity. There was also reluctance on the part of some young people to accept mental health interventions because they feared the treatment they would receive in the mental health care system. It is true however that some services did not record the mental health needs of their clients, so opportunities to conquer fear and receive appropriate care may be missed. Collectively these findings suggest there is a burden of unmet need among an already significantly disadvantaged group.

It is possible however to integrate specialist mental health and homelessness expertise and to equip generic staff with mental healthcare skills. Promising practice examples that achieve these ends were reported in the findings. In particular the START Team, which delivers specialist mental health care by outreaching to generic housing and homelessness services and other services across the voluntary and statutory sector. Consistently working in partnership with generic staff can impart valuable knowledge to the field. The START Team also provides formal mental health training to the voluntary sector. More of these models that deliver specialist community and outreach based interventions and support/train generic staff are needed if the mental health needs of young homeless people are to become a mainstream concern.
Integrated services of this type are not typical and so opportunities for sharing specialist knowledge are limited. Some staff referred to crisis events at which, and sometimes only at which, specialist mental health services became involved. When the mental health needs of young people go unmet the resulting burden can persist into adulthood, typically resulting in socio-economic disadvantage and increased risk of both physical and mental ill health (MHF 2005). The findings from this study suggest more could be done to utilise resources more productively. By failing to meet the needs of these young people the more complex and costly it can be to restore health and functioning in adult life (SEU 2004). Given the inextricable link between homelessness, mental health and substance misuse, service provision needs to be more integrated. Although the young person sample excluded those under the influence of drugs and alcohol a significant proportion of young people interviewed had used drugs and alcohol. It is crucial to recognise that services must be responsive to those with a history of substance misuse. Homelessness increases the risk of substance misuse thus, an agenda which includes a drug relapse prevention role is necessary. This integration has two key functions; to ensure speedy access to specialist mental health services for those who need them and to develop capacity in the generic housing and homelessness sector to manage less severe mental health problems and to promote the mental health of their service users.

4.7 Policy developments

The transition from child and adolescent services to adult services appeared problematic for some young people who lost contact with services as they matured. This was reportedly due to poor communication between services and also age criteria for receipt of service. The vertical integration of child, adolescent and adult services is necessary and policy should support this need and explicitly establish duty of care across key developments in a young person’s life. Furthermore, means of access to services when a mental health problem arises needs to be specified in local operational policy. Many symptoms of mental illness first appear in the teenage years. The principle of speedy access at such times to a responsive, continuous service whatever a person’s age needs to underpin all related policy developments. This point supports the work of the Social Exclusion Unit that calls for the ‘blurring’ of age boundaries to ensure continuity of support (SEU 2005).

Integration is also required horizontally across specialisms to meet the complexity of need that is typical among young homeless people. Policy needs to direct endeavours toward innovative integrated services as previously discussed. It should also work at the interface between existing services, directing specialist resource to support generic housing and homelessness services. The local homeless forum presented in case study 1 is interesting in this respect since it provides a mechanism for all key stakeholders in a young person’s care and development to convene. Integrated
Policy needs to combine health and social concerns rather than appear as stand-alone issues of consideration. Policy also needs to direct greater effort toward the use of preventative interventions for families when a young person is at risk of becoming homeless, and to protect the mental health of young people who become homeless.

4.7.1 Practice developments

The integration of mental health and homelessness care requires operational links between services as demonstrated in the case studies. It also requires capacity building in the generic housing and homelessness sector to review and respond to the mental health needs of their clients. On occasion this will require speedy referral for specialist intervention. At other times generic housing and homelessness staff will need to respond to the psychological needs of their clients and to support their mental health. It is in relation to these latter functions that practice developments are discussed.

4.7.2 Training

Practice development requires a training agenda that includes mental health and substance misuse awareness, cultural awareness, and knowledge on current legislation and policy in the housing, mental health and related sectors. Mental health training needs to go further than raising awareness of the mental health problems young homeless people are likely to encounter. If generic housing and homelessness services are to manage less severe problems then they need a repertoire of appropriate care strategies. At the outset this will require the inclusion of mental health in their assessments of need.

Findings from the young people indicate that they value emotional support and the opportunity to share their fears and anxieties with trusted staff. This type of support does not require specialist psychiatric or psychological input but requires basic interpersonal qualities, which needs to be built into the employment selection process and developed through training. The implementation of training is required in order to effectively reinforce the learning gained through this process, however a training agenda alone is not enough. In addition, a work culture embracing an ethos of continuing professional development, opportunities for meaningful supervision and reflective practice is required to sustain these practice developments. Attention to mental health by its sensitive inclusion in mainstream practice is both necessary and achievable.

Attention needs also to be given to the maintenance of any practice developments. Ongoing support and supervision will be necessary from specialist services. Generic housing and homelessness services need to continue to develop and maintain effective networks with specialist services.
will not only facilitate ongoing supervision with specialist services but will increase and sustain referral routes to specialist services when it is necessary. Once again the START team provides one model for how these developments can be both initiated and maintained.

4.7.3 Access to service
Staff reported barriers in accessing services for people from BME groups, asylum seekers/refugees and those from LGBT communities. Employing a more diverse staff group that better reflects the communities it serves can enhance access opportunities as can the availability of interpreters when necessary. Within the context of mental health these considerations are crucial since mental and physical health is partly defined according to culture. An understanding of mental health needs’ and behavior from the perspective of different BME communities is key to successfully responding to this specific groups needs within their cultural context.

Access remains important once people are in contact with a service. The complexities of a young homeless person’s needs typically necessitate the involvement of several agencies. The service through which they enter the system needs then to facilitate further access on behalf of the young person. Access also refers to the point at which people enter care services and in this respect the opportunity for earlier intervention is required to prevent young people from becoming homeless or developing enduring mental health problems.

4.7.4 Trusted adult role
The young people emphasised the importance of trusted adults in their lives and this role has recently been championed in the SEU’s (2005) Transitions report. The role has two key functions, the first being to build and maintain a trusting relationship and the second, to advise and support young people through ‘small but significant steps towards positive outcomes’. This is accomplished by facilitating the development of trust between the young person and services and presenting the range of services on offer that are available to meet the personal needs of the individual (SEU 2005).

A personal advisor, mentor, key worker or other professional can take the role of the trusted adult. The important issue is to establish who the lead professional is and to ensure this individual is responsible for facilitating joint working between all others involved in a young person’s care. The advocate role from the Local Homeless Forum presented in case study 1 may be valuable in this respect. They broker services on behalf of young people and at other times accompany young people to services. The Local Homeless Forum also addresses individual cases and collectively problem solves difficulties with service delivery. This knowledge is then used to avoid future similar difficulties.
This reflects a recent call by Crisis for the introduction of Service Navigators to act as single points of contact for young homeless people (Crisis, 29/12/2005 press release). In the Local Homeless Forum the advocate role is fulfilled by voluntary sector staff and this may encourage development opportunities for that sector in the years ahead. An alternative approach is for all young people to be supported to understand and accept appropriate services. It is the responsibility of a wide range of services across all sectors to ensure that young people are informed about available service within the local community to meet their needs as well as how to access such services.

4.7.5 Socially inclusive practice
Social disadvantage was common in the histories and contemporary experiences of the young people. There was however an awareness that they needed more than just a roof over their heads. They also needed life skills to make the transition to independent adulthood, and in particular there was a call for more education and training opportunities. Very simple and practical suggestions in this respect were the availability of smart clothes, which could be loaned out to attend interviews, or financial advances once a job is secured to make benefit, rental and other necessary financial transitions realistic. This theme represents not so much a call for housing by the young people but a call for the means to manage their own housing. In this respect, homelessness is but one symptom of a deeper disadvantage and services need to attend to the social development of young people, inclusive of but beyond their immediate housing need.

4.8 Conclusions
In recent years there has been an increasing focus on the needs of young people who struggle with the transition to adulthood (PAT 2000, SEU 2005a). Among this group are those who become homeless, an experience that is reportedly increasing among 16 to 25 year olds (SEU 2005). Other work has identified associations between homelessness and an increased vulnerability to mental health problems among young people (Craig et al 1996, Wright 2002). The findings of the present study contribute to this agenda by reporting current service responses to these challenges in London and the experiences of young people who use those services.

In support of other work the study reports problems with mental health from a majority of the young people interviewed. These problems both preceded and arose as a result of being homeless, and in the former case were at times part of the reason for them having to leave the family home. For some therefore, developing a mental health problem significantly increases their risk of becoming homeless.
Against this backdrop the availability of integrated services that attend to housing and mental health needs simultaneously is patchy. However, promising practice examples were identified that reflect innovative approaches to delivering more comprehensive care. Key challenges in this respect are enabling easy access to specialist services when necessary and developing capacity in the generic housing and homelessness sector to support the mental health of their service users. Greater attention also needs to be given to the development of early intervention services, particularly those that support families to remain together, and to develop the life skills of those who are homeless through education, training, employment and housing opportunities.

A key conclusion to be drawn from the findings is support for the close association between homelessness and mental health problems. As such it would seem prudent to develop joined up policy that addresses its causes and consequences, and to design and commission a service sector in which mental health is a mainstream consideration supported by responsive specialist services. These are significant challenges but the findings demonstrate that progress can be made toward meeting them. Most importantly developments such as these have potential to benefit young people both now and in the future, offering them some protection from social disadvantage later in life.
SECTION V: RECOMMENDATIONS

Policy
♦ A mental health perspective should permeate all policy relating to the needs of young homeless people. Specific attention is needed to support continuity of care as a young person matures through and out of services, to articulate clear care pathway agreements with specialist mental health and drug and alcohol services when needed, and to link together the array of stakeholders involved in a young person’s care. Policy should also spearhead preventative initiatives including early intervention strategies.

Commissioning
♦ Joined up commissioning of integrated service configurations across sectors is necessary. Contracts should specify the mechanisms that enable rapid access to specialist mental health and drug and alcohol services when required.

♦ This research highlights the continuing need for out of hours support and advice to young people who experience homelessness and mental health problems. Further funding is required to develop more flexible service provision.

Services
♦ The development of mental health and substance misuse capacity in the generic housing and homelessness sector should occur through innovative partnerships with specialist mental health and drug and alcohol services. This should also include partnership agreements between these specialist services within each borough.

♦ As far as possible the diversity among young people who experience homelessness should be reflected in the staff of the services that are provided for them. Resources need to be available to promote access such as the ready availability of interpreter services for those individuals who do not use English (i.e. asylum seekers, refugees, BME groups and those with a hearing impairment). Services should build these requirements within contracting and budget costs.

♦ A young person’s trusted adult should have the flexibility to work out of the services catchment area and liaise closely with new professionals and agencies involved in a young persons care in the new area of residence. This should last for at least one month to ensure relationships with new professionals have successfully developed.
Ongoing support is also required through the transition from temporary accommodation to independent living. Support should continue and be reviewed as a young person progresses through this transitional phase until the point of successful and sustainable independent living.

More early intervention services are needed particularly for families where a young person is at risk of becoming homeless, and to help protect the mental health of young people who experience homelessness. This should include a range of psychosocial approaches as well as complimentary and alternative interventions (i.e. exercise referrals, homeopathic therapies, art and music therapy) and should provide the opportunity for parents, carers and dependents to be involved where necessary.

Services responsible for placing young people in accommodation must carry out a full assessment of their clients' needs to ensure that they are placed in suitable temporary accommodation. Support must be readily accessible to young people and their progress reviewed.

Any care package for a young homeless person should not only include accommodation but should also equip them with the means to manage their housing independently. Of importance in this respect is ready access to education, training and employment, emotional well-being support and the opportunity to develop coping skills.

There is potential for voluntary sector staff to act as Service Navigators to young homeless people. This practice role should be formally developed and more widely piloted with Local Authority support.

In order for services to fully meet the needs of specific groups of young people monitoring of sexual orientation must be implemented in service provision. Staff must be supported in this process.

**Training**

There is a significant mental health training agenda for which the Government must allocate resources and responsibility. It should be delivered in tandem with local service development initiatives so that specialist mental health staff contribute to its delivery.

There is a need for all generic housing and homelessness staff who have direct contact with young people to be empathetic of young peoples needs and have basic emotional well being
awareness. This should be built into employment selection processes and developed through training.

♦ Ongoing support and supervision mechanisms between local mental health and housing partners should be established as part of any training programme. A shared learning approach should be central to this process.

♦ Young people who experience homelessness, mental health and drug and alcohol problems should be included in the development and implementation of local training programmes across service sectors. Service users should help develop service workers skills and knowledge by sharing their negative and positive experiences.

Research

♦ Research efforts should focus on recovery strategies to understand how services can make a difference to the present and future lives of these young people. Innovative services should be evaluated, the impact of early intervention needs to be tracked over time and the capacity for some young people to develop resilience in the face of adversity needs to be better understood.
SECTION V: REFERENCES


Social Exclusion Unit (2005a) *Transitions: A Social Exclusion Unit interim report on Young Adults*. London: ODPM


About the Mental Health Foundation

Founded in 1949, the Mental Health Foundation is the leading UK charity working in mental health and learning disabilities.

We are unique in the way we work. We bring together teams that undertake research, develop services, design training, influence policy, and raise public awareness within one organisation. We are keen to tackle difficult issues and try different approaches, many of them led by service users themselves. We use our findings to promote survival, recovery and prevention. We do this by working with statutory and voluntary organisations, from GP practices to primary schools. We enable them to provide better help for people with mental health problems or learning disabilities, and to promote mental well-being.

We also work to influence policy, including Government at the highest levels. And we use our knowledge to raise awareness and to help tackle the stigma attached to mental illness and learning disabilities. We reach millions of people every year through our media work, information booklets and online services.

If you would like to find out more about our work, please contact us.

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Registered charity number 801130

About Centrepoint

Centrepoint is the national charity working to improve the lives of socially excluded homeless young people. It provides a range of services, including emergency nightshelters and short stay hostels, specialist projects for care leavers, ex-offenders, young single parents, foyers and supported flats and floating support services. These services provide the foundations from which young people can start addressing some of the issues that lead to them becoming homeless, and developing the skills they need for a sustainable future.

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