

The Mental Health Needs of Homeless Young People

Bright Futures: Working with Vulnerable Young People

A report commissioned by The Mental Health Foundation
and written by Jo Stephens, Barnardos

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For ***Homeless Young People***

For further information on the research please contact:

Dr Tony Newman
Principal Officer, Research and Development
Barnardo's
46 Marlborough Road
Roath, Cardiff CF23 5BX
United Kingdom
Tel: 029 20485866
Fax: 029 20453083
email: tony.newman@barnardos.org.uk

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The Mental Health Foundation is very grateful to all those supporting the Vulnerable Young People's Project in particular to The Paul Hamlyn Foundation.

Executive summary

Introduction

This report draws on current research into young homeless people as a specific subset of the homeless population. It examines their mental health needs and discusses approaches to meeting those needs. The basic premise of the review is that insecure accommodation is injurious to both mental and physical health. Improved accommodation options will result in better health.

Methodology

A search for the relevant literature was carried out on the following databases: Barnardo's library catalogue, ChildData, CareData, Medline, Assia, Sociological Abstracts and Psychological Abstracts. To complement the literature review, two group discussions were held with young people involved with Barnardo's services and with personal experience of homelessness or insecure accommodation (n=16).

Findings

THE POPULATION

Definitions:

Mental Health: The report uses a broad definition of mental health, emphasising the dual importance of physical health and emotional wellbeing.

Homelessness: While 'rooflessness' may be the extreme end of the homeless continuum, fragile and insecure accommodation renders young people highly vulnerable to both potential rooflessness, and to many of the same psychosocial stressors.

Young people: The experience of children and young people between 11 years (the start of secondary school) and 25 years (the age at which the full adult benefit rate is paid) is reviewed.

Underlying causes: Accumulating disadvantage and exposure to risk can make anyone susceptible to homelessness. The balance between the role of personal histories and the role of structural changes continues to be a source of debate, along with which comes first – mental health problems or vulnerability to homelessness.

Sub-populations: Homeless young people are a heterogeneous population.

Gender: The young homeless population is primarily male, by a ratio of around 2:1. Females display more internalising disorders, as opposed to men who display higher rates of externalising disorders.

Minority ethnic groups: Minority ethnic groups are under-represented in the 'roofless' population, but over-represented in the overall homeless population.

Refugees and asylum seekers: This section of the homeless population tends to be the most isolated and disadvantaged, leading to different referral pathways.

Young Offenders: Running away and homelessness are life events experienced by a substantial number of young offenders aged 16 to 20 years.

Care Leavers: Thirty percent of young single homeless people have been in care and 20% of care leavers experience some form of homelessness within two years of leaving care.

NEEDS OF THE POPULATION

Poor mental health: There is a compelling body of evidence indicating that many homeless young people suffer from severely degraded mental health. Mental health problems are eight times as high for people living in hostels and bed and breakfast accommodation and eleven times higher for those who sleep rough, compared to the general population.

Poor physical health: As with mental health, the homeless population tend to suffer from a similar range of physical problems as the general population, but more often and more severely due to restricted access to basic commodities.

Risk taking behaviour: Self neglect may result from a combination of practical barriers and the manifestation of mental health problems. Self-harming is thought to be relatively common among young homeless people and suicide is the biggest single cause of death among the street homeless. There is a relatively high prevalence of sexual risk behaviour among the young homeless population. Substance use also has a significant effect on security of domicile. Criminal activity can be an inevitable and unavoidable consequence of lengthy periods of insecure domicile. It is preferable to see this risk taking behaviour as something that can be treated, rather than as a dimension of some people's lives that may be to some extent deliberately chosen.

Vulnerability: Young people understand the dangers of street living and harbour associated fears. Young homeless people are more likely to be the victims of crime rather than the perpetrators.

Social exclusion: While 'street children' are the most visible section of the young homeless population, they comprise the smallest. Many more young people with insecure domicile have high levels of need. Homelessness degrades job opportunities, impedes the acquisition of social capital, undermines the young person's sense of identity and exposes young people to a wide range of dangers and stressors.

CHALLENGES OF WORKING WITH THE POPULATION

Accuracy of diagnoses: Mental health issues may be less easily diagnosed than physical health issues by both clinician and patient, especially when there are complex presentations. Diagnostic procedures in adolescence are fraught with difficulties, in that the line between disorders requiring a clinical response and the troubles many children experience during 'ordinary' growing up is a fine one. The behaviour of homeless people may be construed as indicative of mental health problems when it may in fact be adaptive behaviour. It is important to avoid unnecessarily pathologising the problem. Homelessness is essentially a housing or socio-economic problem that can be addressed to a large extent by effective legislation and may be only one dimension of the multifaceted lives of young people.

Co-morbidity: Co-morbidity between mental health problems and substance use is high, but this issue should be treated cautiously in terms of what is problematic 'use'. There is a challenge inherent in meeting the needs of homeless people with severe and multiple problems.

Stigma: Knowledge and understanding of mental health problems among young people is low. While statistics are useful for justifying need, distressed young people may not necessarily be helped by a focus on diagnostic procedures. If a diagnosis is accepted, then discrimination against people with mental health problems may result in their being housed in the poorest accommodation.

Dependency: For many young people with insecure domicile, dependency on others – often people with similarly fragile accommodation – may become normative.

Positive choice: Homelessness may be preferable to sustained abuse or social isolation, or a conscious expression of independence. However, it remains a positive choice made in a context where the range of choices is narrow and mostly undesirable, not one chosen from a number of valued options.

Access: Insecure domicile and high levels of mobility result in young people relying excessively on acute rather than preventive services. Young people with low confidence and self-esteem are reluctant to make full use of public services.

Trust: Young homeless people may distrust statutory and regulatory services. Contact may be irregular, placing additional demands on the informal and voluntary sectors.

Lack of a voice: Young people may not have the experience to recognise and articulate their needs. Unlike most young people however, they may have few or no responsible adults to advocate on their behalf.

Diversity of population: Tensions may occur when the age range served is too broad, especially as adolescents just a few years apart may have had very different experiences and have very different needs.

Need for support: Despite housing long being identified as a pre-requisite for good health, a roof is not always the whole solution and can actually serve to exacerbate underlying problems. Loss of tenancies, further homelessness or use of insecure housing will not be avoided unless financial and emotional security are addressed. Ongoing social support from both lay and professional sources also has proven benefits in reducing psychiatric morbidity.

STRUCTURAL BARRIERS

Resource constraints: Pressures on time and resources mean that workers often have to deal with presenting problems rather than underlying causes.

Lack of statutory cohesion: The homeless are under-represented in CAMHS, and are particularly vulnerable to poor co-ordination between child and adult services. In addition, there is no departmental responsibility for the overall impact of government policies on homeless people.

Care system: Currently the care system provides inadequate preparation for independent living. There are additional pressures on care leavers because they lack the safety nets that others can fall back on.

Housing system: There is a lack of appropriate, accessible and affordable accommodation for young people as a whole. For vulnerable young people, the choices are far narrower.

Interagency collaboration: There is a need for more effective inter-agency working when dealing with a population characterised by multiple needs.

Service focus: Many resources currently reach less dependent and better functioning service users.

Poverty: Compounding the range of problems affecting homeless young people is the incessant impact of poverty. Legal entitlements are low, yet it is likely that due to lack of knowledge and an absence of informed advice, take up of benefits, and access to work or training for work, are lower than in similar domiciled populations.

Opening Hours: Crises tend to occur during un-social hours, provision needs to be flexible enough to respond to this.

Recommendations

Practical support: While specific clinical help is essential, many emotional problems may be alleviated by the simple and reliable provision of practical help.

National Service Framework (NSF): The Mental Health Foundation has called for the establishment of a NSF for children and young people's mental health. Likewise, the Social Exclusion Unit (SEU) proposes a NSF for runaways – ensuring greater resource allocation and better joint working.

Listen to young people: It is critical that young people's voices are heard, not just to map their routes into homelessness and its impact on their mental health, but also to help workers assess the availability and appropriateness of supportive provision.

Active intervention: Early and pro-active, rather than reactive services are essential as are multiple and intense support services. More assertive outreach work is needed to reach young people with the most pressing problems.

Improve access: Access to services has to be negotiated, paying attention to such factors as physical proximity and timing to ensure continued access to benefits, day centres and other essential services.

Improved inter-agency working: There is a need to increase services' capacity to deal with young peoples' varied and multiple needs.

Preventive housing measures: These include improved housing quality and availability to those at the lower end of the housing market, increases in housing benefit, more secure tenancies and better regulated private and social landlords.

Accommodation provision: A range of secure and flexible accommodation will have both preventive and healing effects on psychiatric morbidity. Supported accommodation and half-way houses can be crucial resources for young people.

Definition: The acceptance of a common definition of homelessness would make referrals easier and service provision more consistent.

Preventive familial measures: These include family mediation and respite services.

Preventive health measures: More education and active health promotion around mental health issues is required, in different settings and styles. Preventive and primary care services need to be more accessible to young homeless people and provide continuity.

Support care-leavers: Care-leavers independence needs to be promoted at a time when the young person is receptive and looking to move on.

Increase our knowledge base:

- Research tends to address those who have accessed support – we need to learn more about the “hidden homeless”.
- Homeless people's strategies for coping and surviving, along with resilience factors in the ‘at risk’ population need to be identified and understood.
- More knowledge is needed of the mental health needs of young people from those minority ethnic groups who are more prone to homelessness, both of the domiciled population and of young asylum seekers.
- A resource base of strategies, good practice examples and support networks needs to be developed, which address homelessness and mental health issues.

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The Mental Health Needs of Homeless Young People

Bright Futures: Working with Vulnerable Young People

Preface

The Mental Health Foundation is a leading UK charity working in the area of mental health and learning disability, focussing on research and policy and practice development. The Foundation's *Bright Futures* programme was established in March 1997 with the launch of a major inquiry into the mental health of children and young people in the UK. The report of the inquiry, with wide ranging recommendations for change, was published in 1999. The report was well received and widely promoted through events, the media and other ways. Feedback to the Foundation has shown that the *Bright Futures* report has contributed to, and influenced debate and policy and practice development on the mental health of children and young people across the UK.

The *Bright Futures* inquiry and report were, however, only the first phase of work for the Foundation in the area of children and young people's mental health. They have provided the springboard for the Foundation to pursue this important agenda in a number of different ways. The second phase of work involves a number of projects in key areas identified in the *Bright Futures* report, including:

- promoting mental health in schools
- early intervention for children and young people at risk of developing mental health problems
- improving support for young people in crisis
- the mental health needs of vulnerable young people.

Bright Futures: Vulnerable Young People's Project

In 2001, the Foundation secured funding from The Paul Hamlyn Foundation to review the mental health needs of four particularly vulnerable groups of young people:

- Young Offenders
- Looked After Children
- Homeless Young People
- Young People with Emotional and Behavioural Difficulties.

The aim of the project was to identify ways in which the mental health of vulnerable young people can be protected and enhanced and how those experiencing mental health problems can be better supported. The geographical focus of the project has initially been on policy and practice in England, but the issues raised are relevant to all countries in the UK.

The first phase of the project involved a review of the mental health needs of each group and the extent to which current policy and practice in England addressed these needs. This was achieved by:

- Commissioning four position papers from experts in the respective fields.
- Calls for evidence from policy makers and practitioners.
- Consultation with service users.

Based on the above, the Foundation has published four reports, of which this is one, on each of the vulnerable groups listed above. The reports were issued for consultation across the UK in May 2002 to around 2,000 key organisations and individuals. The findings will feature in *Community Care* magazine and contribute towards a policy seminar in autumn 2002.

The above activities have also informed preparation of an overview, summary report on the mental health needs of vulnerable young people in the UK, to be launched at a major conference in March 2003. This report will include a wide range of recommendations for change, which will be actively disseminated to key policy makers and practitioners across the UK.

The Foundation hopes to gain funding beyond Spring 2003 so it can work with others to secure implementation of the recommendations and thus contribute to improved mental health for vulnerable young people.

Maddy Halliday

*Director Scotland and UK Development
Mental Health Foundation*

1 Introduction

Key messages

- The 'homeless' population includes young people in fragile and insecure accommodation, not just those who are 'roofless'.
- Insecure accommodation damages both mental and physical health; improved housing improves people's health.
- Homelessness degrades job opportunities, impedes the acquisition of social capital, undermines the young person's sense of identity and exposes young people to a wide range of dangers and stressors.

There is considerable evidence of a high prevalence of psychiatric disorder among homeless youth, much less is known about its long-term course or the impact it may have on accommodation outcomes. (Craig and Hodson, 2000)

Rationale and scope of the report

Both the link between health and poverty, and more specifically, the link between health and housing are well attested. There is compelling evidence that the causality is bi-directional – relieve poverty and improve housing and health will improve (Wilkinson (1994), Acheson (1998), Wolff et al. (2001)). We can thus infer that homelessness, is likely to have a severely negative impact on health. Given the widespread agreement that health must be seen from a holistic perspective (WHO, 1948), homelessness is likely to affect physical, emotional and mental well-being.

This review concentrates on young homeless people as a specific subset of the homeless population. They warrant particular attention because of the specific legislation which affects them, their differing access to health services and the highly vulnerable position they hold by virtue of their age. While mental health remains the focus, co-morbidity (i.e. combined physical and mental health problems) is a particular feature of this population and hence responses that lie outside the purview of Child and Adolescent Mental Health Services (CAMHS) will also be considered. The report focuses on the issues and interventions in England, but will have relevance for the other countries of the UK.

Definitions

To clarify the scope of this review it is necessary to define what we mean by:

- mental health
- homelessness
- young people.

Mental health

Mental health problems are indiscriminate in whom they affect. The Health Advisory Service (HAS) uses a broad definition of mental health which emphasises the importance of health and emotional well-being and the need to nurture children's development (Young Minds, 1998). Of the children and young people under 20 living in the UK, it is reported that 20% may experience psychological problems at any one time (Mental Health Foundation (1999) cited in Smith and Leon (2001)). While we can identify sub-populations whom may justifiably be thought to be more vulnerable to problems, it is important that these groups are not seen as exclusive and separate from the population as a whole.

Homelessness

Our definition of homelessness and who is consequently included or excluded affects research results and their comparability. Homelessness can mean literally without shelter, that is, roofless. This is congruent with the Department of the Environment and Transport and the Regions, England (DETR) definition of 'rough sleeping' which includes people sleeping in the open air, or places not designed for habitation (SEU, 1998). Tenants who have been told to leave within 28 days are 'threatened with homelessness' and are legally recognised as homeless (Smith and Gilford, 1993). The Royal College of Physicians working party on health and homelessness describes unofficial homelessness as those sleeping rough and those 'at risk', for example in hospital or prison or with no fixed abode, and the 'hidden' homeless, for example those sleeping on friends' floors or staying in hostels on a temporary basis (Wrate and Blair, 1999). The Report of the Social Exclusion Unit, Policy Action Team 12: Young People (PAT, 2000) states that there are approximately 32,000 homeless 16 – 21 year olds in Britain. In comparison to our EU neighbours the UK's 16 and 17 year olds are disproportionately homeless. Although differing definitions (McCabe et al., 1998) make it difficult to gain a truly representative sample of homelessness in a statistical or narrative form. The important lesson to learn is that while 'rooflessness' may be the extreme end of the homeless continuum, fragile and insecure accommodation renders young people highly vulnerable to both potential rooflessness, and to many of the same psychosocial stressors.

Yeah, I know, but you can't get a job because certain jobs won't take you if you're in a hostel...[...]...they don't like it and they reckon you're homeless, you're classed as homeless if you live in a hostel. Which isn't fair...[agreement among participants that it's not fair]...you're trying to get yourself back on your feet and there's somebody there to slap you down. [Barnardo's service user has experience of living in hostels, and does so at present]

Others who are not officially categorised as homeless are those whom it is felt have a home to go to, or are deemed intentionally homeless. A 'home' implies, to those of us with secure incomes and adequate social capital, characteristics such as multiple rooms, permanency and privacy, features that hostels and the like frequently lack (Masten et al., 1993). Going 'home' evokes notions such as safety, stability, a place or space to call your own (Lilley, 2000), a sense of belonging and social ties. But not for everyone:

I was coming out of hostels for about three months, coming in and out of hostels and then I finally got my own place because I couldn't settle in a hostel. So I got my own place. [Barnardo's service user]

You want something that's your own as you've not got any support, especially if you're...most of the people here haven't got a lot of family that's why they were living in care, and that's all we've got; your home and kids. If you've not got that, then you've got...[Barnardo's service user]

ChildLine defines runaways as 'children who have run away from home and are under 16 years of age, or under 18 if they should be in care, custody or under supervision'. This definition heeds the fact that children under the age of 16 must be in the care of a responsible adult; if a parent evicts their child it may constitute neglect as the child's basic needs are not being met (Barter et al., 1996). Under 16's hold no legal status, increasing their vulnerability further as they have no service entitlements when 'on the streets' (Safe on the Streets, 1999).

Due to the above factors, the definition of homelessness adopted was broadened away from the 'street' to include those vulnerably housed. We believe that the threat of eviction has an impact on mental health that is worthy of note, especially for young people without any formal external support.

By looking at the historical context, the complexity of issues overlying the basic social and fiscal circumstances that can lead to homelessness can be seen, whatever the era. In 1876 Dr Barnardo estimated that in London there were over 30,000 homeless young people (Lilley (2000) and Barnardo (1877)). In the mid 1990's, homelessness was growing fastest amongst 16 – 18 year olds and the 'average age' of the homeless population was falling (McCabe et al., 1998). It is important to note that homelessness data within England are less robust outside London (SEU, 1998), and that data are rarely directly comparable due to baseline populations being selected in different ways (Hirst, 2000). The type of homelessness that young people encounter has been described varyingly. It is claimed that at the beginning of the 1990s, under 25s were under represented amongst the 'street homeless' and over represented amongst those living in hotels, bed and breakfasts and other temporary accommodation (Coles, 2000). The term 'temporary' can, of course be misleading; for example one study found an average stay of 42 weeks in such accommodation (Victor, 1996). An analysis of over 20,000 calls to Shelterline made by young people under 25, between April 1999 – April 2000, revealed that almost half were calls from people that did not have a place to stay that night (Shelter, 2000).

People who experience homelessness are often those vulnerable to structural factors that precipitate homelessness, such as changes in housing supply or labour markets (Pleace and Quilgars, 1999). The problem appears to be growing not diminishing (Rugg and Burrows, 1999):

Youth homelessness remains a growing and pervasive problem which is likely to be exacerbated by structural forces within various housing markets.

Young people

It is extremely difficult to define 'young people', 'youths' or 'adolescents' with any precision (West, 1999). Meanings and boundaries have changed through time and characteristics are far from homogeneous. Those defined as falling within this group are generally seen as being in a transitional stage between 'childhood' and 'adulthood', and are formulating their identity through experimental behaviours and peer influence. It is a period of rapid physical, emotional, social and mental development. It is argued that the successful negotiation of this period requires a safe space (Lilley, 2000), something which homeless people clearly lack. The importance of the here and now for young people should not be underestimated (Davies, 2000).

While there are commonalities of experience between children in families in temporary accommodation, where research is extensive (Masten et al. (1993), Vostanis et al. (1998), Cumella et al. (1998), Tischler et al. (2000)), and unaccompanied homeless young people, this review will focus on the latter. We will examine the experience of children and young people between the ages of 11 and 25 years which is justified on the following basis. Eleven is the start of secondary education and therefore an identifiable 'stage' of life and 25 is the age at which the full adult benefit rate is paid, which clearly has implications for those with adult responsibilities and expectations but no commensurate income (West, 1999). Neither of these arbitrary ages (Lilley (2000) and Vostanis et al. (1996)) suggest any particular stage of emotional maturity. When stages can be identified within this range (Cauce et al., 2000), they will be discussed in relation to the research findings.

Methodology

A search for the relevant literature was carried out on the following databases: Barnardo's library catalogue, ChildData, CareData, Medline, Assia, Sociological Abstracts and Psychological Abstracts.

'Mental health' was combined with 'homelessness', 'temporary accommodation', 'bed and breakfast', 'refugees', 'asylum', 'street children', 'runaways', 'care leavers' and 'leaving care'. Where necessary, this was combined with a selection of terms associated with children and young people. Articles were then selected which were most closely linked with the inquiry: the mental health of homeless young people. In addition, hand searches in Cardiff University library were carried out based on literature referenced in articles already obtained, and via the search tool on their own library catalogue. Relevant web sites, including those of the Social Exclusion Unit (SEU), Shelter and Young Minds were trawled to identify recently published work and to download reports and resources. The literature search concentrated on the UK and studies produced from 1990 onwards. Review articles written from USA and Scandinavian perspectives were included where relevant to the population, in order to complement the picture emerging for the UK.

Summaries of key case studies and key intervention studies reviewed appear as Appendices 1 and 2 respectively.

To complement the literature review, two focus groups were held with young people involved with Barnardo's services and with direct personal experience of homelessness or insecure accommodation (n=16). In addition, one individual interview was carried out, on the young person's request. Their observations appear in bold in the report and act as a commentary to the review.

2 Clarifying the issue

Key messages

- Prevalence of mental disorders increases as quality and security of housing decreases.
- Family breakdown and enforced or voluntary exclusion from home is strongly associated with homelessness.
- Insecure housing impedes emotional growth, degrades self-esteem and increases dependency.
- There are strong links between homelessness and drug and alcohol dependency.
- Criminal activity can be an inevitable and unavoidable consequence of lengthy periods of insecure housing.

There is a compelling body of evidence indicating that homeless young people suffer from severely degraded mental health.

In mid-1998, the Government's Social Exclusion Unit (England) published findings which suggested that between 30 and 50% of people sleeping rough suffer from mental health problems. (Lilley, 2000)

There is now well replicated data indicating high levels of psychological disorder in homeless young people, however, 'disorder' is defined and whatever methodology is used. (Wrate and Blair, 1999)

In a widely cited study, two thirds of young homeless people in London were estimated to have mental health problems, in comparison to a quarter of the housed population (Craig et. al, 1996). In a study conducted by York University, 45% percent of soup-run users and 31% of day centre users under 25, reported mental health problems (Bines (1994) cited in Shelter (2000)). Mental health problems are eight times as high for people living in hostels and bed and breakfast accommodation than among the general population, and the gradient is even steeper for those whom sleep rough, some eleven times as high. Younger people are the most adversely affected (Bines, 1997).

Rates of depression are, unsurprisingly, significantly elevated amongst the homeless population (Wrate and McLaughlin (1997) cited in West (1999)). This becomes more complex when additional issues are taken into consideration, for example two-fifths of people in a Centrepoint study who

had fled physical violence at their parental home had depression or anxiety, in comparison to less than one-fifth of those who became homeless for other reasons (Nassor and Brugger, 2000).

Oh yeah, 'cause I did [get depressed]. I'd sit there and all and tears come down my eyes 'cause there's nobody there...[Barnardo's service user]

This complements the finding that rates for emotional disorders may be higher among those in situations of extreme poverty (Wallace et al. (1998) cited in West (1999)) although evidence of class variation in youth is somewhat lacking. Children in the poorest households are three times more likely to suffer from poor mental health than children in better off households (DoH (1999) cited in Smith and Leon (2001)). In comparative studies (Vostanis et al. (1998), Cumella et al. (1998), Vostanis et al. (1996), Craig et. al, (1996)) between homeless families and those living in poverty the 'question of whether homelessness, per se, had a detrimental effect on children above and beyond other related stressors and conditions associated with poverty' (Buckner et al., 1999) is investigated. The consensus is that it does. In these studies, residential and social stability are found to be more prevalent in the housed population (Vostanis et al., 1998), and children display less delayed communication and lower average scores for mental health problems than their homeless counterparts (Cumella et al. (1998) and Vostanis et al. (1996)). In a study of unaccompanied homeless young people psychiatric disorder was far more common amongst the homeless than the housed sample population (62% v 25%), although a similar proportion of both reported substance use disorders in the absence of mental health problems (Craig et. al, 1996). Depression can be a major barrier to seeking help or coping with the demands of homelessness. In a US study (North et al, 1998), the early onset of depression was shown to predict more chronic homeless.

These conclusions are not universally accepted. A recent survey had suggested that conditions affecting homeless young people may be more severe and enduring but that this does not make it a 'dominant or irreversible feature' (McCabe et al., 1998).

Female rates for neurotic disorders (for example, anxiety and depression) greatly exceed male rates. In contrast, male rates for alcohol and drug dependence exceed female rates (OPCS (1995) cited in Goldberg (2001)). Females display more internalising disorders, as opposed to men who display higher rates of externalising disorders (Cauce et al. (2000), van der Ploeg and Scholte (1997)).

Yeah, but isn't it better to do something...[inaudible]...like to do a job and get a bit less money so you're doing something in the day...

Well, if you do nothing you just get depressed...

You'd lose your self worth.

You can't do anything if you're stuck in a hostel because you're an inmate, basically, you can't go anywhere, you can't do anything, you can't organise anything decent...[Barnardo's service user living in hostel accommodation]

Vulnerability to offending, through lack of social boundaries, poverty, peer group pressure and sheer necessity are distinctive features of the homeless population. Homelessness and mental health problems have been found to be among the under-recognised problems behind the offending behaviour of some young people (Mapp, 1996). One in fourteen young people who run away survive through stealing, begging, drug dealing or sexual exploitation (SEU, 2001). Anti-social lifestyles may become difficult and even impossible to avoid:

Criminal activity, even though mostly of a minor nature, 'is consistently found to be more common amongst homeless populations than their equivalent domiciled population' and it is thought to be 'particularly common amongst those with a mental illness' (Craig et. al, 1996).

Wouldn't get entitlements...I guess that's why you have people begging on the streets. [Barnardo's service user]

While criminal activity may be commonplace, what must be remembered is that young homeless people are also highly vulnerable. The 1996 Inquiry into Preventing Youth Homelessness in England noted that young homeless people were more likely to be the *victims* of crime rather than the perpetrators (cited in Nassor and Brugger, 2000).

A 1997 survey into the psychiatric morbidity of 590 young offenders, aged 16 to 20 years in England and Wales found that running away and homelessness were life events experienced by a substantial number of the study population.

It was only temporarily so...I knew what were happening next. I got locked up. So, it was only temporarily...It was only for two weeks so I wouldn't really expect people to do loads of stuff for two weeks. [Slept at a mate's house]... better than sleeping on the streets. [Barnardo's service user]

Sixty-one percent of male remand young offenders reported running away from home and 46% having been homeless. These figures were 53% and 35% respectively for male sentenced young offenders and 67% and 42% for female young offenders (Lader et al., 2000). This study concluded that the odds of having a personality disorder to be more than two times as great for those who had ran away against those who had never ran away. In another study, offending was not associated with mental health problems at index or follow up, but was strongly related to substance abuse and an unsatisfactory housing outcome (Craig and Hodson, 2000).

Among young homeless people the incidence of alcohol abuse is reported to be about 20% (Grenier, 1996). Alcohol is used in a similar way to the general population; to aid relaxation, to escape reality, as a confidence booster, or for self-medication. Alcohol is also linked to mental health problems and other physical problems.

The use of drugs among rough sleepers is reported as rising, and is linked with the increase in homeless young people (Grenier, 1996), a recent study noting that 'young people aged between

18 and 24 were more likely than other age groups to report a drug addiction' (Pleace and Quilgars, 1999). Approximately 28% of street homeless aged between 18 – 25 have drug related problems (HAS (1999) cited in Shelter (2000)), which is greater than the 20% cited for the whole street population (SEU (1998) cited in Shelter (2000)). There are consequent associated physical problems of drug misuse such as abscesses from injecting sites, Hepatitis B and C and HIV status (Scottish Executive, 2001).

It is reported that 'homelessness is likely to aggravate, or even precipitate, problems related to drug or alcohol misuse' (Leigh, 1993). Nonetheless, this is by no means inevitable and where it does present it could be a precursor or coping strategy (Wrate and Blair, 1999) for either – or both – homelessness and mental health problems. Some studies (e.g. Lilley, 2000) include substance abuse and dependency as factors in poor mental health and this can sharply elevate prevalence rates. In others however, these factors are treated as lifestyle indicators (Wrate and Blair, 1999).

Co-morbidity between mental health problems and substance abuse is high, but this issue should be treated cautiously. For example, 'use' might be considered something that is of a similar prevalence throughout the adolescence population and not necessarily of a problematic nature. Rates of substance use disorders have been reported as being broadly similar to those in the housed population, 'except where occurring conjointly with mental illness', where there is also a suggestion that 'use' may be more frequent (Craig et. al, 1996). While co-morbidity was identified in three studies between mental health problems and substance 'dependency', importantly this did not hold for substance 'use' (Wrate and Blair, 1999).

Substance use, especially where combined with mental health problems, has a significant effect on security of domicile. At one year follow up, young people with persistent substance abuse were twice as likely to have poor accommodation outcomes as those who did not abuse or had 'recovered' (Craig and Hodson, 2000). A large barrier to overcome is that the combination of mental health problems and alcohol or drug related problems is fairly common and 'seems to deny people access to the sophisticated treatments they require' (Grenier, 1996). It is preferable to see risk taking behaviour as something that can be tackled, rather than as a dimension of some people's lives that may be to some extent deliberately chosen.

It is suggested that 'self-destructive behaviours stem from a disregard for one's own self-interest or safety, due to low self-esteem or anger' (Hammersley and Pearl, 1996). In 1998 approximately 24,000 young people aged 15 –19 in England and Wales self-harmed (Barton, 2001). Self-harming is thought to be relatively common among young homeless people, one study estimating a rate of between 14% and 25%, seven times that of the general population (Grenier, 1996).

Oh yeah [I used to get fed up], started cutting myself and then I went back to my parents and then they kicked me out... Then I went back to my parents and they kicked me out again. [Barnardo's service user]

Self-harming may help a young person to feel in control, or it may relieve feelings of anger or tension (Richardson and Joughin, 2000). One third of homeless young people report attempting suicide; mental illness is a frequent associated factor (Craig et. al, 1996). Suicide is the biggest single

cause of death among the street homeless (Grenier (1996) and Conway (2000)). In terms of suicide, the young female homeless population, and the homeless population over the age of 18 may be at 'particularly high risk' (Rohde *et al.*, 2001).

Somebody gave me this 24 hour helpline, it's a suicide helpline. [Barnardos' service user]

Self neglect may result from a combination of practical barriers to keeping clean and warm and the manifestation of mental health problems such as depression or very low self-esteem (Grenier, 1996).

I slept in a car for a night and I felt filthy, really filthy. I'd never do it again...oh, I was comfy when I went to sleep, but I was cold when I woke up. [Barnardo's service user]

Refugees and asylum seekers are amongst the most vulnerable people in society as they are having to deal with the problems from which they have fled while trying to build a new life in a new country. This vulnerability may manifest itself in health problems – physical and mental – therefore there is a need to improve their understanding of, entitlements to, and access to, health care. Nick Hardwick, Chief Executive of the Refugee Council, stated at the Joint Meeting of the All Party Parliamentary Groups on Refugees and for Children on 31 October 2001 that Unaccompanied Asylum Seeking Children (UASC) are falling through the safety net because no-one wants to take responsibility and so there are children being neglected and abused as a result. In addition he suggested that the guiding principle should be that these children are children first and refugees second.

Young people's need for security of housing results in there being a large degree of commonality between different categories of homelessness. Fragility and insecurity of housing can result in chronic problems that impact on all dimensions of a young person's life, especially those with dependants.

I've paid too much rent and then because I wanted my money back I got evicted...I've had to go to court twice and I'm still in the same property. I've had the Housing Association take me to court because the council had paid too much money and then they took a whole chunk back and then it's put me in debt through no fault of my own. And then I'm paying court costs for them taking me to court...How would you feel if you got told you had twenty eight days to move on? [Barnardo's service user with two young children]

Having space allows one to deal with emotions and change. A space to call your own is important for a sense of internal safety – in a psychological sense – and external safety – in a physical sense (Winnicott (1990) cited in Lilley (2000)).

Mental and physical health are intrinsically linked. If one deteriorates, it is highly likely that the other will, especially if the deterioration is extreme. The homeless population tends to have restricted access to facilities for basic needs such as clean, comfortable sleeping and a balanced diet, which lead to poor health in itself and increased susceptibility to illness. In addition, there is

the stress associated with trying to find, or live without, these basic commodities. In two studies of homelessness, high rates of self-reported problems covering a diverse range of complaints were found, for example, stomach problems, headaches, aching joints, chronic bronchitis, skin troubles and epilepsy (Wrate and Blair, 1999). Perceived physical health status was seen as below age-matched 'norms' (Wrate and Blair, 1999). As with mental health, the homeless population tend to suffer from a similar range of physical problems as the general population, but more often and more severely (Grenier, 1996).

There is a relatively high prevalence of sexual risk behaviour among the young homeless population. This behaviour incorporates unprotected sex, sex under the influence of substances and circumstances where sex is used in exchange for money or drugs (Wrate and Blair, 1999). There may be a direct link to factors such as simple survival, or it may be that homelessness and high risk sexual activity are both related to other variables, such as depression, poor problem solving or spontaneity (Wrate and Blair, 1999). Rohde *et al.* (2001) found that 'depression is frequent in homeless older adolescents and has a complex association with STD-related behaviours'. The risks associated with such behaviour include sexually transmitted infections, unplanned pregnancy and potential for abuse or exploitation. For example, in one study 40% (16/40) of homeless young women in London who were re-interviewed a year later had at least one confirmed pregnancy, all of which were unplanned (Craig *et al.*, 1996).

Homeless people, and people with mental health problems, may suffer social exclusion due to their relative invisibility which impedes their access to services that other citizens take for granted. The Scottish Executive report into Health and Homelessness (2001) stated that 'addressing homelessness has to be a critical aspect of the social justice agenda given that homeless people are among the most disadvantaged of our society'.

I suppose some people wouldn't want to invite their friends to a hostel... too embarrassed. [Barnardo's service user]

Crisis believes that social exclusion is not really just a result of homelessness. It is also a very significant cause of street homelessness. The exclusion of single homeless people begins in most cases before they reach the streets. (SEU, 1998)

This exclusion can be a vicious cycle. For example, those who feel that their situation is desperate, are the least likely to seek and therefore receive help (Coles, 2000), and are also unlikely to be noticed by agencies as they tend to withdraw from social contact (Grenier, 1996). Social withdrawal and subsequent isolation is often linked to suicide or attempted suicide (Samaritans (1999) in Coles (2000)). The policy of the Rough Sleepers Unit, England is to ensure that, in seeking to help rough sleepers they are not 'reinforcing street lifestyles rather than providing opportunities for ending them' (RSU, 2000b).

Although it has been argued that hostels and other such 'temporary' living can isolate young people from mainstream society, they may also offer opportunities for mutual encouragement (McCabe *et al.*, 1998) and the sharing of advice and success stories. This may help to address the immediate problems of homelessness.

Not so much isolated, just that nobody gives a fuck to be truthful. [Barnardo's service user]

For many young people with insecure domicile, dependency on others – often people with similarly fragile accommodation – may become the norm. Young people in discussion with Barnardos, described how uncomfortable they felt relying on others, and perceiving themselves as dependants.

Because she gotta rely on other people, she's the sort that don't like to rely on people...I wouldn't see her out on the streets. [Barnardo's service user talking about a friend she is currently putting up, who would be homeless otherwise]

For about a year I didn't have no address and they wouldn't give me no money, nothing...I had to borrow clothes off my girlfriend...you know, it didn't feel nice. [Barnardo's service user lived in a car and hostels during this year]

The Needs of the Population

Key messages

- Insecure domicile and high levels of mobility result in young people relying excessively on acute rather than preventive services.
- Homelessness frequently results from an accumulation of extreme stressors; co-morbidity, both mental and physical, is typical.
- Early and pro-active, rather than reactive services are essential as are multiple and intense support services.
- Young homeless people do not wish to be seen as having 'mental health' problems (reflecting the social stigma associated with mental health problems).
- Minority ethnic groups are under-represented in the 'roofless' population, but over-represented in the overall homeless population.
- The homeless are under-represented in Child and Adolescent Mental Health Services (CAMHS), and are particularly vulnerable to poor co-ordination between child and adult services.
- While 'street' children are the most visible, they comprise the smallest section of the homeless. Many more young people with insecure domicile have high levels of need.

Diagnosing and defining mental health problems

Mental health professionals may use a range of diagnostic tools to identify mental disorder, including the commonly used international classifications such as the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994), the Diagnostic Interview for Children and Adolescents (DICA) and the more general SF-36 health instrument. However, different diagnostic procedures result in varying estimates of mental health problems, very probably because of methodological differences (Slegers et al., 1998). It should also be noted that the labelling of a problem does not demonstrate causation, and furthermore, standardised instruments designed for, and in, clinical environments may be less reliable when deployed in community settings (McCabe et al., 1998). Much investment of time may be made in defining problems and exploring prevalence rates. However, while statistics are useful for justifying need, distressed young people may not necessarily be helped by a focus on diagnostic procedures, especially if the labelling that results is seen by the young person as stigmatising (or inaccurate).

Many professionals, and much of the public, may be antagonistic towards a model which treats presenting symptoms without considering the wider context (Richardson and Joughin, 2000).

To know the background is quite important. [Barnardo's service user]

When offering assessments and interventions, it is important to heed this and most child mental health services do to some degree. Young people may experience a sense of relief when they have a label or a diagnosis, which may also bring easier access to resources (Richardson and Joughin, 2000). However, diagnostic procedures in adolescence are fraught with difficulties, in that the line between disorders requiring a clinical response and the troubles many children experience during 'ordinary' growing up is a fine one. Professionals often find it hard to apply standardised diagnostic criteria and may fall back on terms such as 'personality disorder' to try and give some meaning to the chaotic and complex picture often presented (Lilley, 2000). The young person's well-being and the use of measures to promote this are the paramount factors, and are often likely to be more important than achieving a precise diagnostic consensus.

Prevalence of mental health problems

Two-thirds of a sample consisting of 364 homeless young people were diagnosed as having one or more disorders, using DSM-III-R criteria (Cauce et al., 2000). However, we are warned not to jump to premature conclusions (Hirst, 2000):

High scores on symptom scales in a homeless setting are not in themselves an indication of a psychiatric problem.

Prevalence rates also need to be interpreted with care because conduct disorders, antisocial disorders and substance abuse 'are commonly associated with childhood adversity' and their inclusion in mental health surveys of the young homeless inevitably increases rates (Wrate and Blair, 1999).

Responding to homelessness

One approach to identifying the point at which homelessness moves from an external to an internal reality is the 'three week rule'. This has been defined as 'the period during which people rapidly adapt to homelessness in order to survive, and after which it is more difficult to integrate back into mainstream society'; and is particularly applicable to young people (Grenier, 1996):

....in the first few days, the person is comparatively unprepared for sleeping rough and can probably be seen with just a blanket in a shop doorway. The next stage may be to join up with other homeless people and be huddled in a small group. After a week or so they have probably acquired some form of shelter or 'bash' and moved out of the main highways where they are both continually disturbed and the obvious subject of other people's (dis)interest. Eventually they will tend to gravitate towards one of the soup-run venues or more organised sites. Alternatively, they may use such facilities but hide themselves away in a remote location such as an empty building or car park.

According to this model, once acceptance of being homeless sets in, the young person becomes less angry and less likely to take positive action to remedy the situation. Consequently, unless young people's housing needs are addressed as quickly as possible, and adequate support provided, they are likely to drift into, and remain, in a homeless situation. This is due to the loss of familiar environments, a lack of life skills necessary for adaptation to a more secure domicile (Grenier, 1996), and the reality that becoming homeless can be an overwhelming experience (RSU, 2000b). The review of rough sleeper research conducted by the Social Exclusion Unit, (SEU) confirms that there is a 'window of opportunity' from the onset of homelessness up till three to four weeks later, during which interventions are most effective and after which problems may become more ingrained (SEU, 1998).

In terms of mental health promotion it will be 'most effective when it intervenes at a number of different life-stages, at a number of different times and at a number of different levels' (Gale and Holling, 2001). When an actual health problem presents, the earlier the intervention takes place, (providing it is founded on solid evidence) the more beneficial it is likely to be and the less severe the problem is likely to become (Young Minds, 1998).

The evidence for the risk of early progression is strong... the first three years of illness offers a window of opportunity to prevent or limit this potential decline. (Ryan, 2001)

Cost benefit analyses also provide evidence that investment in early intervention is likely to save considerable amounts of resources 'throughout the lifetime of someone who has a mental health problem which develops in childhood' (Irvine and Morley, 2001). Mental health problems present challenges in terms of identifying an appropriate response, as problems may present themselves in many different forms, through different precipitating factors, and respond to different approaches. It is further complicated by many of the risk factors for mental health problems also being risk factors for homelessness in the young (Wrate and Blair, 1999).

Despite housing long being identified as a prerequisite for good health (Lilley, 2000), a roof is not always the whole solution and can actually serve to exacerbate underlying problems. For example, young people are unlikely to benefit from hard-to-let tenancies with inadequate support (Fitzpatrick, 2000). Also, staying with friends and partners is not always a safe alternative to the street as violence, abuse, and victimisation may occur there (Barter et al., 1996). Sharing accommodation with friends and acquaintances may also involve a lack of privacy, the sharing of facilities and cramped conditions and tends to be a short-term solution only (Scottish Executive, 2001). Risk factors on the street have to be compared to those associated with certain types of accommodation. The choice is not as clear as it may first appear.

...there's always new people coming in and out so I'm used to new faces, but it's just not fair on the young children, you know...you can't keep changing the faces in front of a child because it messes their head up. [Barnardo's service user lives in a hostel]

I'd rather stay on the streets than go in to hostels. [Barnardo's service user]

On a more individual level, loss of tenancies, further homelessness or use of insecure housing will not be avoided unless financial and emotional security are addressed (Coles, 2000).

Your housing benefit and that doesn't cover more than rent...There's your shortfall, where you gonna get that? You've got no family, you've got no help from social services and they're not in a position to help even if you have got health problems. [Barnardo's service user]

Housing is not much good to a young person unless it is located near informal networks of support or supportive services which they can access, and general amenities. Without this, they are likely to become more isolated and vulnerable to distress (Mind, 2000). When re-locating asylum seekers it is important to ensure access to religious or cultural centres, if requested. Also, there should be an avoidance of placements in hostile populations where awareness is low (Garvie, 2001).

Stigma

There continues to be a stigma attached to mental health problems. This factor is compounded for young people who are homeless and who lack access to information and support. This issue was a significant factor in seeking to access young people during the compilation of this report. While the problems presented by insecure domicile were seen as legitimate subjects for discussion by young people, issues of mental health had to be discussed without recourse to any clinical terms or any suggestion of pathology or abnormality. The young people spoken to clearly wished to access services without being 'pigeon holed' along the way. Young people's fear of psychiatric labelling was not irrational. Accessing mental health services can make securing accommodation more difficult (McCabe et al., 1998). Negative professional and public attitudes to mental health still need to be challenged (Wilson, 2001) and 'hidden discrimination' continues to be a problem within the health care service (McCabe et al., 1998).

Risk Factors

A number of studies have helped to identify the risks associated with mental health problems (among them homelessness itself), the antecedents of homelessness, and factors homelessness might initiate and compound. These include having a parent with a mental health problem, a violent or abusive family environment, volatile family relationships, harsh or erratic discipline, parental separation, the experience of death and loss, unemployment, poverty, ill health, lack of social support and discrimination (Coles, 2000). There is rarely one simple cause of homelessness, but rather a number of factors that lead to increasingly intolerable situations (Hammersley and Pearl, 1996).

Risk factors are cumulative. Where there is known to be one risk factor present, this increases the chance of developing mental illness by only 1 or 2 per cent. However, where there are three factors present this increases the likelihood by 8 percent and when four or more by 20 per cent. (Rutter and Smith (1995) cited in Coles (2000))

Depends on what sort of person you are. [Barnardo's service user]

Accumulating disadvantage and exposure to risk can make anyone susceptible to homelessness (West, 1999). Mental health problems are not a unique precipitating factor (Craig et. al, 1996):

...the reasons for the loss of accommodation among the mentally ill homeless directly mirrors reasons given by healthy homeless people: evictions because of failure to keep up with rent payments, victimisation by unscrupulous landlords and dissatisfaction with poor quality, cramped conditions of much 'temporary' accommodation.

I've been through that. You feel very helpless. You seek help and if you don't you've lost out. [Barnardo's service user who has experienced problems with an insensitive landlord.]

I think the law should be changed and that they you do something about that. [Barnardo's service user talking about private landlords.]

Adverse childhood accounts are common in research studies, as are less favourable adolescent and adult outcomes. Better accommodation outcomes are predicted by prior educational achievement (indicative of support, ability to cope with structured surroundings, behaviour and breaks in schooling), and 'the absence of conduct disorder, and shorter and less chaotic homelessness histories' (Craig and Hodson, 2000).

In comparison to a domiciled population, the homeless young people in our study were more likely to be unemployed, in receipt of state benefit, 'topping-up' benefits through unofficial temporary/part-time work, through begging and petty crime. They were significantly less likely to have been successful at school and less likely to be involved in or considering further education (including youth

training schemes). Their childhoods were characterised by multiple breakdowns in care arrangements, high levels of domestic violence and extremes of parental indifference, inconsistent supervision, and physical and sexual abuse that far outstripped that seen in their domiciled contemporaries. These observations are broadly in line with those of the majority of American studies of young homeless people. (Craig et. al, 1996)

Youth homelessness should be seen as a 'process' rather than a specific 'endpoint' (Cauce et al., 2000). 'Housing pathways' can illustrate this, by defining the progress over time of an individual or household through the housing system in generalised terms. A principal strength of this perspective is that homeless episodes can be related to each other and to housing circumstances before and after (Cauce et al., 2000). The incidence of institutional living tends to increase with the lengthening of homeless experience, probably because of the difficulties associated with sustaining 'unofficial' homelessness (Fitzpatrick and Clapham, 1999). When looking at 'housing pathways', questions are raised. For example, are looked after children more prone to homelessness and mental health problems because of their difficult personal histories or because of the structures not being in place to adequately support them when they leave care? Trends can also be identified, such as girls' histories are more often marked by sexual abuse and victimisation, and boys' histories by physical abuse and assault (Cauce et al., 2000). This gender-related trend follows through into street experiences and behaviours adopted by homeless young people (Cauce et al. (2000), Wrate and Blair (1999)). Defining pathways and outcomes identifies areas where preventive services can be targeted and/or responsive alleviation measures provided (Cauce et al. (2000), Lilley (2000)).

Poor accommodation outcomes were related to lengthy histories of homelessness, rough sleeping and persistent runaway behaviour. These in turn are all closely associated with conduct disorder in childhood and under-achievement in education. (Craig et. al, 1996)

The more predominant the push factors in a young person's decision to leave home, the more problematic the transition to independent living tends to be (Cauce et al., 2000). Unlike housed peers, young homeless people have often made an abrupt, and traumatic, transition to independence (Boulton, 1993). The reasons why some young people are able to cope better with drastic changes in their personal lives for longer before leaving needs further exploration.

The risk of young people who have been in care becoming homeless, is widely acknowledged to be substantially higher than that of the general population. Thirty percent of young single homeless people have been in care (Richardson and Joughin, 2000) and 20% of care-leavers experience some form of homelessness within two years of leaving care (Biehal et al. (1995) cited in Richardson and Joughin (2000)).

I'd like to hear a good story if anybody's got one. I don't know anybody who's come out of care and done well, or come out of care or looked after and had anything good... usually it's gone from bad to worse, and worse and worse.
[Barnardo's service user]

Forty-three per cent of homeless young people who had experienced being looked after by a local authority had health problems compared to 23 per cent of those who had not been in care. Thirty-two per cent of those who had been looked after by a local authority suffered from depression/anxiety compared to 18 per cent of those who had never been in care. (Nassor and Brugger, 2000)

The fact that care leavers lack emotional support, in addition to help with the practicalities of independent and healthy living, was acknowledged in group discussions to support preparation of this report:

They [staff at residential home] know you that well that anyway if you don't want to talk to them they've still got an insight into, they still...like your mum knows how you are and what...I don't know...a lot of emotional support and stuff like that. Because that's when you fuck up, when you haven't got anybody, because it gets to your head... [Barnardo's service user]

It's not a case of you don't know or you don't try, you ain't got nobody. It's not a case of don't know, you've got nobody. [Barnardo's service user on it being more than not knowing who or where to turn to]

Young people have distinct needs:

The usually rigid distinction made between childhood and adulthood rushes many young people into an adult status for which they are not ready – and which fails to recognise their particular, especially adolescent needs. (Davies, 2000)

Mental health is one of those 'needs' and the 'rigid distinction' is particularly evident in the delivery of statutory mental health services. The age of a person when they run away can lead to different 'homeless' characteristics (Safe on the Streets (1999), Craig et al. (1996)). This is particularly pertinent when considering mental health (Craig et al. 1996):

A history of having run away from home under the age of 16 was associated with lifetime risk of mental illness or substance use disorder (Craig et. al, 1996).

Young people who are under 16 have very limited options, with only a few projects catering for younger children in the UK. While not a representative group, it was disturbing to learn that half the participants in one of our focus groups described themselves as leaving care before they turned 16:

Q: How old were you when you left care?

A: **16; 15; 14; 15; 16; 14; 16; 18**

The last respondent commented:

I was on a care order for 17 years. When I left it were like one hell of a big step, innit? I went straight into a [inaudible] and then I was in like loads of trouble.

[Barnardo's service user]

It is suggested that the transition between childhood and adulthood is not sufficiently acknowledged in the planning and development of services (Wilson, 2001). The YIACS (Young People's Information, Advice, Counselling and Support services) has raised particular concerns about transitions that occur in tandem with difficulties, such as homelessness or family or care breakdown. What is required is quick and easy access to a range of age-appropriate and young person friendly mental health services (Wilson, 2001). This is not seen to be happening currently and is a gap that YIACS is trying to fill, as a bridge between CAMHS and adult services (for further information on YIACS see Appendix 1).

They take liberties, and because you are so young they think they can take the piss even more. [Barnardo's service user on statutory service provision]

Services working with early adolescents are likely to encounter the most disturbed young people (Cauce et al., 2000). Thinking about the future may also be more problematic for younger homeless people, along with those who have a longer history of homelessness (McCabe et al., 1998).

Risk factors are balance by resilience factors, that is, the capacity to avoid or manage mental health problems despite adverse circumstances (Coles, 2000). Resilience factors, which have been widely discussed elsewhere, are as relevant to homeless young people as to any other group faced with severe adversities (Mental Health Foundation, 1999).

Characteristics of homelessness

The street homeless are the most visible homeless. They represent a very distinct, and probably relatively small subgroup of the young homeless population (Fitzpatrick and Clapham, 1999). Those sleeping rough may not have access to temporary accommodation because of challenging behaviour, lack of knowledge of provision, or because they may be young 'runaways' who do not wish to be returned home or to care. As this population is the most visible and is given the most political attention, homeless agencies tend to concentrate their activities at city centre locations (Fitzpatrick and Clapham, 1999). There is a tendency to see street homelessness as more serious, when it would probably be more helpful to see it as the tip of the iceberg (Boulton, 1993). One in twenty young people are likely to experience homelessness at some point in their lives (Smith *et al.* (1996) cited in Nassor and Brugger (2000)), and around a tenth of them sleep rough (Inquiry into Preventing Youth Homelessness (1996) cited in Nassor and Brugger (2000)).

'Territoriality'; or level of attachment to local area, was one of the most important factors identified in research which influenced the pathway a young person took, and their degree of 'invisibility' to homelessness services (Fitzpatrick and Clapham, 1999). Territoriality, however, may be enforced rather than optional in that a lack of emergency accommodation means that young people tend to stay in

urban areas, or move to them, where such accommodation is present. This can increase risks for some young people who have little experience of urban life and its dangers (Nassor and Brugger, 2000).

Homeless young people are a diverse and dynamic population (Pleace and Quilgars, 1999) with:

- an disproportionate representation from minority ethnic groups,
- people from the looked after system, who comprise one third of young homeless people in the UK (Lilley, 2000),
- those in custody (Coles, 2000),
- those from re-constituted families,
- those who have suffered violence or sexual abuse.

It is also primarily male, by a ratio of around 2:1 (Wrate and Blair, 1999). It is likely that the extent of women's homelessness is underestimated because they are more likely than men to find alternative forms of accommodation, such as staying with friends (Jones, 1999). This emphasises the multiple and complex causes of homelessness. Homelessness has a deep hinterland, illustrated by a comment one young person made to the authors of this report:

So she's got that to deal with...[personal history]...and the fact that she's homeless to deal with. [Barnardo's service user commenting on the situation of a friend]

In contrast to assumptions often made about homeless young people, the two most common routes identified by Childline in their call survey of young people were repeated running away, and being thrown out of their homes by their families (Keep, 2000):

All of the young people that Childline referred spoke of their fears and anxiety about not having a home... They were well aware of the dangerous situation they were in, but were often still preoccupied with the events that had made them homeless.

Young people understand the dangers of street living and harbour associated fears. This questions how effective the Department for Education and Employment's (England) (now DfES) scheme to peer educate school children about the experience of sleeping rough will be (RSU, 2000a and RSU, 2000b).

The point at which someone actually becomes homeless is difficult to define, especially when there is a history of running away (Grenier, 1996). A review of three studies into youth homelessness illustrates this complexity (Wrate and Blair, 1999). [These are summarised in Appendix 1.]

The dismal conclusion from this history of adversity is that for many homeless young people the situation they were living in whilst housed was the problem – homelessness may well be the solution. (Tomas and Dittmar (1995) cited in Wrate and Blair (1999))

It is undisputed in the literature that homelessness is more often than not a symptom of underlying difficulties (Lilley, 2000), for example, poverty, educational disadvantage or abuse. Most young single homeless people who seek housing help have 'to some extent, problems beyond their lack of permanent shelter' (Hammersley and Pearl, 1996). It is claimed that 'running away is always a secondary problem to the severe difficulties that forced them to take flight in the first place' (Barter et al., 1996). The balance between the role of personal histories and the role of structural changes (for example, in the housing market, employment opportunities, welfare policies) continues to be a source of debate (Rugg (1999), Lilley (2000)). However, precursors to homelessness can yield some ideas as to what preventive strategies could feasibly be deployed.

Young people already on the run, perhaps especially the under-16s, often experience a strong feeling of confusion, and an inability to think about anything other than the immediate problem of survival. They may have no mental space to consider their underlying problems (Buckner et al., 1999).

Associated with this is a loss of identity, which has inevitable implications for an individual's mental health.

Being 16 and a young person in a new town, very scary. Everything goes through your head at once. Where am I? Who am I? What am I doing? Basically, who am I? You don't know who you are anymore. [Barnardo's service user]

Managing to live independently can be a struggle for some and may be a factor in causing youth homelessness (Pleace and Quilgars, 1999), especially where there is a lack of external support. There are additional pressures on care leavers because they lack the safety nets that others can fall back on (Boulton, 1993). Making mistakes is an essential part of adolescence, and in the case of care leavers the wrong decisions can often have long term implications, in terms of both their emotional wellbeing and accommodation arrangements.

I know people now what's thirty years old and still get kicked out their house, move back in with their parents, its like a game, its a big joke...they've got that safety net, they can run back whenever they feel like it and they can go out and make mistakes, take chances and do what normal teenagers and that are gonna do, but they haven't got the comebacks off that like we've got. Like, we've made a bed, we'll lie in it. We've got no choice but to lie in it.

We're going to make mistakes, that's what we're supposed to be doing. We make mistakes to learn life. But we shouldn't make mistakes and then have to live with them for ever and a day because you've made a mistake and you didn't have the knowledge that you've got at the end of the mistake to go back and not do it. You've done it regardless, you shouldn't be fucked because you've done it.

[Barnardo's service users]

While support needs to be provided alongside accommodation, it is also important not to segregate the 'young, single homeless somewhat arbitrarily into those with special needs and those who simply require housing' (Hammersley and Pearl, 1996).

Homelessness and mental health

The Audit Commission recognised that certain groups of children and young or those living in certain conditions are at greater risk of developing mental health problems than others (Audit Commission, 1999). Among the factors known to increase vulnerability to mental health problems are homelessness or temporary accommodation.

It was either stay and die, or go, basically. Because I was putting everybody else at risk by staying here, because the place just kept on getting broken into because of stuff that I'd gotten involved with. So, you know, I had to get out, as soon as possible, basically... But it's not easy. [Barnardo's service user who has recently moved from supported housing to a hostel]

For a minority, homelessness can be a positive choice. It may be preferable to sustained abuse or social isolation, or as a conscious expression of independence (Lilley, 2000). However, it remains a positive choice made in a context where the range of choices are narrow and mostly undesirable, not one chosen from a number of valued options.

Care must be taken not to exaggerate the adversities facing young people with respect to homelessness (Fitzpatrick and Clapham, 1999). The behaviour of homeless people may be construed as indicative of mental health problems when it may in fact be adaptive behaviour (Snow *et al.* (1988) cited in Fisher and Collins (1993)). It is important to avoid unnecessarily pathologising the problem, when homelessness is essentially a housing or socio-economic problem that can be addressed to a large extent by effective legislation (Grenier, 1996) and only one dimension of the multifaceted lives of young people (Fitzpatrick and Clapham, 1999).

The provision of stable accommodation should have two principal effects on the health of homeless people; firstly, to improve their health status because of the reduced risk of illnesses associated with street or hostel living, and secondly, to improve access to health care by removing the barriers imposed by having no fixed abode. (Connelly and Crown, 1994)

Everyone who is homeless has their own story and their individual needs: and the most urgent need, without which neither their mental nor physical health can be addressed effectively, is for a home. (Grenier, 1996)

Provision of safe accommodation may alleviate the most immediate triggers of some mental health problems, but long term conditions will need identifying and appropriate remedial action taken.

Young homeless people are vulnerable to health problems because they have high levels of complex needs which cannot be met by conventional health services and arrangements (Vostanis *et al.*, 1998).

Becoming homeless does not guarantee poor health. Rather, being homeless can mean an increased risk that someone will develop health problems. (Pleace and Quilgars, 1997)

Exposure to the cold and wet, unhygienic living conditions and associated exposure to infectious diseases, increased accident risk, interrupted sleep cycles, and an unbalanced diet are among the factors that both cause and compound ailments (Victor, 1996).

Young people away from home face risks of hunger, fear, loneliness and are vulnerable to being hurt or exploited by others. These risks are in evidence not only for those who sleep rough but also for those who stay with relatives and strangers. (Safe on the Streets, 1999)

Young people told us:

To be safe...have a baseball bat down the side of the seat, innit? Especially in a car in XXX [an area of the city]. [Barnardo's service user lived in a car for a couple of months]

- ...but when I went to a hostel they gave us a ... and that and it was just like we were sharing rooms with like four people at a time and that, and you just didn't get any sleep...

- your personal possessions and that?

- ...yeah, gone

[Barnardo's service user favoured living in a car to living in a hostel]

...hostels could be a safe place, or there is a sense of community, the friendliness of it. But this particular girl who I know lived there had the complete opposite, she was scared of the other women in there...they were name calling

Might not feel safe because it's a hostel...Do get women only hostels, family only hostels, put similar people together, makes it safer.

[Barnardo's service users]

Mental health problems, particularly among highly vulnerable populations, tend to be multiple (Hirst, 2000) and can be severe and enduring. This clearly has implications for positive housing outcomes. The issue of co-morbidity is of paramount importance here, as 'what rough sleepers present with medically is only the tip of the iceberg' (Grenier, 1996). In the literature, the biggest challenge appears to be meeting the needs of homeless people with severe and multiple (social and health) problems (Craig and Hodson, 2000). Individuals can often find they are pushed from one service to another without receiving adequate help (Shelter, 2000).

Whether homelessness exacerbates existing mental health problems or poor health status results in greater likelihood of homelessness is disputed (Pleace and Quilgars, 1997). 'Trying to unravel any possible aetiological links between homelessness and mental ill-health is extremely difficult.' (Balazs, 1993). However, whichever direction is more powerful, there is widespread agreement that young homeless people are at the most risk (Masten et al., 1993).

Poverty

Compounding the range of problems affecting homeless young people is the incessant impact of poverty. Legal entitlements are low, yet it is likely that due to lack of knowledge and an absence of informed advice, take up of benefits, and access to work or training for work, are lower than in similar domiciled populations (Craig et al., 1996). This inevitably leads to the seeking of other sources of income, including begging and petty crime and involvement in the untaxed economy, with all the corresponding risks of poor health and safety precautions and lack of insurance cover.

Minority ethnic groups

While there is broad consensus that young people from minority ethnic groups are more likely to become homeless than their white peers (Craig and Hodson, 2000), they are 'less likely to sleep on the streets, as they tend to find accommodation with relatives and friends.' (Davis et al. (1996) cited in Shelter (2000)). Why people from minority ethnic groups are more prone to homelessness needs further investigation; it may be due to the fact that they are often already economically marginalised within society. It is important to acknowledge the special case of refugees and asylum seekers who are much more isolated and disadvantaged and consequently likely to have different referral pathways (Woodhead, 2000).

Accessing services

Services cannot be accessed easily by those without an address, or who change address frequently (Vostanis et al., 1998), though GP registration for homeless people remains relatively high (Victor, 1996). There is reduced access to immunisation and other preventive health procedures (Vostanis et al., 1998). There may also be a lack of knowledge about where to seek information and advice. As a result, the homeless population in general tends to rely on crisis-led rather than preventive services. Even seeing a mental health professional does not guarantee a continuing service, with single consultations being common (Craig et al., 1996). Half of one homeless study population was found to have a *treatable* psychiatric disorder, but only 20% had ever received psychiatric help (Craig et al., 1996). The Royal College of Physicians stated that efforts to improve homeless people's access to health and social care can only have limited impact if the root cause of illness – namely homelessness – is not addressed (Connelly and Crown, 1994).

It has been argued that the high use of secondary care among the homeless population 'may simply reflect difficulties in accessing primary care or a lower threshold for admission to such services (or some combination of the two)' (Victor, 1996). A pattern similar to that for physical health problems is present, where homeless people bypass primary care and make disproportionate use of emergency departments (Conway, 2000) when conditions become acute. However, unlike physical health problems, mental health issues may be less easily diagnosed by both clinician and patient, and treatment is likely to be perceived as more stigmatising by the

young person. Complex presentations exacerbate this, with mental health problems often being overlooked while physical symptoms are being addressed (Wrate and Blair, 1999). In addition, Accident and Emergency departments will not have immediate access to the young person's medical records. This lack of knowledge of the young person's medical history and housing situation may lead to an inadequate medical response (Boulton, 1993).

There are numerous barriers to young people receiving the support they need with regard to mental health problems. These include bureaucratic referral procedures, long waiting lists to attend statutory services and liaison between CAMHS and adult mental health services (Wilson, 2001). Pressures on time and resources mean that workers often have to deal with presenting problems rather than underlying causes (Grenier, 1996). Geographic boundaries and the ad hoc availability of services can present difficulties in the treatment of people living in temporary accommodation or on the streets. Services may also be provided some distance from place of residence, necessitating clear communication channels between authorities and recognition of respective responsibilities (Hargreaves, 1999). Floating support could play a part here, as it is able to meet changing needs by continual adaptation. By moving location when the young person moves, the abrupt withdrawal of services and all the problems that ensue can be avoided (Fitzpatrick, 2000).

Access to specialist child and adolescent mental health services may not be easy for homeless young people. Even when this does occur, a CAMHS response may vary according to perceived needs, referral routes, waiting times and 'opening times' (Audit Commission, 1999). As a result, young people may be prone to non-attendance. In the audit sample, only 20% of children presenting to specialist services had no complexity factors. However, it is important to note that this sample is only concerned with those who actually managed to access CAHMS help, in which the homeless population are probably under-represented. Primary care services, schools, social services and education authorities need to provide the first level of support to children and young people at risk of, or having mental health problems (Audit Commission, 1999). These services are rarely available to young people without stable accommodation, and if they are, they may often be mistrusted. It is also suggested that 'many front-line professionals have very limited understanding of children's mental health issues, mainly due to inadequate training on core professional courses' (Young Minds, 1998).

3 Current policy and practice

Key messages

- Both statutory and voluntary sector services have distinctive strengths, investment is needed in both as is closer working relationships.
- While specific clinical help is essential, many emotional problems may be alleviated by the simple and reliable provision of practical help.
- Ongoing social support from both lay and professional sources has proven benefits in terms of reduced psychiatric morbidity.
- More clinical treatment should be made available in settings that young people are to be found, including voluntary sector provision.
- A range of secure and flexible accommodation will have both preventive and healing effects on psychiatric morbidity, these include supported housing, safe houses and hostels.
- Crises tend to occur during un-social hours, provision needs to be flexible enough to respond to this.

Policy context

Robust evidence of the implications of structural changes is sparse, but it is likely that such changes are a contributory factor to homelessness and related issues. It has been suggested that the NHS and Community Care Act (England) (1990) failed to recognise the needs of homeless people (Connelly and Crown, 1994). The legislation was to have created a framework for a unified system of community care provision (Shelter, 2000), placing specific duty upon local authorities to assess individuals needs for accommodation and support services. The Mental Health Act (England and Wales) 1983 and its subsequent reforms should be complementary to this. The NHS Health Advisory Service's Report 'Together We Stand' concluded that CAMHS do not systematically consider and respond to local need (Williams and Richardson (2001) cited in Cumella et al. (1998)). The Government's Green Paper on reform of the Mental Health Act (England and Wales) implies that:

CAMHS will need to be able to provide a speedy, comprehensive and assertive assessment and treatment service in the community... It is no longer safe to assume that children who come into contact with specialist mental health services will generally be dealt with, or managed, outside a statutory regime, as they are at present. (Harbour and Bailey, 2001)

'Our Healthier Nation' (1999) acknowledges mental health by including suicide and undetermined injury as one of the Government's priorities (DoH, 1999). The Government's Drugs Strategy for England is concerned with improving access to drug treatment services (SEU, 1998).

The Homeless Mentally Ill Initiative (England) (HMII) funds mental health teams working directly with mentally ill homeless people. It was established by the Department of Health at the start of the 1990's to provide outreach workers as a complement to hostels and move-on accommodation (Conway, 2000). It is claimed that it has been limited in what it can achieve because of the fundamental failure to provide the 'promised accommodation' (Hirst, 2000). This initiative ran in parallel with the Department of the Environment's (England) Rough Sleepers Initiative (RSI). The Rough Sleepers Unit (RSU) was set up in 1999 to carry the work of the latter initiative forward (Shelter, 2000), expanding outside of London but still geographically limited. In London, one initiative the RSU developed was the 'Safe Stop' for young people. This provides accommodation linked to a family mediation scheme (RSU, 2000a).

The RSU has directed efforts at homeless people with mental health problems or who misuse drugs and alcohol (RSU (2000) cited in Shelter (2000)). They have created contact and assessment teams, acknowledging 'ongoing, targeted outreach work with individuals was the best way of improving outcomes for them' (Winchester, 2002). Tenancy support teams have also been founded to help former rough sleepers maintain their tenancies. The RSU claims to have reached their target of reducing street homelessness by two-thirds (from a 1999 baseline by 2002 (RSU, 2000b)) early. However count methodologies have been disputed (for further information on the debate refer to www.shelter.org.uk). The RSU's initial remit comes to an end in April 2002.

The new Homes Bill recognised that there are a disproportionate number of teenagers and people who have left some sort of institution without secure accommodation. Priorities need to be expanded to include others at increased risk, such as 16 and 17 year olds, care leavers, people leaving prison, the armed forces and those fleeing violence or harassment (Hunter, 2001). The Bill also reinstated the requirement for councils to find permanent housing for homeless people (Hunter, 2001) and removed some of the restrictions on local authorities regarding their use of housing stock for temporary accommodation (Hunter, 2001). The Homes Bill fell prey to the General Election and was reintroduced as the Homelessness Bill. The Homelessness Act (2002) was instated in February 2002 and promotes the use of social housing and places requirements on local authorities to adopt homelessness strategies. Likewise, the Homeless Persons (Priority Need Order 2001 Wales) has officially extended the remit for classifying people as in priority need, as above, while also including people at particular risk of sexual or financial exploitation aged between from 18 to 21 years olds (Hunter, 2001 and Local Government and Housing Committee, 2001).

The creation of a new Homelessness Directorate is in the pipeline and will hopefully look to address the wider problem of homelessness (which is increasing), not just rough sleeping (which is decreasing) (Winchester, 2002). For example, it will include the recently formulated Bed and Breakfast Unit. The National Homelessness Strategy is also under development by the Department of Local Government, Transport and the Regions to lay out the action to be taken by local and central government and other stakeholders to try and alleviate the problems associated with homelessness.

In Autumn 2001 a consultation document was released, responses to which supported the recognition of the need to tackle 'hidden homelessness', although concern was expressed that the strategy does not link with other social exclusion strategies nor with policies for health and housing benefit (www.housing.dtlr.gov.uk). It was also suggested that 'links be made between the NHS national service frameworks and health improvement plans' (Community Care, 2001b).

In November 2001 the Government set up an affordable housing unit which intends to have the means in place by the end of 2002 to increase affordable housing in certain regions in the short to medium term (Winchester, 2002). Currently, it is not clear how this work will relate to the work of the Homelessness Directorate.

The DETR has recently launched a Youth Homelessness Action Partnership to bring together the various departments of central government, local government and the voluntary sector. Together the aim is to agree on a definition of youth homelessness, estimate corresponding numbers, identify what works in preventing and tackling it, sharing good practice and to aid in the evaluation of related government policies (SEU, 1998). Tackling these issues will address the issue of social exclusion, and is thus part of a crucial governmental agenda.

Supporting People is a funding mechanism which will come into force in April 2003 tying together the existing funding streams which relate to supported housing (this includes the relevant part of Housing Benefit, the Supported Housing Management Grant, the Probation Accommodation Grant and Home Improvement Agency grants) (Connexions, 2001). This will allow for the more effective distribution of funds as local authorities will be enabled to administer them from a single pot. Connexions Partnerships are intended to work with Supporting People Partnerships to map the housing needs in their area. Support services can then be developed that reflect these needs and fill in existing gaps in provision (Connexions, 2001).

Social Services have a duty under Section 20(3) of the 1989 Children Act to provide accommodation to any 'child in need' who has reached 16 years (but is under 18) and whose welfare would likely be 'seriously prejudiced' without it (Connexions, 2001). The Housing Act 1996 requires local authorities to secure accommodation for someone who is homeless *and* in priority need (Shelter, 2000). However, this classification of 'priority need' or 'vulnerability' is rarely used due to a lack of proper assessments being carried out or proof of circumstances (Shelter, 2000). Assessing a person's mental health is known to be problematic for housing officers (Bines, 1997). Some rough sleepers are seriously ill and one might expect them to be classified as 'vulnerable' and therefore eligible for housing under present legislation, but this rarely happens (Grenier, 1996). Under the Act, housing authorities are required to have a homelessness advice service in their area, which may act in both a preventive or a remedial capacity (SEU, 1998).

The new Children (Leaving Care) Act (England and Wales) 2001 entitles looked after children to support from their Local Authority until they are 21 years old (Hunter, 2001). For young people aged 16-21 or beyond who qualify for these new arrangements a personal adviser must be provided and a pathway plan devised with the young person – a key element of which is accommodation (Connexions, 2001). The Department of Health Programme 'Quality Protects'

supports improvements to the care leaving packages which local authorities provide (RSU, 2000a). The Department of Health is to audit care leaving packages in London and disseminate good practice encountered (RSU, 2000b).

The National Service Framework for mental health (England) (NSF) aims 'to ensure that health and social services promote mental health and reduce the discrimination and social exclusion associated with mental health problems' (Mentality, 2001). It acknowledges people who sleep rough as a vulnerable group. The NSF is experienced by most as only focussing on adults, although aspects do refer to young people (Wilson, 2001). The Mental Health Foundation has called for a statutory duty to be placed upon Local Authorities and Health Authorities to establish a National Service Framework for children and young people's mental health (Mental Health Foundation, 1999).

The Government has expressed (February 2001) an intention to establish a National Service Framework for all aspects of children's services. Although it remains reluctant to establish a Children's Rights Commissioner for England (a model is operational in Wales). A Children's Rights Director has been created in the National Care Standards Commission to cover the rights of looked after children. Likewise, the Social Exclusion Unit (SEU) proposes the idea of a NSF for runaways which would ensure greater resource allocation and better joint working (SEU, 1998).

The 2001 SEU consultation on young runaways states (SEU, 1998):

There is no national policy on runaways so practice varies widely. Most runaways return home or are returned but receive little help in sorting out the problems that they ran from.

This is a major acknowledgement and one suggested preventive strategy takes the form of a "flexible refuge model" "where a few trained staff could check into temporary accommodation with a young runaway, or alternatively where specially trained foster carers could be used' (Rickford, 2001).

Structural change at governmental level is acknowledged as essential (Pleace and Quilgars, 1999):

The emphasis on the social exclusion of youth and developments like the Social Exclusion Unit and the New Deal, alongside the Foyer initiative introduced under the Conservatives, could create a situation in which more services and more options are available to marginalised or vulnerable young people, which in turn may prevent entry into homelessness.

Some anomalies are still apparent. For example, rough sleepers who are claiming the Job Seekers Allowance can join the New Deal for Under 25s before they have been claiming for 6 months, but only at the discretion of the their personal advisor (SEU, 1998 and RSU, 2000a). The fact that 'no department had overall responsibility for the total impact of government policies on rough sleepers' (SEU, 1998), nor homelessness in general, aggravates this predicament. 16 and 17 year olds 'may be entitled to a Young People's Bridging Allowance, Jobseeker's Allowance or Income Support' (Connexions, 2001). Also, if a young person can prove that they are estranged from their parents they are entitled to Severe Hardship Allowance (SHA), although this is only available for

eight weeks before the claim has to be renewed. Similarly, 18 – 25 year-olds receive only 75% of the full income support rate.

I tried to get on the New Deal course at college. I went to sign on properly, and thought I'd wait 6 month. Six month gone, and oh you got to wait for 18 month now. So I've got to stay on the dole another so many months till I can go to college, you know what I mean? She didn't know what to say to me, you know what I mean... I mean she could've told me if I was a heroin addict, drug user, or I'd just come out of prison I'd go on New Deal straight away in college. They'd put me through straight away. So I've got to go out and cause crime just to get on a course I want to do to better myself. It's stupid. It don't make sense to me. It makes me dead angry, that does. [Barnardo's service user]

The new Department for Work and Pensions (DWP) has initiated the National Action Plan on Social Inclusion, which is of relevance because it aims to achieve positive outcomes for vulnerable children through action across Government and through existing programmes such as the Children's Fund and Connexions.

Connexions is an initiative to work with young people aged 13 – 19 years. It will offer all young people access to information, advice and guidance. For young people (potentially) disengaged from school more intensive one-to-one support will be offered based on a needs-assessment. A personal adviser will also be available to young people to broker specialist support (for example, drug, mental health or housing services) and ensure co-ordination of the services they receive (Connexions, 2001).

The local Connexions services will enable young people who run away to access support (including Social Services), helping them to deal with the situation from which they have run. Young people who are considering a transition to independent living will be informed of their choices and the implications of leaving home and support provided to either access or maintain independence. Existing homeless young people will be supported in finding and settling into suitable accommodation. How Connexions Personal Advisors will fit into existing homeless agencies work with young people will depend on local circumstances (Connexions, 2001).

Presently local authorities are responsible for approximately 6,000 unaccompanied children and young asylum seekers and refugees (Klaushofer, 2002). In certain areas, primarily ports of entry, the authorities are under pressure by the increasing numbers. For example, Hillingdon (where Heathrow is situated) is responsible for 560 unaccompanied children, whereas last year the number stood at 380. Similarly in Kent (where Dover port is situated), the number of child asylum seekers exceeds the number of local children in its care (1,420 to 1,400) (Klaushofer, 2002). Kent has had to place some of the young people aged over 16 in other areas, retaining the duty of care but privately contracting out accommodation with support to access education and health services. These out-of-county placements have raised a number of concerns to do with the standard of accommodation and level of support. Some initiatives to overcome the burden of care are being developed. For example (Klaushofer, 2002):

The Association of London Government, which leads the work of the London Asylum Seekers Consortium, is soon to pilot a scheme bringing together children with similar needs in hostels with support services, care would be improved while addressing the unequal distribution among authorities.

There are fears that increasing numbers may tempt authorities 'to place unaccompanied children with relatives about whom little is known', which would carry associated risks (Klaushofer, 2002). With regards to this population the transition to 18 years can also be problematic as a young person may then be defined as an adult and become subject to the national dispersal system that is in operation. A study published by Shelter in January 2001 found that one in six of dwellings provided by local authorities for refugees were unfit for human habitation (Batty, 2001). Entitlements compound this situation, standing at around 70% of Income Support levels (BRAP, 2001). As Means and Sangster (1998) state: 'Local authorities need to implement the existing law in a way which is respectful of refugees and asylum seekers and which minimises bureaucratic delays and 'people shunting.'

The February 2002 Government White Paper on the asylum system is entitled 'Secure Borders, Safe haven on asylum, migration and citizenship'. In terms of transition through the housing system: induction centres, located near points of entry, will provide accommodation for 2 – 10 days while claims are made and screening and health checks are carried out. Presently, due to the rate of applicants, waiting time in emergency accommodation can drastically exceed the cited 5 to 7 days. For example (BRAP, 2001), in Birmingham in 2001 it was found that the 'normal waiting time' was 10 weeks.

The system of dispersal throughout the country to suitable areas will continue, with accommodation centres containing 750 beds each on trial in four areas. Allocation to the centres will depend on various criteria such as suitability, language, family circumstances and point of entry to the UK. Accommodation centres will offer food, health care, advice and education. They will allow residents to come and go freely; however they are required to sleep there. The Refugee Council is concerned that this will increase institutionalisation and believe that more freedom should be allowed, especially for children to attend local schools.

However, the Refugee Council (2002) broadly supports the announcement of a resettlement programme but is concerned by the 'plans to widen measures around interviewing unaccompanied asylum seeking children about their asylum claims' meaning that they may be interviewed more frequently than is currently the case. The Nationality, Immigration and Asylum Bill was published in April 2002, following on from the aforementioned White Paper.

The Refugee Council runs a supported housing project in West London for 16 – 18 year old unaccompanied refugees and asylum seekers. It is a joint venture with Hillingdon Social Services. Their aim is:

To equip residents with the skills and self confidence they will need to live independent lives in the UK. Each resident has a keyworker who assists in areas such as budgeting, cooking, shopping, and dealing with outside agencies, gaining access to education, health care and welfare benefits (www.refugeecouncil.org.uk).

Interventions

Prevention/ Early intervention

As a preventive measure there should be more support available for troubled families during periods of crisis, to prevent the young person embarking on a route that may end in homelessness (Barter et al., 1996).

Services and Support

A holistic approach is essential that encompasses health, housing and community care needs, as appropriate (Bines, 1997). There have been calls for improved services in two broad domains; more complementary health and social care (Vostanis et al., 1998) and more specialist services (Cumella et al., 1998). At present, provision is often limited to the voluntary sector (Winchester, 2000). Both providing and accessing services can be problematic because of the characteristic mobile and chaotic lifestyle many young homeless people have (Hirst, 2000). These young people, in common with their peers, may not have the experience to recognise and articulate their needs, unlike most young people however, they may have few, or no, responsible adults to advocate on their behalf.

There are certainly difficulties in providing an acceptable service to the homeless through existing generic services, but this argues as much for modifying existing practices as it does for establishing entirely new services. (Timms, 1993)

An understanding of gender and age-based differences is important in developing intervention programmes. For example, when considering what works with the different genders; a person-centred approach for females who have been sexually victimised and depressed may be more appropriate, whereas for males with conduct-related problems interventions may examine 'impulse control' (Cauce et al., 2000). Research in the late nineties also suggested that 'about a quarter of newly homeless young people arriving in London are women and there has also been an increase in the numbers of young women using winter night shelters who have slept rough' (Jones, 1999).

The setting and style of service delivery is important as it needs to be sensitive to the very specific needs of a young homeless population (Craig et al., 1996). This is where specialist services are important.

They should be:

- 'out there'
- informal
- flexible
- able to deal with social needs as well as health ones
- multidisciplinary
- collaborative
- responsive to changing circumstances. (Timms, 1993)

Proponents of the generic model suggest that where health and social care services are sufficient, improved co-operation and flexibility can greatly improve the service to the homeless population (Victor, 1996). Mental health problems can also be seen as so pervasive that generic services are needed to recognise those in need of further support (Coles, 2000). The key benefit of specialist services is that they can meet the needs of homeless people more efficiently and effectively by targeting those at risk. Conversely, this may contribute to the marginalisation and further stigmatisation of the population (Victor, 1996). This suggests that the two sources of help can, and should be complementary.

There are additional and compounding challenges associated with being homeless, such as finding warmth, food and money (Lilley, 2000). These in turn raise issues of malnutrition, interrupted sleep cycles, inadequate clothing and threats to personal safety (Hirst, 2000). Addressing mental health problems in isolation is unlikely to impact on the young person to a significant degree without an overall attempt to resolve these practical issues also.

While unstable peer relationships can play a role in the breakdown of shared accommodation (Wrate and Blair, 1999), supported accommodation and half-way houses can be crucial resources for young people, especially where there is continuity of staff and informal sources of support. They afford young people the independence they crave and wish to experiment with, while providing support when things do not go as anticipated.

Well, I'm living with xxx housing for homeless people. I'm on the XXX board, that's a flat but the staff, like you can ring up if you're unsure about certain things. I've got lots of support from them, but I'm still living there.
[Barnardo's service user]

Positive outcomes are associated with maintaining contact with trusted staff at a secure base (Craig et al, 1996), and allowing a development of greater independence while providing support when necessary (Pleace and Quilgars, 1999).

Good quality advice on available services is essential (Shelter, 2000). Many professionals currently lack knowledge of the facilities available locally to the homeless (Timms, 1993). Children who call Childline show they do need and can benefit from private and confidential counselling help, advice, information and mediation – such help needs to be more available, at the time when young people need it (Barter et al., 1996).

I'm more likely to have a crisis at 10 o'clock at night till two in the morning rather than it going to be 9 in the morning. [Barnardo's service user]

Safe houses and street projects can reach and help young runaways but these are limited and there is a need for a network of provision across the UK (Barter et al., 1996). For example, three of England's four voluntary sector refuges for runaway children that accept under 16s, have recently closed due to lack of funds (Rickford, 2001).

Statutory agencies and police should prioritise their obligations under the Children Act, rather than duties under the Street Offences Act (Barter et al., 1996) to avoid criminalising those involved in sexual exploitation, an example of a tension that illustrates 'the complexity of the relationship between the various legal regimes that apply to children' (Harbour and Bailey, 2001).

The role of social support in moderating the impact of homelessness has been highlighted (Buckner et al., 1999). Social exclusion, superficial contacts, shallow attachments and lack of confidants are often features of homelessness (Craig et al., 1996). Close and reliable social contacts, both lay and professional, can alleviate the antecedents of mental health problems.

Someone to moan at, and say what you like and...even if they can't give you advice, they listen to you. Someone who listens to you and they're not thinking 'listen to her..' [Barnardo's service user]

However, 'social adversity may be so great and social support so poor within the homeless that additive effects for mental illness may be minimal.' (Wrate and Blair, 1999)

Hostels are predominantly seen as a short-term solution, though may also be a source of support, social contact and security (McCabe et al., 1998).

Oh yeah, all the girls in there are brilliant, they're all really chatty to one another, they're younger girls, they're much younger than me...and there's a couple of women who've been there for quite a few years. [Barnardo's service user lives in a hostel]

Higher levels of depression are associated with the winter months. A combination of the weather being miserable, life being harder because of harsher physical conditions, and greater isolation due to passers-by stopping less are contributory factors (Grenier, 1996), increasing the need for emergency winter shelters. The DETR runs a programme of these in London, which are very popular because they have fewer restrictions than permanent hostels (SEU, 1998).

'Without improved housing stability, no accommodation can feel like 'home'' (Wrate and Blair, 1999). There is enough evidence from successful projects in the voluntary sector to demonstrate that young people can be brought out of homelessness, and more importantly, be kept out of it by providing the right housing, social and practical support alongside education, training or employment (Pleace and Quilgars, 1999). For example, the Social Exclusion Report entitled 'Bridging the Gap' recommended the introduction of an experimental Education Maintenance Allowance (EMA) for some 16 – 19 year olds to aid participation in post-16 education (RSU, 2000a).

I think what you [Barnardo's] help with is like the more practical things. Things like filling out forms, benefits, and things like that. Practical things, not so much the emotional side of things... [Barnardo's service user]

She's trying to look for a job, but she can't really have a job without a stable address. So, its just...[...]...she just wants a job, that's all she wants, just to see her through. [Barnardo's service user talking about a friend she is currently putting up, who would be homeless otherwise]

There is a corresponding need for follow-up, rather than just detached services, to enable recognition of regression to behaviour associated with former homelessness (Wrate and Blair, 1999).

When a young person achieves the home they have been planning and struggling for in the months gone by, it is often the most difficult time of all. It is then that they let down their defences, so crucial to survival on the streets and now no longer needed. Most are overcome with intense and conflicting feelings of elation, fear of failure, feelings of isolation, loneliness and guilt. We feel that continued support and home visits at this point are absolutely vital and may be needed for a year to alleviate these teething problems, to protect young people against failure and a return to the streets. (London Connection cited in SEU (1998))

Medical facilities provided in the environment of single homeless people are made greater use of than mainstream services (Anderson et al. (1993) cited in Bines (1997)). Currently a NFA (No Fixed Abode) rota allocates consultants to people who do not seem to belong to anybody's catchment area, but this means that there may be no continuing responsibility, and care can often get fragmented (Timms, 1993). By adopting the key worker model, treatment plans are more likely to be held together across agencies and through time with the young person (Timms, 1993). Young people experiencing mental health crises need access to short-stay crisis intervention facilities, similar to those that exist for people who (ab)use drugs (Boulton, 1993), similarly, community based problem solving over 'psycho-pharmacological treatment' has been recommended (Wrate and Blair, 1999).

Joint working

The majority of studies agree on the need for effective multi-agency working when dealing with a population characterised by multiple needs. Professionals from various disciplines increasingly work together to deliver the best possible response to young people's needs. This should be actively promoted as it will ensure continuity of service and meet needs in a holistic way. At present, there is often inadequate collection and sharing of information between relevant agencies (SEU, 1998), though whether this is caused by differing definitions, objectives, processes of data collection or inherited professional divides is disputed. For example, current medical interventions may assume that the social factors needed to make health possible are already in place (Timms, 1993), which limits how successful an intervention will be.

A review of the foyer pilot demonstrated generally positive outcomes, however it did highlight the problem of tying service use to accommodation – with some young people leaving the service due to rent arrears or another breach in their tenancy agreement (Quilgars and Anderson, 1992). The Foyer Foundation have stated that 'a fifth of foyer residents have some form of mental health problem, nearly 40 per cent drink excessively and 70 per cent are smokers' (www.foyer.net). This emphasises the need for multi-skilled health professionals at the frontline and improved multi-agency working (Community Care, 2001a).

A wide variety of organisations serve the homeless population and those with mental health problems. 'But the sheer variety can mean that services are fragmented' – resulting in inconsistent provision and at worse, no provision (RSU, 2000b). Improved services for homeless young people requires joint commissioning between health, social services, housing and voluntary agencies (Wrate and Blair, 1999). It is also important to remember the role of the police, who have more contact with rough sleepers than any other agency (NCH, 2001). Multi-agency work is not just about meeting multiple needs, but also ensuring that boundaries, whether they be age or area related, are overcome and a seamless service is provided to the young person. Allied to multi-agency collaboration, is the need for work at different levels to be consistent and compatible, that is, consistency of policy and planning, and that of delivery (SEU, 1998).

Involving young people

It is critical that young people's voices are heard, not just to map their routes into homelessness and its impact on their mental health, but to help workers assess the availability and appropriateness of supportive provision (McCabe et al., 1998). Furthermore, to sensitise adults to the impacts on young people of not just homelessness, but the circumstances that project a young person into homelessness. Children who have fled from the care system should not be returned to their placements without examining their reasons for running away (Barter et al., 1996); the same commitment to listening should hold for all young people.

4 Key challenges and concerns: barriers

Key messages

- Young people with low confidence and self-esteem are reluctant to make full use of public services.
- Homeless young people on the one hand, and professionals and lay people on the other, may harbour misconceptions about the other party.
- Housing options remain narrow for young people; for young people affected by mental health problems they are even narrower and when accommodation is made available, it may be at the bottom end of the housing market.
- Services must develop the ability to serve young people with multiple needs; co-morbidity is a strong feature of homeless young people with mental health difficulties.
- Services still fail to reach young people with the most pressing problems; more assertive outreach work is needed.

Attitudes

Young homeless people may often distrust statutory and regulatory services (Rickford (2001) and Timms (1993)). Contact may be irregular, placing additional demands on the informal (Craig et al. (1996)) and voluntary sectors (Boulton, 1993). The distrust of young people may be expressed as cynicism towards some services, such as telephone help lines. Several informants in our focus groups told us:

...they're strangers aren't they?

... it wouldn't be so bad if they'd actually done it themselves...put experienced people behind the phones...

They don't do nothing...When I was homeless they just said can you go and stay with one of your friends but you don't want to put that on your friends, do you?...EDT [emergency duty team] do nothing for you they just say, 'ah go to stay with one of your friends' and then they ring your family up, try to stir it even more. [Barnardo's services users]

Common misconceptions about homelessness (Davies, 2000) can affect the way a service is delivered, and whether it is taken up and followed through. Stereotyping may generate low expectations of people with mental health problems (Timms, 1993). Myths may be harboured by both parties. These often stem from genuine concerns and may sometimes be legitimate, but these need to be carefully unpacked if services are to respond effectively. For some young people there may be cultural differences in the way ill health is described and accounted for (Hylton, 1998). This can be further compounded by language difficulties (Woodhead, 2000).

Access to housing and support services

The major barrier for young people is that mental health problems are low on their list of priorities (Timms, 1993) and they tend to lack the knowledge of what to do if it does become a priority.

Health, loads of health. Being on your own, you know what I mean, you need to be learnt and stuff, don't you? [Barnardo's service user]

Even if this is overcome, then access to services has to be negotiated, paying attention to such factors as physical proximity and timing to ensure continued access to benefits, day centres and other essential services. Young people are often anxious about accessing mental health services for fear of not being understood or listened to properly (Irvine and Morley, 2001). They may also lack confidence to attend public clinics because of low self-esteem associated with past experiences and present homeless status, combined with not knowing what to expect.

Inadequate preparation for independent living and a care system that fosters over-reliance on others (Boulton, 1993) needs urgent attention. Survival skills are acquired for group rather than independent living (Wrate and Blair, 1999).

'Many young people who do get accommodation feel that they are being 'set up to fail' as they need more help with budgeting and basic life skills.' (Nassor and Brugger, 2000)

A disinclination amongst agencies to define young people as having mental health problems (Safe on the Streets, 1999) is compounded by fewer choices.

There are far fewer housing options for people with mental health rather than physical health difficulties and it is far harder both for the individual and for agencies to identify and prove that they are in need of assistance. (Murdoch (1994), Boulton (1993))

If a diagnosis is accepted, then discrimination against people with mental health problems may result in being housed in the poorest accommodation (Connelly and Crown, 1994).

There is a lack of appropriate, accessible and affordable accommodation for young people as a whole (Lemos, 1999); for vulnerable young people the choices are far narrower. People with mental health problems may have greater difficulties in understanding how the housing system works and gaining access to services and support as needed (Bines, 1997). This is exacerbated by the limited entitlements available to young people aged 16 and 17 (Nassor and Brugger, 2000) and the single room rent restriction on under 25s which will only meet the cost of shared rented accommodation (Hirst, 2000). For young people with chronic mental health problems achieving housing stability in the long term is less likely than for those who have never experienced or have recovered from such problems (Craig et. al, 1996). These issues indicate that fundamental structural reforms may be needed.

Accessing mainstream NHS services can be difficult for homeless people, some of the barriers may be related to: the criteria for accessing a service (for example being drug/alcohol free); the content of a service (like having the resources to identify and deal with diagnosable mental illness, but not general mental health problems); or the way in which the service is delivered (such as limited GP consultation times, or some A&E staff's poor knowledge of homelessness issues despite their often being the first point of contact) (Scottish Executive, 2001).

People with co-morbidity can have problems accessing homelessness services, notably drug users or people with histories of violence who may not be accepted by hostels, and gaining access and consistent support from the appropriate dimension of the health services may be difficult. Services are needed that are able to manage substance abuse and mental health problems together. Treatment needs to be multi-focused (Vostanis, 1999) with teams that are skilled to deal with multiple needs as and when they are presented (Timms, 1993). Some needs may be obvious and others less-well defined but no less acute (RSU, 2000b).

Rejecting, say, people with...drug dependency, as 'too problematic' may merely mean that beds fill with people whose problems have not been identified. At worst, this prevents adequate planning for problem management and problems only manifest in the form of an extreme crisis which results in the resident's discharge. Projects need to be designed to accommodate residents' problems. (Hammersley and Pearl, 1996)

This however, introduces an added dimension of agencies rendering themselves vulnerable to prosecution if they house people who use drugs, 'if they are seen to collude with the illegal actions of those they are housing' (NCH, 2001).

Successful resettlement may depend upon integrated services that address and treat persisting substance abuse and mental health problems *as well as* the immediate housing need (Craig and Hodson, 2000).

The need for medical and surgical care in this population is so staggering that it falls well outside the bounds of what a traditional mental health service might offer. (Bachrach (1992) cited in Wrate and Blair (1999))

Service design and culture

Other problems may manifest themselves within organisations. Tensions may occur when the age range served is too broad, especially as adolescents just a few years apart may have had very different experiences and have very different needs (Davies, 2000). Estimating the right balance between user participation and organisational efficiency can be hard to gauge (Davies, 2000). Compromises must be made at the service formulation stage between the issues of specialist v. generalist and open v. targeted (Davies, 2000). The internal culture and ethos of the organisation may then encounter barriers when interacting with the external environment with collaborators and funders, who may differ in their perception of problems, interventions and desired outcomes.

Additional institutional barriers identified are rigid working practices (Timms, 1993), and correspondingly poor follow-up arrangements. For example, if a young person fails to turn up for an appointment they risk being dropped by that service, which in turn may exacerbate their problems. Obviously this needs careful management, but ideas such as taking the service to their environment may go some way to overcoming such problems. Many resources reach less dependent and better functioning service users, but the question remains: 'what about those with more intractable and long term mental health problems?' (Timms, 1993).

5 Recommendations

- Practical help needs to be more widely available to young homeless people. It needs to be flexible enough to accommodate crises at anti-social hours, and structured to ensure a low-stigma community based approach.
- Young people must be consulted to help services develop the most supportive, accessible and acceptable provision possible.
- Services must be culturally sensitive in order to reach the most vulnerable of the homeless population. This is particularly the case for unaccompanied asylum seekers and refugees who may require more support, including leisure services.
- Early and proactive services are essential. The under-representation of young homeless people in CAMHS must be rectified by utilising more active, community based approaches to identifying young people who need help.
- Services needs to address accessibility factors such as physical proximity and timing, to ensure continued access to benefits, day centres and other essential services.
- Professional education across the core disciplines of health care, social care, education, crime and housing (both voluntary and statutory) needs improvement in quality and quantity.
- Housing quality for those at the lower end of the housing market needs improvement. A range of secure and flexible accommodation could have preventive effects on psychiatric morbidity. Supported accommodation and half-way houses can also be crucial resources for young people.
- A definition of homeless is required that is accepted by all statutory and voluntary agencies. This would make referrals easier as there would be fewer debates over whether a young person meets a service's entry requirements. It would also ensure consistency of service.
- There is a need for family mediation and respite services. These services could include befriending, mentoring and peer support.
- More education and active health promotion around mental health issues is required, in different settings and styles. Preventive and primary care services need to be more accessible to young homeless people and provide continuity.
- Further research is needed to:
 - identify the prevalence and needs of the hidden homeless
 - explore and understand strategies for coping, surviving and resilience factors in the 'at risk' population

- look at longer term issues. For example, longitudinal studies could help to establish how and why young people recover, or fail to recover, from the adversities they face
- gain knowledge of the mental health needs of young people from those minority ethnic groups which are more prone to homelessness
- develop a resource base of strategies, good practice examples and support networks which address homelessness and mental health.

Glossary

SEU	Social exclusion unit, based in the Cabinet Office, England.
HAS	Health Advisory Service.
CAMHS	Children and Adolescent Mental Health Services.
DSM-IV	Diagnostic Statistics Manual.
UASC	Unaccompanied asylum seeking children.
RSU	Rough Sleepers Unit.
YIACS	Young People's Information, Advice Counselling and Support Services.
NFA	No fixed abode.
NSF	National Services Framework.
HMII	Homeless Mentally Ill Initiative.

References

- Acheson, Sir D. (Chair) (1998) *Independent Inquiry into Inequalities in Health Report*. Department of Health. London: The Stationery Office.
- American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders (4th Ed.)*. Washington D.C.: American Psychiatric Association.
- Audit Commission (1999) *Children in Mind: Child and Adolescent Mental Health Services*. London: Audit Commission for Local Authorities and the National Health Service in England and Wales.
- Bachrach, L. (1992) 'What we know about homelessness among mentally ill persons: an analytical review and commentary.' *Hospital and Community Psychiatry* 43, 453 – 464.
- Balazs, J. (1993) 'Health care for single homeless people.' In: Fisher, K. and Collins, J. (eds), *Homelessness, health care and welfare provision*. London: Routledge.
- Barnardo, Dr. (1877) 'Preventative Homes: A paper read before the Social Science Congress at Liverpool, October, 1876.' *Night and Day*, pp. 2-5. London: Barnardo's.
- Barter, C., Keep, G., and MacLeod, M. (1996) *Children at Crisis Point: A study by ChildLine*. London: ChildLine.
- Barton, L. (2001) 'The story in statistics: depression.' *Guardian Education Supplement*. 04-03-01.
- Batty, D. (2001) 'Asylum Seekers: the issue explained.' *Society Guardian* March 12th 2001 (www.society.guardian.co.uk/asylumseekers)
- Biehal, N., Clayden, J., Stein, M. and Wade, J. (1995) *Moving On*. London: The Stationery Office.
- Bines, W. (1994) *The health of single homeless people*. York: Centre of Housing Policy, York University.
- Bines, W. (1997) 'The health of single homeless people.' In: Burrows, R., Pleace, N. and Quilgars, D. (eds), *Homelessness and Social Policy* pp. 133-144. London: Routledge.
- Birmingham Race Action Partnership (BRAP) (2001) *Shattered homelands, scattered dreams. A research report exploring the current debates around asylum seekers and refugees in Birmingham*. June 2001. (pdf at www.iarp.org.uk/shattered.htm)
- Boulton, I. (1993) 'Youth homelessness and health care.' In: Fisher, K. and Collins, J. (eds), *Homelessness, health care and welfare provision* pp. 136-148. London: Routledge.
- Buckner, J., Bassuk, E., Weinreb, L. and Brooks, M. (1999) 'Homelessness and its relation to the mental health and behavior of low-income school-age children.' *Developmental Psychology* 35 (1), 246-257.
- Cauce, A., Paradise, M., Ginzler, J., Embry, L., Morgan, J., Yvette, L. and Theofelis, J. (2000) 'The characteristics and mental health of homeless adolescents: age and gender differences.' *Journal of emotional and behavioural disorders* 8 (4), 230-239.
- Coles, B. (2000) *Joined-up youth research, policy and practice: a new agenda for change?* Leicester: Youth Work Press (National Youth Agency in partnership with Barnardo's).
- Community Care (2001a) 'Ill health of young homeless demands holistic approach' *Community Care*. 16 –22 August 2001, page 8 www.community-care.co.uk
- Community Care (2001b) 13 Dec. 2001 – 9 Jan 2002, page 9.

- Connelly, J. and Crown, J. (1994) *Homelessness and Ill Health*. London: Royal College of Physicians of London.
- Connexions (2001) with the RSU *Working together: Connexions and youth homelessness agencies* pdf file (www.connexions.gov.uk)
- Conway, J. (2000) *Housing Policy*. Eastbourne: Gildredge Press.
- Craig, T., Hodson, S., Woodward, S. and Richardson, S. (1996) *Off to a Bad Start: A longitudinal study of homeless young people in London*. London: The Mental Health Foundation.
- Craig, T. and Hodson, S. (2000) 'Homeless youth in London: II. Accommodation, employment and health outcomes at 1 year.' *Psychological Medicine* 30, 187-194.
- Cumella, S., Grattan, E. and Vostanis, P. (1998) 'The mental health of children in homeless families and their contact with health, education and social services.' *Health and Social Care in the Community* 6 (5), 331-342.
- Davies, B. (2000) *StreetCred? Values and Dilemmas in Mental Health Work with Young People*. Leicester: National Youth Agency in association with 42nd Street.
- Davis, J. et al. (1996) *Discounted voices, homelessness amongst young black people and minority ethnic people in England*. Leeds: University of Leeds.
- Department of Health. (1999) *Saving Lives: Our Healthier Nation*, Cm 4386. London: The Stationery Office.
- Fisher, K. and Collins, J. (1993) *Homelessness, health care and welfare provision*. London: Routledge.
- Fitzpatrick, S. (2000) *Young Homeless People*. Basingstoke: MacMillan Press.
- Fitzpatrick, S. and Clapham, D. (1999) 'Homelessness and young people.' In: *Homelessness: Public Policies and Private Troubles* pp. 173-190. London: Continuum.
- Gale, E. and Holling, A. (2001) 'Young people and stigma: responding effectively to young people's views on mental health.' *Young Minds Magazine* 49, 23-24.
- Garvie, D. (2001) *Far from home: The housing of asylum seekers in private rented accommodation*. January 2001. London: Shelter.
- Goldberg, D. (2001) 'Mental health.' In: Gordon, D., Shaw, M., Dorling, D. and Davey Smith, G. (eds), *Inequalities in Health: The evidence presented to the Independent Inquiry into Inequalities in Health, chaired by Sir Donald Acheson* pp. 207-212. Bristol: Policy Press.
- Grenier, P. (1996) *An update of Crisis' 1992 investigation into the links between homelessness, health and mortality*. London: Crisis.
- Hammersley, R. and Pearl, S. (1996) 'Drug use and other problems of residents in projects for the young, single homeless.' *Health and Social Care in the Community* 4 (4), 193-199.
- Harbour, A. and Bailey, S. (2001) 'Acting lawfully: children and reform of the Mental Health Act.' *Young Minds Magazine* 51, 14-17.
- Hargreaves, S., Bardsley, M., Barker, M., Kenny, D., Morgan, D., Roberts, I. and Streetly, A. (1999) *Child Health in London: The health and social characteristics of London's children*. London: The Health of Londoners Project.

Hirst, J. (2000) 'It's a street crime.' *Community Care*.

Housing Service Agency (HSA) (1999) *The Outreach Directory Annual Statistics 1998 - 1999*. London: HSA.

Hunter, M. (2001) 'Homes Bill gets thumbs-up from charities.' *Community Care*, 8-9.

Hylton, C. (1998) 'The mental health and well-being of African, African-Caribbean and South Asian communities in the UK.' *Healthy Minds*, 3, 32-34.

Irvine, B. and Morley, D. (2001) 'Children's mental health: creating comprehensive services in a climate of change.' *Young Minds Magazine* 51, 20-21.

Jones, A. (1999) *Out of Sight, Out of Mind: The Experiences of Homeless Women*. Executive Summary, Centre for Housing Policy, York University. www.york.ac.uk/inst/chp/women.htm

Keep, G. (2000) *No Home and Alone: Runaway and homeless young people calling ChildLine*. London: ChildLine.

Klaushofer, A. (2002) 'Nervous Hosts' *Society Guardian* January 9 2002 (www.society.guardian.co.uk/asylumseekers)

Lader, D., Singleton, N. and Meltzer, H. (2000) *Psychiatric Morbidity among Young Offenders in England and Wales: Further analysis of data from the ONS survey of psychiatric morbidity among prisons in England and Wales carried out on behalf of the Department of Health*. London: Office for National Statistics.

Leigh, C. (1993) 'Right to Care: Good practice in community care planning for single homeless people.' *Housing Campaign for Single People*. London: CHAR.

Lemos, G. (1999) 'A Future Foretold: New approaches to meeting the long-term needs of single homeless people [Executive Summary].' *New Solutions*. London: Crisis.

Lilley, D. (2000) 'Young people, mental health and homelessness.' In: Aggleton, A., Hurry, J. and Warwick, I. (eds), *Young People and Mental Health* pp. 183-195. Chichester: John Wiley & Sons Ltd.

Local Government and Housing Committee (2001) *Homelessness Commission – Progress Report*. (www.wales.gov.uk)

Mapp, S. (1996) 'Someone to rely on.' *Community Care*.

Masten, A., Miliotis, D., Graham-Bermann, S., Ramirez, M. and Neemann, J. (1993) 'Children in homeless families: risks to mental health and development.' *Journal of Consulting and Clinical Psychology* 61 (2), 335-343.

McCabe, A., Stanyer, A. and Commander, M. (1998) 'Youth homelessness and mental health in Birmingham.' *Social Services Research* (4), 1-19.

Means, R. and Sangster A. (1998) *In Search of a Home: An evaluation of refugee housing advice and development workers*. Bristol: Policy Press.

Mental Health Foundation (1999) *Bright Futures: promoting children and young people's mental health*. London: Mental Health Foundation.

Mentality. (2001) *National Service Framework: Standard One*. (www.mentality.org.uk)

Mind (2000) 'Response to Quality and Choice: A decent home for all.' Mind Policy Briefing, July 2000.

(www.mind.org.uk/take_action/Supported_Housing.asp)

Mind. (2001) *Statistics 6*. (www.mind.org.uk)

- Murdoch, A. (1994) *We are human too: a study of people who beg*. London: Crisis.
- NCH Action for Children. (2001) *Promoting the Health of Children and Young People*. (www.nchaqc.org.uk)
- Nassor, A. and Brugger, A. (2000) *Centrepoint Factsheet Series 1999/2000*. London: Centrepoint. (www.centrepoint.org.uk)
- Pleace, N. and Quilgars, D. (1999) 'Youth homelessness.' In: Rugg, J. (ed), *Young People, Housing and Social Policy*, pp. 93-108. London: Routledge.
- Pleace, N. and Quilgars, D. (1997) 'Health, homelessness and access to health care services in London.' In: Burrows, R., Pleace, N. and Quilgars, D. (eds), *Homelessness and Social Policy*. London: Routledge.
- Policy Action Team (2000) 'Report of Policy Action Team 12: Young People', *National Strategy for Neighbourhood Renewal*. March 2000. (www.neighbourhood.dtlr.gov.uk/management/pat/pdf/pat12.pdf)
- Quilgars, D. and Anderson, I. (1992) *Foyers for Young People*. York, Centre for Housing Policy. www.york.ac.uk/inst/chp/foyersum.htm
- Refugee Council (2002) *Refugee Council's response to Government White Paper*, February 2002. (www.refugeecouncil.org.uk/infocentre/asylumprops/wp_exec_summary.htm)
- Rohde, P., Noell, J., Ochs, L. and Seeley, J. (2001) 'Depression, suicidal ideation and STD-related risk in homeless older adolescents.' *Journal of Adolescence*, 24, pp. 447 – 460.
- Richardson, J. and Joughin, C. (2000) *The Mental Health Needs of Looked After Children*. London: The Royal College of Psychiatrists.
- Rickford, F. (2001) 'Somebody else's problem.' *Community Care*, 20-21.
- Rough Sleepers Unit (2000a) *Coming in from the Cold: Progress Report on the Government's Strategy on Rough Sleeping*. July 2000. London: Department for the Environment, Transport and the Regions.
- Rough Sleepers Unit. (2000b) *Coming in from the Cold: Delivering the strategy*. London: Department for the Environment, Transport and the Regions. (www.detr.gov.uk)
- Rugg, J. (ed.) (1999) *Young People, Housing and Social Policy*. London: Routledge.
- Rugg, J. and Burrows, R. (1999) 'Setting the context: young people, housing and social policy.' In: Rugg, J. (ed), *Young People, Housing and Social Policy* pp. 1. London: Routledge.
- Rutter, Sir. M. (1999) 'Services for children with mental health problems: how should they be developed?'. *Developing Effective Child & Adolescent Mental Health Services: current initiatives and innovations*. Conference notes from 02-02-1999.
- Rutter, M. and Smith, D. (1995) *Psychological Disorder in Young People*. Chichester: John Wiley and Sons.
- Ryan, P. (2001) 'Mental Health.' *Research Matters*. October 2000 - April 2001, pp. 22-24.
- Safe on the Streets Research Team (1999) *Still Running: Children on the Streets in the UK*. London: The Children's Society.
- Scottish Executive (2001) *Health and Homelessness Guidance* September 2001, Scottish Executive Health Department, pdf file. (www.scotland.gov.uk)

- Shelter. (2000) *Shelter launches 'Wise Up' initiative to reduce street homelessness*. (Press Release: www.shelter.org.uk)
- Shelter. (2000) *Mental Health and Homelessness*. (www.shelter.org.uk)
- Slegers, J., Spijker, J., van Limbeck, J. and van Engeland, H. (1998) 'Mental health problems among homeless adolescents.' *Acta Psychiatrica Scandinavica* 97 253-259.
- Smith, J. and Gilford, S. (1993) *Young and Homeless in Birmingham*. Barnardo's Midlands, Staffordshire University, and Birmingham Standing Conference for the Single Homeless. Birmingham: Barnardo's Midlands.
- Smith, K. and Leon, L. (2001) *Turned Upside Down: Developing community-based crisis services for 16-25 year olds experiencing a mental health crisis*. London: The Mental Health Foundation.
- Social Exclusion Unit. (1998) *Rough Sleeping – Report by the Social Exclusion Unit*. London: Social Exclusion Unit.
- Timms, P. (1993) 'Mental Health and Homelessness.' In: Fisher, K. and Collins, J. (eds), *Homelessness, health care and welfare provision* pp. 94-116. London: Routledge.
- Tischler, V., Cumella, S., Bellerby, T. and Vostanis, P. (2000) 'Service innovations: a mental health service for homeless children and families.' *Psychiatric Bulletin* 24 339-341.
- Tomas, A. and Dittmar, H. (1995) 'Housing histories and the meaning of home.' *Housing Studies* 10, 493-515.
- van der Ploeg, J. and Scholte, E. (1997) *Homeless Youth*. London: SAGE Publications.
- Victor, C. (1996) 'The health of the temporary homeless population.' *Journal of Interprofessional Care* 10 (3), 257-266.
- Vostanis, P. (1999) 'Child mental health problems.' In: Vostanis, P. and Cumella, S. (eds), *Homeless Children: Problems and Needs*. London: Jessica Kingsley.
- Vostanis, P., Cumella, S., Grattan, E. and Winchester, C. (1996) *The impact of homelessness on the mental health of children and families*. Birmingham: Birmingham City Council and the University of Birmingham.
- Vostanis, P., Grattan, E. and Cumella, S. (1998) 'Mental health problems of homeless children and families: longitudinal study.' *British Medical Journal* 316 899-902.
- Wallace, S., Crown, J., Cox, A. and Berger, M. (1998) *Epidemiologically based needs assessment: Child and adolescent mental health*. Winchester: Wessex Institute of Public Health.
- West, P. (1999) 'Youth.' In: Gordon, D., Shaw, M., Dorling, D. and Davey Smith, G. (eds), *Inequalities in Health: The evidence presented to the Independent Inquiry into Inequalities in Health, chaired by Sir Donald Acheson*, pp. 12-22. Bristol: The Policy Press.
- Wilkinson, G. (1994) *Unfair Shares: The effects of widening income differences on the welfare of the young*. London: Barnardo's.
- Williams, R. and Richardson, G. (2001) *Together We Stand: The Commissioning, Role and Management of Child and Adolescent Mental Health Services*. London: The Stationery Office.
- Wilson, C. (2001) *Breaking down the barriers: key evaluation findings on young people's mental health needs*. London: Youth Access.

- Winchester, R. (2000) 'Too much pressure.' *Community Care*, pp.18-19.
- Winchester, R. (2002) 'Rough Figures?' *Community Care*. 10 – 16 January 2002, pp. 28 – 30 (www.community-care.co.uk).
- Winnicott, D. (1990) *Deprivation and Delinquency*. London: Routledge.
- Wolff, C., Schroeder, D. and Young, M. (2001) 'Effect of improved housing on illness in children under 5 years old in northern Malawi: cross sectional study.' *British Medical Journal* 322, 1209-1212.
- Woodhead, D. (2000) *The Health and Well-Being of Asylum Seekers and Refugees*. London: King's Fund.
- World Health Organisation (1948) 'World Health Organisation Constitution.' *Basic Documents*. Geneva: World Health Organisation.
- Wrate, R. and Blair, C. (1999) 'Homeless Adolescents.' In: Vostanis, P. and Cumella, S. (eds), *Homeless Children: Problems and Needs* pp. 83-96. Jessica Kingsley, London.
- Wrate, R. and McLaughlin, P. (1997) *Feeling Bad: The troubled lives and health in young homeless people in Edinburgh*. Edinburgh: The Young People's Unit, Royal Edinburgh Hospital.
- Young Minds (1998) *Our Healthier Nation: A response by Young Minds*. (www.youngminds.org.uk)

Appendix 1: Summary of key case studies

This chart summarises the key case studies used in the literature review. For each study there is:

- a summary of the sample population and comparison population, if used
- the instruments used to measure and define mental health problems
- a key results section. This is the evidence that supports comments made in the review.

Authors	Sample population	Instruments	Comparison	Results
Cauce et al. (2000)	13 – 21 year olds n = 364 Homeless young people (no viable residence (e.g. streets/ emergency shelters), or unstable residence. Three sites: downtown Seattle, Bremerton, and Everett, Washington (USA)	<ul style="list-style-type: none"> • Diagnostic Interview Schedule for Children – Revised (DISC-R) • Youth Self-Report Form • Reynolds Adolescent Depression Scale (RADS) • Children's Manifest Anxiety Scale – Revised (RCMAS) • Rosenberg Self-Esteem Scale (RSES) 	None	<ul style="list-style-type: none"> • Two thirds had one or more psychiatric diagnoses based on the DSM-III-R. • Homeless youth came from generally troubled backgrounds and had elevated rates of psychiatric disorders. • For young men, their histories typically included physical abuse during childhood, physical assault on the street, and elevated rates of externalising disorders, e.g. a disruptive behaviour disorder was higher among boys ($\chi^2 = 9.25, p < .01$). • For young women, their histories were more often marked by sexual abuse during childhood, sexual victimisation on the streets, and elevated rates of internalising disorders. • Early adolescents (13 – 15 years old) appeared to display more externalising problems than middle (16 / 17 years old) or late (18 – 21 years old) adolescents.
Craig et al. (1996)	16 – 21 year olds n = 161 n = 107 at one year follow up Homeless young people utilising London Connection and Centrepoint (have in the last 24 hours been sleeping rough or using emergency accommodation)	<p>Interviews covering:</p> <ul style="list-style-type: none"> • Demographics • Homelessness history • Childhood experiences of care and abuse (CECA) • Physical health record (and agency record) • Psychiatric disorder – the Composite International Diagnostic Interview (CIDI, combines DSM-III-R and ICD10) • Childhood conduct disorders 	16 (bar one at 15) – 21 year olds n = 104 Domiciled population from inner London	<ul style="list-style-type: none"> • After excluding cases of minor conditions such as simple phobias, psychiatric disorder was far more common amongst the homeless (62% v/s 25%). This excess disorder seems to be mainly due to higher rates of mental illness. Similar proportions of homeless and domiciled young people report substance use disorders in the absence of mental illness. • 'Multiple' diagnoses (i.e. anxiety and bulimia) are far more common in the homeless group. • High rates of co-morbidity of substance dependency and mental illness are reported (45% of subjects with a mental illness were also dependent or regularly abusing one or more substances of addiction). • Summary statistics listed overleaf.

- **Minimal estimate of mental health problems as looks only at the diagnosis present in the month preceding the interview:**
- No symptoms 12% (60%)
- Mental illness only 22% (8%)
- Depression 18% (3%); Anxiety 3% (5%); Depression and anxiety 6%; Depression and obsessive compulsive disorder 2%; Bulimia and depression 5%; Schizophrenia 1%; Bipolar disorder 1%
- Mental illness and substance abuse 6% (0%)
- Mental illness and substance dependency 12% (2%)
- **Summary diagnoses: Lifetime before interview:**
- Mental illness only 22% (10%)
- Mental illness and substance abuse 17% (9%)
- Mental illness and substance dependency 23% (10%)
- Chronic disorders (>1 year) accounted for the majority of mental illness reported by homeless respondents (74% v's 36%).
- The majority (70%) of psychiatric disorders among the homeless population had begun before their first episode of homelessness.
- 33% had made at least one suicide attempt (v's 9% of domiciled population). There is a strong association between suicide attempts and psychiatric diagnosis.
- 55% (v's 14% of comparison population) were given retrospective diagnoses of childhood conduct disorder. Conduct disorder was also related to current psychiatric diagnosis.
- Substance use disorders are more common amongst males in both samples. In contrast mental illness (with and without co-morbid substance use disorders) are more common among women and markedly more so amongst homeless females.
- Respondents homeless for two years or longer were more likely to report psychiatric disorder, (difference largely accounted for by male respondents).
- Having run away from home under the age of 16 was associated with lifetime risk of mental illness or substance use disorders (85% v's 71%; $\chi^2 = 4.396$, $p < 0.05$).
- Respondents who reported at least one period of stable accommodation in the past year were just as likely to have a current psychiatric diagnosis 9 less surprising as includes a wide variety of sub-standard accommodation and living in punitive parental homes).
- Homeless young people with a psychiatric disorder were twice as likely to be frequent rough sleepers than those with none (40% v's 20%; $\chi^2 = 4.983$, $p < 0.05$). Observation held for both sexes and maybe explained by an excess of substance use disorders amongst those who reported frequent rough sleeping.
- Childhood adversity is strongly associated with current mental illness. Reported by 81% of those who reported suicide attempts compared with 19% of remaining subjects ($\chi^2 = 25.275$, $p < 0.0001$).
- Eight young people reported exchanging sex for money, shelter or drugs.
- Although the proportion of cases having some contact with psychiatric services (inpatient / outpatient / CPN / Homeless team) was similar (22% of homeless population with a psychiatric diagnosis (66%) v's 26% of domiciled), those amongst the homeless were more often one-off assessments.
- At the 12-month follow-up interview 55% of subjects were diagnosed as having psychiatric disorders.
- Two-thirds of young people with a psychiatric diagnosis at first interview were still symptomatic at 12-month follow up. (Masks changes within different diagnostic groups).
- Of the nine young people who developed new onsets in the course of the follow-up, all were episodes of depression.
- Chronicity of mental illness was associated with being female and with childhood adversity.
- Those with long histories of homelessness at first interview were more likely to continue to suffer from their mental illness throughout the follow-up.
- Trend for chronic cases to have less positive housing outcomes largely due to substance use disorders.
- Of 40 women who were re-interviewed 40% reported one or more medically confirmed pregnancies, all of which were unplanned. (Issues around physical and sexual health).

Authors	Sample population	Instruments	Comparison	Results
Craig and Hodson (2000)	16 – 21 year olds n = 161 n = 107 at 1 year follow up Random sample of consecutive attendees at two large London facilities for young homeless people	Baseline measures <ul style="list-style-type: none"> Demographic characteristics Childhood experience of care and abuse (CECA) Childhood conduct disorder Composite International Diagnostic Interview (CIDI) Follow-up measures <ul style="list-style-type: none"> Psychiatric disorder Social outcomes Accommodation 	None	<ul style="list-style-type: none"> Psychiatric disorder was identified in 55% at follow up. 66% of those with a psychiatric disorder at index interview remained symptomatic at follow-up. Persistence was associated with adverse childhood experiences and rough sleeping. Satisfactory accommodation outcomes were achieved by 42%. Better accommodation outcomes were associated with: minority ethnic status; educational achievement; presence of accommodation plans. Psychiatric disorder at index interview was not associated with not associated with accommodation outcome; persistence substance use in the follow-up year was negatively associated. Offending and antisocial behaviour in the follow-up year were related to a history of conduct disorder, persistent substance abuse and poor accommodation outcomes.
Fitzpatrick and Clapham (1999)	16 – 19 year olds n = 53 Follow up of 25 young people a year later Drumchapel in Glasgow	<ul style="list-style-type: none"> Eight group interviews 25 biographical interviews n.b. opportunistic sample selection 	None	<p>Identified six pathways:</p> <ul style="list-style-type: none"> unofficial homelessness in the local area: in and out of the family home, often hide homelessness from family / friends and appropriate agencies; process of leaving home tends to start at age 14 / 15. unofficial / official homelessness in the local area: access the official network of young person's accommodation in local area; mixed with periods at home / staying with friends/ sleeping rough. stable in local official network: tend to be older and more mature, favourable experience partly reflects the selection process in local area where most vulnerable young people are not accepted. alternating between unofficial homelessness in the local area and the official city network official city network: staying in official network on a relatively long term basis, social networks tend to be limited to other homeless people, evidence of severe personal problems resulting from difficult childhoods. Different residential projects; those that are small and designed to prepare young people for independent living with support, v.s adult hostels – large scale institutional hostels where young people are dumped on a more or less permanent basis. city centre homeless: most visible group of the public, very unstable situation with periods of homelessness interspersed with stays in hostels, drug rehabilitation units or prison. For these young people homelessness simply a continuation of a long history of disruption, insecurity and trauma. At follow up little had improved with continued chaotic lives, or set to become long-term hostel dwellers (bar one).

Authors	Sample population	Instruments	Comparison	Results
Hammersley and Pearl (1996)	16 – 30 year olds n = 100 Young single homeless who make use of housing organisations in Glasgow	Semi-structured Interviews including items from: <ul style="list-style-type: none"> Standard psychological test General Health Questionnaire (GHQ) Severity of Dependence Scales (SDS) Scottish Crime Survey 	None	<ul style="list-style-type: none"> Most young single homeless people who seek help have problems beyond a lack of permanent shelter. 59% of the sample reported mental health problems as measured by >4 on the GHQ. 39% had received medical treatment for mental health problems.
McCabe et al. (1998)	16 – 25 year olds n = 70 8 direct access hostels / women's refuges in Birmingham	<ul style="list-style-type: none"> Semi-structured interview Mental health (MHI-5) and energy sub-scales of the SF-36 Additional in-depth / semi-structured interviews and focus groups with service providers and young people 	None	<ul style="list-style-type: none"> 17% of men and 33% of women were identified as high risk in relation to their mental health status. An area identified as being of greater concern was the perceived number of young people within hostels with learning disabilities. 30% of men and 48% of women had taken an overdose or self-mutilated at some point, 5% and 22% doing so within the last 6 months. Gender difference in pattern of harm: men most frequently citing 'accidental overdose' / illicit drugs, and women 'attempted suicide' or 'cutting'. 16% of young men (and no women) had been a patient in a psychiatric hospital at some point in their life – predominantly with a diagnosis of depression.
Safe on the Streets Research Team (1999)	Young people who ran away at 16 or 17 years old n = 17 (from a purposive sample of 69 young people)	<ul style="list-style-type: none"> Views of professionals Views and experiences of young people 	Rest of sample (n = 52), who ran away before they turned 16.	<ul style="list-style-type: none"> Legal situation very distinct from under-16s. In contrast to the under-16s who had run away, for this older age group the incidence of overt abuse was relatively rare. Relatively few had been in substitute care, unsurprising given the high rate of running away amongst under 16s. 3 out of the 4 that had run away at 16 + did so after being returned to their family from care, suggesting that the transition can be problematic. Influence of peer relationships on running away was less. Amongst workers mental health problems were mentioned more in connection with homeless 16 and 17 year olds. (n.b. 'there is a disinclination amongst agencies to define young people as having mental health problems'). The young people's interviews suggest that, where mental health was an issue, many young people had started running away before 16. One third reported mental health issues, predominantly depression.

Authors	Sample population	Instruments	Comparison	Results
Safe on the Streets Research Team (1999)	16 and 17 year olds n = 48 (11 first run away before 11 yrs; 20 between 11 and 15yrs; 17 at 16 to 17yrs) No stable place to live	<ul style="list-style-type: none"> Views of professionals Views and experiences of young people 	Under 16 age-group	<ul style="list-style-type: none"> Alcohol and drugs were as prevalent, offending perhaps less of an issue for this group. Economic factors were more important to this group. Substantial evidence that these young people had access to a much wider range of services than under 16s. Includes possibility of independent supported accommodation in hostels and housing projects. Over a third slept rough at some point whilst away. In general, young people were more geographically mobile in this group. Limited extent more able to access legitimate financial support through work / benefits, but still evidence of a heavy reliance on other survival strategy (e.g. dependent on friends, illegal activities). Findings suggest that young people with extensive experience of running away at a young age are likely to remain a marginalised group as they move into adulthood.
Sleepers et al. (1998)	16 – 23 year olds n = 50 4 service sites for homeless adolescents in Amsterdam (homeless = no permanent place to stay during last 3 months)	<ul style="list-style-type: none"> Diagnostic Interview Schedule (DIS) Diagnostic and Statistical Manual of Mental Disorders, Revised 3rd ed. Selected 16 adverse life events (yes / no answers) 	Results of pilot study are consistent with 18 surveys reviewed.	<ul style="list-style-type: none"> 78% at least one lifetime DIS / DSM-III-R diagnosis. 64% at least one one month diagnosis. Prevalences of all specific DSM-III-R diagnoses were higher for female than for male adolescents. <p>Rest of data based on male sub-sample population only (88%) for statistical significance:</p> <ul style="list-style-type: none"> Those of Dutch origin were more likely than those of other ethnic backgrounds to have experienced more than four adverse life events (69% v's 32%; X2 = 5.50, p = 0.019). Anxiety disorders, mood disorders and schizophrenia and other psychotic disorders (AMSD) most prevalent among homeless male adolescents who had experienced more than 4 adverse life events (53% v's 21%; X2 = 4.07, p = 0.044). Most likely to have substance use disorders (85% v's 52%, X2 = 5.25, p = 0.022). Antisocial personality disorder (APD) related to duration and onset of homelessness: Increased likelihood if homeless for more than one year (69% v's 33%; X2 = 5.12, p = 0.024) Increased likelihood if first homeless period two years earlier (t = 3.48, df = 25.67, p=0.003).

Authors	Sample population	Instruments	Comparison	Results
Vostanis et al. (1998) (Cumella et al., 1998)	58 rehoused families, with 103 children aged 2 – 16 years, in Birmingham 113 homeless families, 251 children aged 2 – 16 years, in Birmingham	<ul style="list-style-type: none"> • Semi-structured interview with mother • Child behaviour checklist (CBCL) • General health questionnaire (GHQ) • Interview schedule for social interaction (ISSI) • Communication domain of the Vineland adaptive behaviour scales (VABS) • All above, plus height and weight percentiles of children 	21 comparison families of low socioeconomic status in stable housing, with 54 children 29 comparison low income families who were not homeless, with 81 children	<ul style="list-style-type: none"> • Mental health problems remained significantly higher in rehoused mothers and their children than in the comparison group (mothers: 26% vs 5%, $p = 0.04$; children: 39% vs 11%, $p = 0.0003$) • Homeless mothers continued to have significantly less social support at follow up. • 49% of homeless mothers had current psychiatric morbidity • Children in homeless families had delayed communication and higher mean scores for mental health problems. • Homeless families had high rates of contact with primary healthcare and social services, but few had been in contact with specialist child and adolescent mental health services. • 85% of families became homeless because of domestic or neighbourhood violence, and in 54% of families homelessness coincided with the separation of partners.
Vostanis et al. (1996)	Children aged 2 – 16 years $n = 194$ From 89 families admitted to 7 centres for the homeless in Birmingham	<ul style="list-style-type: none"> • Semi-structured interview with parent • Child Behaviour Checklist (CBCL) • Youth Self-Report Form (YSR) – a version of CBCL for self completion by those aged 12 years and above • Teacher Report Form (TRF) • General Health Questionnaire (GHQ) • Interview Schedule for Social Interaction (ISSI) • Communication Subscale of the Vineland Adaptive Behaviour Scales • Measurement of height and weight • 20 of homeless children 	Children aged 2 – 16 years $n = 57$ From 19 deprived families in housing in Birmingham	<ul style="list-style-type: none"> • Homeless children had a level of communication significantly lower than that found among children in the comparison sample. • 30% of children in the sample of homeless families had total scores on the CBCL above the clinical threshold, indicating the presence of mental health problems of sufficient severity to require referral for treatment vs 9% of comparison sample. • Mental health problems among homeless children were frequently associated with other types of problems. • Those with mental health problems were more likely to have low height and weight centiles and have delayed communication skills. • A child's age, sex, ethnic group or type of hostel was not associated with the presence or absence of mental health problems.

Authors	Sample population	Instruments	Comparison	Results
Wilson (2001)	<p>The providers of YIACS (Young people's information, advice, counselling and support services) n = 109</p> <p>13 – 25 year olds The young people (7 of 9 regions represented) n = 62</p> <p>Reference Group, made up of external agencies in addition to urban and rural YIAC managers and service users England</p>	<p>under 11 years interviewed by child psychiatrist</p> <ul style="list-style-type: none"> Combination of qualitative and quantitative methods Two different questionnaires used to survey both the service providers and users Telephone interviews used with people who had difficulty in completing questionnaire In-depth interviews conducted with representatives of agencies (health and social services, mental health commissioners, the NHS Executive, education, child and adolescent psychologists and a psychiatrist) 	N/A	<p>Barriers to accessing YIACS services include:</p> <ul style="list-style-type: none"> Access to patchy YIACS characterised by a postcode lottery. Inadequate public transport. Incoherent funding strategies not concerned with sustainability and accessibility. Negative attitudes towards counselling. YIACS seen as providing mental health services at tier level one only. Age and geographical boundaries restricting access to CAMHS. A lack of appropriate referrals of young people to adult services. Bureaucratic referrals procedures and long waiting lists to and between (CAHMS) and adult mental health services. A lack of planning and joined up working. 75 YIACS identified homelessness for young people as a problem. Over 80% of YIACS work with young people with mental ill health. Of young people surveyed over half had a diagnosis or had experienced mental ill-health. Over one third of YIACS did not use a definition of mental health, some for fear that it would alienate young people from using the agency. A third used their own definition, or those following a non-medical model. Over a third of young people described mental ill health as being about the state of your mind, followed by mental illness, madness and emotional wellbeing. Just under half of all YIACS have made onward statutory referrals where a young person was experiencing severe mental ill-health and a quarter because of serious risk of harm to self or others. Under a quarter referred because of high / medium suicide risk, severe drug and alcohol problems, severe eating disorders, child protection issues and active aggression. Some requested a referral or a need for family therapy identified. Many YIACS and some CAMHS staff did not know if they were in a HAZ, an EAZ, if there was a local mental health plan, or the mental health leads in their area.
Wrate and Blair (1999)	<p>Reviews: 1. Craig et al (1996) study, as above</p>	<p>1. As above 2. Brief structured</p>	<p>1. As above 2. Some age cohort</p>	<ul style="list-style-type: none"> Young men were significantly over-represented, by a factor of at least two to one (all studies). Young men particularly over-represented among the long term homeless (study 3).

Authors	Sample population	Instruments	Comparison	Results
	<p>2. Subsample of OPCS prevalence study of psychiatric morbidity 16 – 24 year olds n = 361 Britain</p> <p>3. Wrate and McLoughlin (1997) assessment of mental health needs of young homeless / 'at high risk' 16 – 21 year olds n = 145 Edinburgh</p> <p>All studies included official and unofficial homeless.</p>	<p>interviews</p> <p>3. Semi-structured interviews in a wide range of community settings including a structured psychiatric interview</p>	<p>comparisons made by reviewers</p> <p>3. None</p>	<ul style="list-style-type: none"> • Most of the young people report deprived family backgrounds. • Homelessness seen as a solution to situation at home. • Ability to plan ahead a predictor of stable housing at one year follow up (study 1). • Duration of homelessness beyond two years significantly associated with mental health problems (study 1). • Rate of 36% reported for psychiatric disorder (study 2). • 10% of respondents suffering from a major depressive episode (study 3). • One young person with probable psychosis and two of uncertain diagnosis (study 3). • One-third reported a past episode of depression, 'the presence of poor physical health perhaps increasing the likelihood of depressive illness being overlooked, for example where presentations are complex.' (study 3). • No association was found between reported social contacts and depression (studies 2 and 3). • Similar rates of mental health problems for young women and men were found (studies 2 and 3). • Lifetime prevalence of recurring suicidal thoughts was 54% (study 3). • 28% had made an attempt on their life (study 3). • Use of drugs greatest amongst 16 – 24 year old cohort, then other age cohorts (study 2). • Co-morbidity identified between substance dependence and mental health problems, but not substance use (all studies). • Strong association between substance use (including legal forms) and number of changes of address since 15 years old, but not with measures of ill-health (study 3). • Clear relationship between a very high overall drug intake and current depression (study 3).

N.B. Some of the results section may be directly quoted from the references

Appendix 2: Summary of key intervention studies

This is a brief summary of some of the interventions covered in the reviewed literature. The majority are existing services, and deal with homelessness and its prevention. They tend to be accepted strategies, the pros and cons of which are examined further in the literature. In terms of mental health problems, interventions regarding these in the context of homelessness appear limited. This may be because it is seen as a secondary issue to the homelessness, or because it is harder to 'diagnose' and 'treat'. It is probable that there is good practice in this field, but that it will be local and less visible to other agencies.

Articles	Intervention	Commentary	Preventive/ Reactive (P/R)
Fitzpatrick (2000), Safe on the Streets (1999), Keep (2000)	Early intervention and support for families	For example: the Sure Start, Children's Fund and Connexions programmes, respite care for children and young people, family mediation, family group conferences, parenting support (especially for parents of teenagers). Reduce familial tension and prevent family break up / entry to care. Where this is not possible, at least help to plan the next steps. Identification of, and support for, problematic behaviour by schools. Importance of economic as well as social support needs to be recognised.	P
Lilley (2000), Safe on the Streets (1999), Wrate and Blair (1999), West (1999)	Education	Role of schools in helping young people learn about the processes of development, parenting, social and emotional relationships. Putting mental health issues into their broader context. Health promotion and awareness raising. Peer support / educators. 'Running away' / 'homelessness' as a topic within the personal, social and health education curriculum.	P
Lilley (2000) Fitzpatrick (2000)	Employment and Training	Improve chances of accessing and sustaining employment. Financial security needed. Provide individual with a sense of worth, self esteem and independence.	P and / or R
Safe on the Streets (1999) Tischler et al. (2000)	Professional training	Staff training, particularly in relation to drug awareness, sexuality and sexual health, and mental health. Ensure that housing staff make appropriate referrals. Needs to be a rolling programme to maintain effectiveness.	P
Hargreaves (1999)	Provision of specialist voluntary sector services	For people, particularly refugees, who are cautious about dealing with government agencies: Less stigmatised.	P and / or R

Articles	Intervention	Commentary	Preventive/ Reactive (P/R)
Safe on the Streets (1999) Smith and Leon (2001) Wilson (2001)	Advice and information services	Use of tv / radio/ articles / leaflets / posters in accessible places identifying sources of help. Help could take the form of a telephone help line, drop-in advisory service, virtual web site etc. Mental workers working within existing advice and information centres for young people Example: YIACS (Young Peoples Information, Advice, Counselling and Support Services) <ul style="list-style-type: none"> • Provides counselling, information, advice and support 'under one roof' to 13-25 year olds • Bridges gap between CAHMS and adult services • Is confidential • Provides a whole range of counselling through a multi-disciplinary team • Enables young people to build up their resilience against the development of mental health problems in adulthood (Wilson, 2001) 	P and / or R
Safe on the Streets (1999), Davies (2000)	Outreach and Informal support	Accesses those with chaotic and maybe withdrawn lives, through a range of settings.	P and / or R
Fitzpatrick (2000)	Practical support	For example, around budgeting, dealing with bureaucracy and planning ahead. There is an issue around who should provide support and how.	P and / or R
Lilley (2000), Safe on the Streets (1999)	Counselling and emotional support	If long term offers stable reference point.	P and / or R
Smith and Leon (2001), Coles (2000), Fitzpatrick (2000)	Floating Support / Resettlement Services	Aimed at young people living independently who have mental health problems and require intensive emotional and practical support in order to maintain their tenancy. Importance of continuity, with 'floating support' that moves rather than the young person.	P and / or R
Davies (2000)	Therapy	Starts from young person's definition of the problem	R
Davies (2000)	Youth work	Young person friendly and promotes interaction	R
Safe on the Streets (1999), SEU (1998)	Drop-in centres, Day centres	Offer practical support, housing advice, confidence building, life skills, foster independence. Arts and sports can be used therapeutically. Alleviate boredom, peer pressure	R

Articles	Intervention	Commentary	Preventive/ Reactive (P/R)
Smith and Leon (2001)	Mental health focused resource	Community-based Variety of short term and longer term support (counselling, group work, drop-in) Assisting young people in identifying coping mechanisms First assessment carried out a.s.a.p. But, opening times more restricted (i.e. daytime and early evening / Saturday)	P
Smith and Leon (2001)	Respite Service / Centre (re: mental health)	Building on existing models of good practice Range of activities provided Regular breaks at a residential facility for those already linked to services (CAHMS, AMHS, Voluntary Services)	P
van der Ploeg and Scholte (1997)	Personal / Social Rehabilitation	Sometimes there is a need to tackle addiction first.	P and / or R
SEU (1998)	Tracking of runaway incidents	Can prioritise repeat runaways, a potential role for Connexions Personal Advisors. Refer to specialist services if needed.	P
Safe on the Streets (1999), Mind (2001), SEU (1998)	Safe Houses (especially for under 16s)	Safe houses – a network for immediate access linked to a network of outreach workers and drop-ins SEU (1998) proposes different types: <ul style="list-style-type: none"> • Refuge in fixed premises • Dedicated refuge staff who stay with runaways in temporary accommodation • Specially trained refuge foster carers 	R
Safe on the Streets (1999), Lilley (2000)	Supported Housing / Systems of community living	A 'half-way house' in which young people have access to counselling and support (both formal and informal) Opportunity to gain a measure of independence People of a similar age / background grouped together, artificial but beneficial?	R
Lilley (2000), Coles (2000)	Foyers	Provide a mix of housing and social support, tied to employment and training – in theory, providing a more sustainable solution. Critics view as a return to large institutional style hostels.	R
Coles (2000)	High Support Hostels	Follows a holistic assessment of young person's needs; good for young people who need significant amounts of personal support; often deal with 16/17 year-olds.	R

Articles	Intervention	Commentary	Preventive/ Reactive (P/R)
Smith and Leon (2001)	Crisis Intervention Team	<p>Non-medical approach to mental health crises Referrals as and when necessary Can take different forms:</p> <ul style="list-style-type: none"> • Telephone • Face-to-face support for young people in their own accommodation • One-to-one work • Follow-up work (i.e. ensuring that young people leaving care have a plan) 	R
Van der Ploeg and Scholte (1997), Smith and Leon (2001)	Crisis Shelter	<p>Non-clinical setting that is safe and supportive 24 hour support, if wanted Overnight and short-stay accommodation available</p>	R
Lilley (2000), Fitzpatrick (2000), Coles (2000), Safe on the Streets (1999), SEU (1998), Smith and Leon (2001), Hargreaves (1999)	Desirable Service characteristics	<ul style="list-style-type: none"> • Accessible • Flexible (No interventions are appropriate for all young homeless people, nor are they appropriate for them at all stages of their transition to independent living. Need to be flexible to changes in young person's needs and capabilities) • Non-stigmatising • Holistic (Recognises the interconnections between different aspects of young peoples lives) • Tolerant (Allows for the inexperience, unreliability, mobility, experimentation and mistakes, which are often part of being a young person) • Listen to the young person's viewpoint • To understand running away / homelessness within the context of young people's lives • Interagency Co-ordination • Mental health service designed by young people: <p>Example: Save the Children Fund UK, NCH Action for Children and Bolton MBC: 'Developed a service for young homeless people via a planning group consisting of potential service users, with the support of a worker. Over time this has developed as a service model and been replicated across the country. This includes a café, food co-operative, crèche, advocacy, advice and information, a service health service, an in-care group, supported lodgings, a bond board, counselling, and laundry and washing facilities.' (Smith and Leon, 2001)</p> <ul style="list-style-type: none"> • But, may require culture shift and is time consuming. 	P and / or R

Articles	Intervention	Commentary	Preventive/ Reactive (P/R)
Coles (2000), Safe on the Streets (1999), Fitzpatrick (2000), Shelter (2000), SEU (1998), Wrate and Blair (1999)	Policy Interventions	<p>Current policy implications (Safe on the Streets, 1999):</p> <ul style="list-style-type: none"> • This age group of young people need to be more visible in family social policy re: Supporting Families green paper and the Children's Act • Urgent need to improve quality / choice of substitute foster and residential care re: Quality Protects programme • Develop more strategic responses to running away through central monitoring and identification of placement with high rates of running away re: The Government's Response to the Children's Safeguards Review • Reduce risk of disaffection among young people re: Social Inclusion: Pupil Support guidance • Proposed that care leavers and homeless 16 and 17 year olds without 'back-up support' should be accepted as 'vulnerable' by housing authorities under the homelessness legislation (SEU, 1998). Urgent need for policy response. • Impact of low level of benefits for under 25s and single room restrictions on the quality and availability of property to rent. • Need for joint strategies between the police, social services and voluntary agencies re: procedures issued by Local Government Association and the Association of Chief Police Officers • Need for more systematic information and recording of running away, and improved co-ordination at a corporate level • Mental Health Foundation inquiry (Mental Health Foundation, 1999) concludes that the government should legislate to establish a statutory duty for local and health authorities to establish a National Framework for children and young people's mental health. • Financial help is needed, 16 / 17 year olds are particularly vulnerable because of benefits system. • National Service Framework for running away to ensure better joint working and resourcing • Not sufficient to secure a roof, as (Fitzpatrick, 2000) demonstrates 'dumping young people in hard-to-let tenancies with no support, or in poor quality adult hostels exacerbates their problems.' • Improve incomes and benefits • Improve the quality and accessibility of affordable housing <p>Improvements to the care system:</p> <ul style="list-style-type: none"> • More stable placements • Enhance individual problem solving and capacity to plan ahead / manage conflict • Help with leaving care and after care support P and / or R (van der Ploeg and Scholte, 1997) 	P and / or R
		<p>Comprehensive case management approach</p> <ol style="list-style-type: none"> 1. Building a community service network • Mapping and networking of multiple agencies • Interdisciplinarity • Case management • Arranging drop-in shelters 	

Articles	Intervention	Commentary	Preventive/ Reactive (P/R)
		<ol style="list-style-type: none"> 2. Building contact with homeless youths <ul style="list-style-type: none"> • Outreach approach • Establishing contact • Covering basic needs • Providing medical aid 3. Assessment and planning of the care <ul style="list-style-type: none"> • Assessment of psychosocial background • Planning of feasible solutions 4. Execution of the care <ul style="list-style-type: none"> • Remaining the major resource of the care • Co-ordination of multiple pathways • Monitoring the progress of the care 5. In-depth after-care <ul style="list-style-type: none"> • Early detection of backsliding • Monitoring of stability and growth 	

N.B. Some of the commentary may be directly quoted from the articles



The Mental Health Foundation is the UK's leading charity working for the needs of people with mental health problems and those with learning disabilities. We aim to improve people's lives, reduce stigma surrounding the issues and to promote understanding. We fund research and help develop community services. We provide information for the general public and health and social care professionals. We aim to maximise expertise and resources by creating partnerships between ourselves and others including service users, Government, health and social services.

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The Mental Health Foundation
83 Victoria Street , London SW1H 0HW
Tel: 020 7802 0300 Fax: 020 7802 0301
Email: mhf@mhf.org.uk

Scotland Office
5th Floor, Merchants House, 30 George Square, Glasgow G2 1EG
Tel: 0141 572 0125 Fax: 0141 572 0246
Email: Scotland@mhf.org.uk

www.mentalhealth.org.uk
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