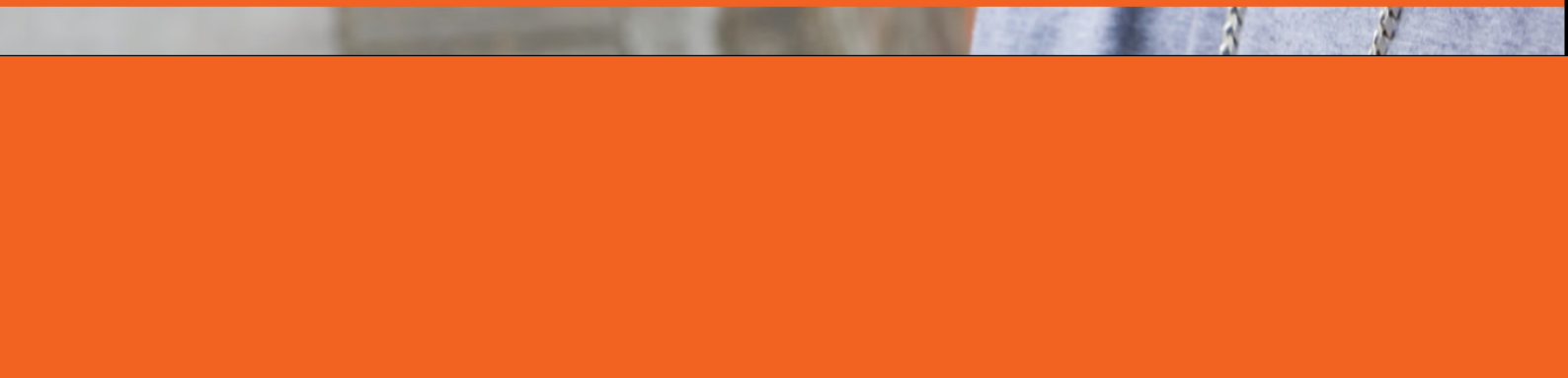




Making it matter: improving the health of young homeless people

AstraZeneca 
Young Health Programme

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**Report collated by Annie Crowley,
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Depaul UK.**

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**AstraZeneca is funding and developing the
Young Health Programme with Depaul UK.**

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INTRODUCTION

Paul Marriott, Chief Executive, Depaul UK

Catriona McMahon, Medical & Regulatory Affairs Director,
AstraZeneca

Our research highlights some challenging considerations for policy makers, commissioners and health care providers. It affirms both concerns in the current system and opportunities in its reform for those who work with young homeless people on a daily basis.

As we explored the health issues of these vulnerable young people it became clear that mainstream health services are not meeting their needs. As a result, poor health has become part of the cycle of youth homelessness, described by one young person as the 'web of disadvantage'.

Our results paint a complex picture. The young people we worked with to produce this research have complex and overlapping needs with mental health, substance abuse and physical health issues. They access certain health services more and report higher levels of health needs than their peers. The challenge is to design services which address these issues in a joined up way.

However, we should not be overwhelmed by the complexity of the problem. Successful interventions are very often much simpler than the problems they seek to address. The reform of the Health and Social Care system, particularly the introduction in 2013 of the Public Health Outcomes Framework and of Health and Wellbeing Boards, offers an opportunity to afford greater priority to the issue of homelessness and it is important that this is acted upon. The principle of "No decision about me without me" is intended for all patients, and engaging young homeless people in the decision making process and making sure that their needs are represented is vital.

Our hope is that this information, and the recommendations put forward, will help providers and commissioners design more integrated services. In doing so we can better meet the needs of vulnerable young people and deliver long-term savings by preventing long-term illness, reducing unnecessary hospital admissions, cutting emergency service use and avoiding missed appointments.

If we can intervene successfully at an early age we offer young people the opportunity to achieve better health, turn their lives around and fulfil their potential.

FOREWORD

Professor Steve Field, Chair of the NHS Future Forum

I was very pleased to be asked to provide a foreword for this report. As Chair of the National Inclusion Health Board, my role is to drive improvements in health outcomes for the most vulnerable and excluded groups in our society. Whilst the general population's health continues to improve, the most vulnerable groups are all too often being left behind and have significantly poorer health outcomes than those enjoyed by the general population. The Inclusion Health Programme focuses on driving improvements for those groups vulnerable to the worst health outcomes. Homeless people have some of the poorest health outcomes and therefore are a key priority.

Although there are good examples of local services for young homeless people, barriers which prevent them from accessing health and social care services still exist. This report highlights the main issues faced by the young homeless population and sets out key recommendations for each part of the health and social care system to take forward. It is clear that integration and joined up working between different parts of the system is vital.

I encourage policy makers, Health and Wellbeing Boards, commissioners and service providers to use this report to help address the health outcomes of the young homeless population within their community.

Professor Steve Field CBE FRCGP FFPH FRCP
Chairman, NHS Future Forum
Chairman, National Health Inclusion Board
& General Practitioner at Bellevue Medical Centre in Birmingham

The web of disadvantage

Executive Summary

These are some of the key findings of our research, which was carried out between May and October 2011 and in which more than 380 young people (16 – 25) participated. A health questionnaire was completed by about 130 young people from Depaul UK services, and by a control group of 200 young people from around the UK. Four focus groups and 26 individual interviews with young people also took place. A group of young homeless people were trained in research skills and carried out research with their peers.

Ethnographic films were made with four young people from Depaul UK services. More than 25 Depaul UK staff members took part in interviews and in regional focus groups. In addition, a steering group of experts guided the research and met to discuss its findings and recommendations.

The Context

An estimated 80,000 young people experience homelessness in the UK each year. This fails to account for the growing number of hidden homeless living in poor quality hostels or on a friend's sofa. The main cause of youth homelessness is known to be family breakdown.

Of the young people from Depaul UK services who participated in the research, around half were not in education, employment or training, almost five times as many as in the control group. They were at least twice as likely to have moved in the last 12 months.



17% of young homeless people have higher levels of disability compared to 4% of the control group



In the last 12 months, 37% of young homeless people had visited A&E, compared to 14% of the control group



... 24% of young homeless people had been in an ambulance compared to 3% of the control group



... 27% of young homeless people had been admitted to hospital compared to 6% of the control group

£ A visit to A&E costs £100

£ Ambulance call out costs £253

£ Average cost of unplanned hospital admittance is £1,400



80% of young homeless people are registered with a GP compared to 92% of the control group

£ GP appointment costs £36
Nurse appointment costs £21



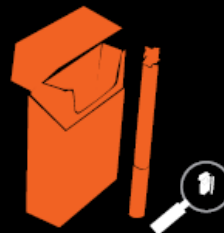
40% of young homeless people are likely to be suffering from depression compared to 21% of the control group



27% of young homeless people have been diagnosed with a mental health condition compared to 7% of the control group



48% of young homeless people use cannabis compared to 6% of the control group



64% of young homeless people smoke every day compared to 5% of the control group



27% of young homeless people eat less than 2 meals a day compared to 5% of the control group

ABOUT THE ORGANISATIONS BEHIND THE RESEARCH

Depaul UK

Depaul UK is the largest national youth homelessness charity in the UK. Depaul UK has helped over 50,000 people since it was founded in 1989. We now work with more than 5,000 young people a year through our own services and those run by our accredited Nightstop emergency accommodation schemes.

In the context of increasing youth homelessness, Depaul UK's current strategic objectives are to prevent, protect and provide. It has six key areas of work to meet these objectives: accommodation and resettlement; training and employment; family mediation; prison and resettlement; volunteering and mentoring; and work in the community.

AstraZeneca

AstraZeneca is a global, innovation-driven biopharmaceutical business with a primary focus on the discovery, development and commercialisation of prescription medicines. As a leader in gastrointestinal, cardiovascular, neuroscience, respiratory and inflammation, oncology and infectious disease medicines, we invest around £3.1 billion in Research & Development each year.

Partnership - AstraZeneca Young Health programme

AstraZeneca is committed globally to a long term community investment programme to improve the health of young disadvantaged people. It aims to reach one million young people aged 10 to 24 by 2015. In the UK, AstraZeneca is partnering with Depaul UK to improve the health of young homeless people.

PURPOSE OF THE STUDY

The overall aim of the Young Health Programme partnership is the development and implementation of interventions to improve the health practices, both present and future, of homeless and disadvantaged young people. This first step of this programme was therefore a phase of research to gain a thorough understanding of the health issues affecting this group of young people, and any barriers that exist to them accessing relevant health services. It was also to provide insight into existing good practice, and the ideas of young homeless people and Depaul UK staff into appropriate health interventions.

WHAT ARE THE MAIN BARRIERS TO QUALITY CARE FOR YOUNG HOMELESS PEOPLE?

- Young homeless people do not consider health and health-related issues to be a problem or **priority** for them: other issues such as the need for housing and employment are more pressing.
- **Long waiting times** lead to a lack of timely care which is especially vital in this group who often seek help, particularly for mental health issues, at the point of crisis.
- **The transition from paediatric to adult services** often leads to a breakdown in continuity of care and challenges accessing adult services.
- **Them-and-us mentality** – some GPs are perceived to be judgmental and don't always provide the support needed to enable young homeless people to voice their concerns.
- Young homeless people often **lack confidence, motivation and a sense of purpose** which not only negatively affects their mental health but leads to an apathy in seeking care.
- Appointments are often short and with **different healthcare professionals** meaning issues are not fully addressed and young people often have to recount distressing personal stories repeatedly.
- **Lack of money** to attend appointments is a particular issue due to the transient nature of the lives of the young homeless population.
- **Chaotic lifestyles** can lead to challenges with continuity of care, keeping appointments and implementing healthcare recommendations.
- **Interrupted and chaotic upbringings** have resulted in a lack of knowledge about when and how to seek help.
- Some young people have a **limited vocabulary** to convey health concerns.
- Help is often needed **out of hours**, but not often available.

KEY RECOMMENDATIONS

For policy makers

We would like national recognition that young homeless people require a more effective, tailored and integrated health service, notably:

- Ensuring that organisations such as Healthwatch England & local Healthwatch have the skills and knowledge to engage and consult young homeless people, in order to ensure that they are represented in national and local decisions.
- Structured guidance for both voluntary sector organisations and health commissioners to equip them with the knowledge, skills and motivation to engage with one another.

For Health and Wellbeing Boards

We welcome the commitment of the Ministerial Working Group on Homelessness to improving the inclusion of homeless people in Joint Strategic Needs Assessments (JSNAs) by the Health and Wellbeing Boards. To ensure this, we recommend that:

- A framework is put in place and monitored to ensure that voluntary and community groups are actively consulted during the JSNA process in order to provide non-clinical data and research. Direct recognition in health and wellbeing strategies of the complex needs of young homeless people, including strategies to ensure the provision of joined-up services and specialist commissioning for this group.
- Cooperation with neighbouring Health and Wellbeing Boards, including pooling budgets where appropriate to ensure the needs of this marginalised population are met.

For commissioners

- Integration is key: services for young homeless people should be easily accessible in places such as drop-in centres; specific services for mental health or for substance misuse should not exclude those with multiple needs; and more consideration needs to be given to creating an effective pathway between child and adult services.
- Each Clinical Commissioning Group should have an officer accountable for homeless healthcare.

For AstraZeneca and Depaul UK

- Increase training and resources for Depaul UK staff in supporting young people with mental health issues, including ongoing support.
- Improve the links between Depaul UK services and clinical health services from both sides, through education and local relationships.
- Build upon Depaul UK's activity and skills programmes, to ensure that young homeless people have access to appropriate resources that will impact upon physical and mental health and wellbeing, including the opportunity to participate in a wide range of positive activities, and to access peer to peer support.

Depaul UK is committed to ensuring the participation of young people in developing our responses to existing and emerging health needs.

RECOMMENDATIONS FROM PEER RESEARCH:

- Integrate services to prevent young people repeating themselves and accessing multiple services
- Raise awareness on issues of homelessness in schools and for front line workers such as health care and council staff
- Ensure sustainable funding for voluntary sector orgs that support young people
- Support and provide family mediation services to prevent youth homelessness
- Cut down on waiting times for counselling and support

METHODOLOGY

Research Aims and Objective

The core research objective was to identify the key healthcare needs and challenges of Depaul UK services.

More specifically it aimed to explore:

- Current healthcare needs of young people accessing Depaul UK services
- How they access healthcare, and barriers to this
- Current practice to address health needs at Depaul UK services
- Prioritisation of needs

Summary

The health research was carried out between May and October 2011. More than 380 young people (16 – 25) participated in focus groups, interviews, peer research, ethnographic films and a survey. In addition, more than 25 Depaul UK staff members took part in interviews and in focus groups, and a steering group of experts guided the research and met to discuss its findings.

A mixed methods approach was adopted for the research. Quantitative data was generated through a paper-based questionnaire, with qualitative material produced through focus groups and interviews. A group of young people who were currently accessing Depaul UK services received training and were supported to carry out a peer led research project. In-depth research was carried out through the making of four ethnographic films. Depaul UK staff took part in focus groups and interviews. Additionally the research process was guided by a steering group of experts in the fields of homelessness and health.

The different strands of the research were carried out by different research organisations:

- Questionnaire, 1:1 interviews and focus groups with homeless young people, and peer-led research was undertaken by the Community Research Company (<http://www.community-research.co.uk/>)
- Ethnographic research with homeless young people was undertaken by Naked Eye (<http://nakedeyeresearch.co.uk/>)
- Staff interviews and focus groups with Depaul UK staff, and online GP Community research was undertaken by Insight Research Group (<http://www.insightrg.com/>)

Each agency provided a report on the findings of their research which have directly informed this report.

Questionnaire

A questionnaire was developed by the Community Research Company (CRC). The aim was to produce a holistic picture of the health needs of the homeless young people Depaul UK works with, and to compare this with that of the general population of young people of the same age (16 – 25). It was designed so as to include information on physical and mental health needs, sexual health, nutrition and exercise, wellbeing, access to services, alcohol, smoking and illegal drug use.

The questionnaire was informed by many sources including the following:

- existing questionnaires for homeless people (e.g. the audit tool developed by Homeless Link¹)
- other relevant surveys for young people (e.g. the National Statistics/NHS study on smoking, drinking and substance misuse²)
- measures of wellbeing and mental health (e.g. the NHS self-assessment tool for depression³)

The draft was reviewed by a number of experts from the steering group convened by Depaul UK and piloted with eight young people, some of whom were clients of Depaul UK and some not. The final version of the questionnaire was twelve pages long and produced in paper format only for the client group of young people (See Appendix 4). The questionnaire was filled in by the young people, with support from their key worker at Depaul UK. As an incentive, young people were offered entry to a prize draw for all those who completed the survey. Data entry was completed manually with 10% checked for accuracy. A series of statistical analyses were carried out by CRC, and by the Department of Psychology, Southampton University.

A total of 127 young people (aged 16 to 25 years) accessing services from Depaul UK completed the questionnaire. An additional 27 older women supported through Depaul UK's partnership with the Women @ the Well project also completed the questionnaire. The responses from Women @ the Well were from a much older age group and these were analysed separately for a separate report.

The questionnaire was also completed by a control group of 200 young people. This was conducted online based on an opportunity sample with young people aged between 16 and 25 self-selecting from a database of around 37,000 held by Dubit Ltd (for more information see Appendix 2). The wording of a small number of questions was very slightly altered for reason of clarity – e.g. adding an option for 'living with parents'.

1. Homeless Link (2010) The Health and Wellbeing of People who are homeless: Evidence from a National Audit – Interim Report.

2. Fuller, E., Sanchez, M. et al (2010) Smoking, drinking and drug use among young people in England in 2009. Copyright © 2010, Health and Social Care Information Centre, Lifestyles Statistics. All rights reserved. Available at: <http://www.ic.nhs.uk/pubs/sdd09fullreport>. Last accessed 4th October 2011.

3. NHS Depression self-assessment test (developed by Drs Robert L Spitzer, Janet B.W. Williams, Kurt Kroenka and colleagues with a grant from Pfizer Inc). <http://www.nhs.uk/Tools/Pages/depression.aspx>

1:1 Interviews

A total of 26 semi-structured interviews were completed with young people accessing services from Depaul UK. These were carried out by CRC. Recruitment was via the questionnaire – young people could indicate if they would like to participate in an interview or a focus group, for which they received a £20 voucher. Interviews were conducted face-to-face and by telephone (depending upon preference of the participant) by three researchers using a standardised semi-structured question template of eight core questions (see Appendix 3). Where data was recorded, 15 males and 11 females participated in the interviews.

The interviews included questions to illicit more qualitative information around some of the key topics in the questionnaire and around other topics not covered elsewhere – such as accessing information on health issues/campaigns. Interviews took place between 26th September and 7th October 2011. Contemporaneous notes were taken during the interviews which lasted between 20 and 30 minutes.

Focus groups

A total of five focus groups with people accessing Depaul UK services were held by the Community Research CRC. Each focus group was attended by between 4 – 10 participants, lasted up to two hours and was structured around a number of interactive activities (See Appendix 1 for schedule). As guided by the Depaul UK staff, the focus groups were of mixed sex. One was exclusively for young parents. Participants were recruited through indicating their interest on the questionnaire, and advertising by staff at the different Depaul UK projects. Participants received a £20 voucher.

One focus group took place at the Women @the Well project, with whom Depaul UK are working. However, the women who participated were of a different age (all over 25), and therefore the focus group findings were separately reported due to the **Different age of the participants**. This offered distinctly different opportunities and historical perspectives to explore health issues and homelessness.

The peer led research project was produced by a group of young people accessing services from Depaul UK in Whitley Bay in the North East. Two full-day training sessions were delivered by CRC to a group of eight young people on 6th and 20th August 2011 at the Resource Centre in Whitley Bay. The training programme provided an introduction to research for those with no previous experience. A series of interactive and participative activities were used to learn about all aspects of the research process with additional support provided throughout the project.

A crucial aspect of supporting the peer led research project is the freedom the young researchers are allowed to define the research question. Whilst the broad research topic of 'health and youth homelessness' was prescribed to the group, beyond that,

the focus of the research and all other aspects – the methodology, the research tools used, the dissemination of findings – were all defined by the young researchers.

The young researchers chose to focus their research on mental health and how it relates to youth homelessness. After an initial piloting phase involving paired interviews with young people working with Depaul UK, a more detailed template for semi-structured interviews was developed for use with young people and Depaul UK staff. The field work was structured around the development of detailed case studies. The information, generated through the case studies, was used to develop a script and presentation for the findings.

Ethnographic Study

Ethnographic research with four young people from Depaul UK services was undertaken by Naked Eye. The objective of this was to gain a close-up understanding of Depaul UK's clients in relation to:

- their concerns, fears, hopes and aspirations
- who they look to for advice and support when making important life decisions
- how they live day to day
- which services they most value and trust
- what meaning is attached to the things they do

Naked Eye spent three days filming four Depaul UK clients aged between 18-25 years. The four young people had a range of physical and healthcare needs and shared a similar path to homelessness, including family breakdown, substance abuse and eviction. The research was carried out with the clients, rather than on them. Deferring to the young people as experts helped with two key areas: it has helped to validate the data to other young people; and it worked to access in-depth insights into their lifestyles and to gain their trust, as well as an insight into their lives and key people in their network. The films can be viewed at www.depauluk.org/videos, and a summary of each film can be found at Appendix 3.

Staff Research

Research with Depaul UK staff was carried out by Insight Research Group. The objective was to learn from the experiences of Depaul UK frontline staff – the professionals working with young homeless people day-to-day. This perspective is crucial as the staff have many years of experience working with this client group and so have an in-depth understanding and knowledge of their situation. The research was also intended to identify areas of strength and good practice in the work of Depaul UK relating to the health of homeless young people, but also gaps or areas for improvement.

Eight 1:1 in-depth interviews took place with key staff working on health related projects within Depaul UK, and three focus groups were held with Depaul UK staff in London, Stockport and Newcastle, covering London & South-East, North-West and North-East regions. Staff were from a variety of services, including accommodation, prisons, training, family mediation, mental health and sports.

Expert Steering Group

A group of experts in the fields of homelessness and health were invited to form a steering group (see Acknowledgements for list of group members) to guide the research process and to address its findings in order to make recommendations. The group met twice formally (with a number of additional 1:1 consultations) and established the current level of understanding of health needs and interventions available for young homeless people, as well as discussing potential interventions and examples of past good practice.

Ethical considerations

The topic of research – physical and mental health – presented a number of key ethical considerations which were discussed at the design stage and in weekly meetings. External advice was sought when required from members of the expert steering group.

A key ethical consideration for this project was the potential for disclosure of physical and mental health problems, including the use of illegal drugs by Depaul UK clients taking part in the research.

It was agreed at the design stage of the methodology that Depaul UK staff would offer assistance to young people completing the questionnaires and if there were any disclosures of physical or mental health problems that these would be discussed further with the individual and, if necessary, the issue would be carried forward to the regular key worker sessions or the young person signposted to further support, advice or treatment.

With regards to disclosure about illegal drug use, it was agreed with Depaul UK that no punitive action would be taken in relation to this as it was essential to ensure that the questionnaire was a sound reflection of the lifestyle of clients. For example, those living in hostel accommodation would normally have further action taken against them if illegal drug use was reported. This was not the case with regards to any information reported in the questionnaires. In the questionnaire itself this was also clearly outlined to respondents at the start of the questionnaire and again just before the relevant section.

Young people participating in focus groups and those trained as young researchers were reimbursed for any travel or subsistence costs (e.g. child care) to ensure that no one was excluded from taking part or disadvantaged financially by doing so.

Confidentiality

All participants in the research were assured of the confidentiality of their responses to the questionnaire and their contributions to focus groups and interviews. At the outset of focus groups and interviews participants were reminded of the anonymity and confidentiality of any responses.

Participants in the ethnographic study were fully informed as to the purpose of the research, and to the future usage of the films that were made as part of the process.

All participants in the overall research project were reminded that they were participating on a voluntary basis, that they did not have to take part in any activities they did not want to or answer any questions they did not want to and were free to withdraw at any time. A standard text was developed to cover this and was included at the start of each interview template to ensure that it was always read out as part of the introduction.

Completed questionnaires were input manually using an Excel template. The only personal details on the questionnaire were on the final sheet which offered the opportunity for further participation in the research and for entry into the prize draw. The questionnaire was designed so that this information, and nothing else, was on the final sheet of the questionnaire and was detached on data entry. No information could be traced back to individual responses. Hard copies of the questionnaires were saved and stored in a locked filing cabinet in a locked office and will be destroyed on completion of the project. Digital data capture through the project is saved under a password protected folder on a secure server.

FINDINGS AND DISCUSSION: SETTING THE CONTEXT

| Summary Characteristics of Respondents | | client group | | control group | |
|--|--|--------------|----|---------------|----|
| | | N | % | n | % |
| age | 16-18 | 48 | 40 | 68 | 34 |
| | 19-21 | 42 | 35 | 66 | 33 |
| | 22-25 | 29 | 24 | 66 | 33 |
| gender | Male | 74 | 60 | 100 | 50 |
| | Female | 49 | 40 | 100 | 50 |
| disability | disability | 25 | 17 | 8 | 4 |
| | no disability | 125 | 83 | 192 | 96 |
| employment status | NEET | 61 | 51 | 21 | 11 |
| | Education | 28 | 24 | 129 | 65 |
| | Training | 20 | 17 | 8 | 4 |
| | Employment | 10 | 8 | 71 | 35 |
| offending | comm. order/ bail/ susp. sentence | 15 | 12 | 0 | 0 |
| | left prison/remand | 12 | 10 | 0 | 0 |
| care | left care | 13 | 10 | 0 | 0 |
| movement | moved - where you live | 82 | 69 | 53 | 27 |
| | moved - school/collage | 24 | 24 | 46 | 23 |
| | moved - local area | 43 | 42 | 42 | 21 |
| ethnicity | White British | 73 | 58 | 159 | 80 |
| | Black, Asian & Minority Ethnic groups | 53 | 42 | 41 | 20 |
| sleeping arrangements | With parents / guardians | 4 | 3 | 138 | 69 |
| | Own tenancy | 29 | 24 | 46 | 23 |
| | Other | 4 | 3 | 14 | 7 |
| | Second stage or supported accommodation | 7 | 6 | 1 | 1 |
| | Sleeping on somebody's sofa/floor | 2 | 2 | 1 | 0 |
| | Nightshelter | 0 | 0 | 0 | 0 |
| | Squatting | 0 | 0 | 0 | 0 |
| | Nightstop Scheme (emergency accommodation) | 3 | 2 | 0 | 0 |
| | Hostel | 68 | 55 | 0 | 0 |
| | Sleeping rough on streets/parks | 1 | 1 | 0 | 0 |
| | Prison | 5 | 4 | 0 | 0 |

Employment Status

Of the young people from Depaul UK services who completed the questionnaire, around half were not in education, employment or training (NEET) - almost five times as many as in the comparison group (51% compared to 11%). Of the 49% from Depaul UK services who were not NEET, the majority were in training rather than education or employment.

Accommodation

As might be expected, homeless young people were more likely – around twice as likely – to have moved home, and also to have moved from the local area in which they lived. Around two-thirds of homeless young people (69%) had moved where they lived in the last 12 months. Similar proportions in both groups had moved school/college in the last 12 months (24% of homeless young people and 23% of all young people).

A higher proportion of homeless young people had moved where they lived in the last 12 months and they had also moved more often, than the comparator cohort group. Homeless young people had, on average, moved 'home' 2.3 times in the last 12 months compared to their cohort who had moved on average 1.2 times. Two respondents from the homeless group had moved home 10 times in the last year.

In some cases it was evident that frequent movement was also evident while the young person was still in the family unit. One young girl in Newcastle said that,

“We have always moved around loads, usually to avoid the rent man or somebody after us, so it’s normal for me to be able to pick up my stuff in a bag and move on quickly. I have never had roots,”

“We never really had a permanent home, we were moving from home to home. My mum didn’t really have a lot of support around us, and we did get evicted from one home because we didn’t have enough money to pay rent so we did end up living in two homeless shelters.” (Female, NE, Ethnographic study)

Just over half the homeless young people surveyed currently live in hostel accommodation, compared to the fact that 69% of the other young people still lived with their parents. Similar proportions from both groups – around a quarter – now had their own tenancy.

Interestingly, in the focus groups it was clear that young people did not consider themselves to be 'homeless'. Although they had left the family home and have experienced homelessness before they reached 16 years they considered 'homeless' to refer solely to sleeping rough on streets/in parks. Only one participant in the research was currently sleeping rough.

Care Services

Of the homeless young people who participated in the health survey, around one-in-ten had left Care Services in the last 12 months, compared with none of the other group of young people who took part. There was clearly a link between the care system and homelessness amongst young people. One young man in Bradford commented that,

“I kept running away from care and my foster parents and the police just took me back, so I hid out at my mates shed and they looked out for me until people just got fed up of bothering where I was”

Offending

None of the control group of young people had any history of offending, however, among the homeless group of young people, around one-in-ten were currently on a conditional discharge community order, bail or suspended sentence and the same proportion had left prison or been on a custodial remand.

Priorities for homeless young people

For many of the young people interviewed health was seldom their major concern, they are young and generally in good physical health with an expectation of staying that way. This is more a comment on youthful optimism and invulnerability. Until prompted physical and mental health was not a topic that either took up much of their time or that they gave much thought to. The quotes that follow were typical of responses generated through the qualitative fieldwork:

“Why should I worry at my age?”

“I want a job, things to do and somewhere decent to live!”

“I have never really been ill since I was a kid.”

The homeless young people often revealed a rather limited understanding of their healthcare needs and uncertainty around physical conditions. These were often just seen as “add ons” to a list of problems, not a primary concern. The nature of their hectic lives made it difficult to adhere to a medical regime – but this did not appear to be a concern. Instead, the homeless young people in the study discussed the following issues as their major concerns:

- poor accommodation options: “nowhere to live and nowhere to go”
- relationship problems
- family breakdown
- vulnerabilities around personal safety and fear of victimisation
- friendships
- lack of money,
- zero opportunities
- no jobs or no prospects
- little hope for the future

It appeared difficult for young people to relate these issues to health or to aspects of their lifestyle such as diet, exercise, sexual activity, smoking, drinking and drug usage.

The peer researchers were asked to carry out a piece of research looking at the health needs of young homeless people. They chose to focus this on mental health, despite being given a completely free choice with regard to what aspect of health they explored, or even whether they did indeed narrow the subject matter. They explained that their choice was due to feeling that mental health was such a pressing issue for their peer group.

The Depaul UK staff interviewed do consider healthcare to be a priority, and are acutely aware that the vast majority of Depaul UK clients do have underlying health needs which need to be addressed. They said though that clients prioritise safety and security (e.g. accommodation / employment / benefits) before health, and it is only when the young people begin to feel more stable that healthcare can play a more important role in the rehabilitation process.

Relationship breakdown

Relationship breakdown, often clearly related to family breakdown and poor childhood experiences, sometimes linked to neglect and/or poor parenting models, was experienced as a deciding and pervasive factor for many of the young people interviewed. One young person commented:

“I moved out cos of family arguments and disagreements and I’ve got two little sisters so it’s easier to get out than them having to put up with loads of arguments every day.”

In the research carried out by young homeless people, it was found that for every person who participated in their research, family breakdown had been the cause of their becoming homeless (eg through bereavement, divorce, abuse etc). In most cases young people were still in, often regular, contact with at least one member of their family and few of those taking part in interviews and focus groups had moved very far from where they grew up.

“I have not seen my Dad for years since he walked out but I see my Mum every week and my Gran, we have a brew and a chat and they give me some smokes if they can”

“I go round my Gran’s a lot for a brew but I never see my folks although they live just round the corner”

For some young people this was also a potential source of anxiety and conflict in their lives. One young person living in the north west had not seen his parents since he was four or five years old having spent his formative years in care and commented ***“I don’t want to see them either.”*** Another said that ***“I see my step dad every day down town but I hate the b*****d so never talk to him.”***

One topic of discussion in the qualitative research was about the general health of the respondents' families. Many responded that they did not know or did not care with regards to the health of their family, whilst some referred to the other people living in the hostel because ***“this is my family.”***

Alcohol, drugs and cigarettes were often used as self-medication in trying to deal with what was usually described as the stress or violence associated with failing relationships, behaviour problems and emotional trauma, sometimes characterised by exploitation and a chronic lack of support.

Social Exclusion

One young person from the north east described their social exclusion as ***“the web of disadvantage.”*** Clearly some of the young people endure an unstable mix of all or many of the casual factors associated with homelessness and trauma identified here which creates a range of complex needs that can impact negatively on physical and mental health.

The majority of young people interviewed or who participated in the focus groups were unemployed and NEET, with few qualifications, prospects or ambitions. With very little disposable income for consumables such as gym membership or engagement in hobbies, plus few pro-social role models available, the motivation of young homeless people to “get out and do things” is low, and needs encouragement. Better management of what income young people do have was also an issue. A young girl from London told us,

“To be fair if I ever have any cash I spend it straight away with my mates on fags or whatever... so how could I ever join a club like badminton? That’s just bonkers!”

These factors can lead to forms of social exclusion and difficulties in accessing help and support services. It also appears to have created a general suspicion of authority amongst those who participated, and in some a quite profound rejection of formal avenues to guidance or involvement in community activity.

In a sense the usual group of young smokers in each locality exhibited a group bonding despite the health, financial and social negatives now associated with heavy smoking. To some extent aspects of this type of “outsider mentality” were evident in some of the young people. This is particularly true for those who have been homeless for some time and are regularly sofa surfing or between various types of temporary accommodation. This creates a ‘them and us’ mentality which seemed to relate directly to low aspirations amongst the young people DPUK work with. One young man in Bradford summed it up as,

“I can’t see how me and my mates can ever fit in with posh people can you?”

Young parenthood

A common theme, for both male and female homeless young people participating in the qualitative research was the desire to have children and thus create a family environment.

“I would absolutely love to have my own home, a home where I could live for hopefully a long, long time, have a family there, so I’m creating an atmosphere for my own family, where they’re not constantly moving about, and a bright future, which is what I’m really really hoping to have.”

(Female, NE, Ethnographic study)

It was evident that for those young mothers working with Depaul UK, their experience of having a child early in life had had a positive influence on their own health. Many talked about much lower levels of alcohol consumption, stopping smoking and drug use following pregnancy. It was also their main source of joy and happiness in their lives and, by their own assessment, had helped them to mature and develop better life skills, such as cooking and organisation skills. One young mother commented that,

“My baby comes first and last, its difficult managing on the money I get and sometimes I could really do with a break but I just have to get up and get things sorted in mornings”

Another young mum said,

“Since I have had Tammy things have been better with my own health and I am less moody”

However, despite the young mothers reporting better health and wellbeing they did feel that they were ‘looked down on’ by others as being ‘a slag or being stupid’.

Motivation & aspirations

Many of the young people interviewed expressed a desire to have a different life. A life they described very much as that similar to the norm, with a house, money, family, car and above all a good job or career. The problem was that for some of the young people this seemed somewhat unobtainable given their current situations and the realistic options open to them. The current poor economic outlook was also impacting on this, fuelling a feeling of hopelessness and lack of confidence. One girl from Manchester reflected the following:

“To be fair how can we get on in this society without any qualifications or a decent job, it just seems like impossible to me..”

“Even when I was really poorly, I always, always knew that, this wasn’t what I wanted my life to be like, and I always wanted to have a career, and, a nice job that I enjoyed doing.” Female, NE, Ethnographic research

Despite wanting to achieve future change in their lives, it also appeared that a lack of motivation to make current changes was a key barrier to homeless young people accessing the services or activities which could potentially have a positive effect upon their circumstances. Both staff and the expert advisory group felt strongly that homeless young people often lack motivation to access care. This was felt to be due to a multitude of factors, including a lack of confidence, very low self-esteem, previous negative experiences, and often a lack of guidance during their childhood.

Support networks

The importance of support networks to homeless young people was very apparent from the different strands of the qualitative research. This was illustrated particularly saliently in the ethnographic research films. Most young people appeared to have at least one person to turn to, upon whom they relied quite heavily. It was normally a limited group, commonly consisting of a boy/girlfriend, key family member or Depaul UK key worker, but its influence was strong. These networks were felt to be important in terms of being able to motivate clients to improve their health and wellbeing and engaging young people in health-related matters.

In particular, the influence of girlfriends on the males was extremely strong, and in all cases mentioned, very positive.

“Nine months ago before I got with Rebecca, I was fighting every other day [...] Before I got with Rebecca I was really negative, now I’ve got with Rebecca I’ve been feeling really positive. And since I’ve been feeling positive I’ve been kicked out of places and stuff like that but I’ve still not let them get me down.”
(Male, NE, Ethnographic study)

The young man quoted above demonstrated difficulty in regulating his emotions, but his issues were largely resolved when he formed an attachment with his girlfriend. The expert advisory group commented that this reveals how emotions are regulated by attachment, and that there is an evolutionary element at play – inherent male aggression ceased to be a functional behaviour when attachment was formed and they started to look towards a future and think in the long term. However, this also raised the concern of the potential consequences, should the relationship breakdown, and highlighted the need for such vulnerable young people to have their support networks strengthened and increased.

FINDINGS AND DISCUSSION: DESCRIBING THE HEALTH ISSUES

MENTAL HEALTH AND WELLBEING

Through the research it became apparent that mental health is the key health issue of concern with regard to homeless young people. It was the health issue most commonly referred to in some form when discussing health needs with homeless young people. Often references were made to “*an inability to get out of bed or sleep properly*”, a complete lack of motivation, to getting very stressed, to being harassed, angry, sad or depressed. Often it was translated as “*I couldn’t care less*”, or “*sod them*”, “*they can’t make me*” and a general mistrust by some young people of official representatives such as the police⁴, GPs and social workers.

Mental health was chosen by the peer researchers as their priority area of focus. They found that mental health problems start or increase when a young person becomes homeless, due to feelings of rejection, low self-esteem, loneliness, dwelling on the past, or being subjected to further abuse or violence. Their research showed that the particular mental health issues that homeless young people suffer from are depression and anxiety, eating disorders, self harm, self medicating with drink and drugs.

Compared with the general population of young people surveyed, young homeless people were significantly more likely to have been diagnosed with a mental health condition (**27%** compared to **7%**). Using the NHS Choices self-assessment tool for depression it was found that **40%** of homeless young people are very likely to be suffering from depression, compared to just **21%** of the control group. Thus, depression is almost twice as likely amongst young people who are homeless compared to those who are not.

Just over a quarter (**27%**) of homeless young people reported that they had a mental health need or condition which had been diagnosed by a doctor or other health professional (compared with **7%** of the control group). The most common diagnosed mental health condition was depression; around half of all those with a diagnosed condition (**52%**), followed by around a fifth who were diagnosed with attention deficit and hyperactivity disorder (ADHD, **21%**).

4. One notable exception being the group in Bradford where a group of police staff led by a local community support officer regularly came into the hostel to lead cooking sessions.

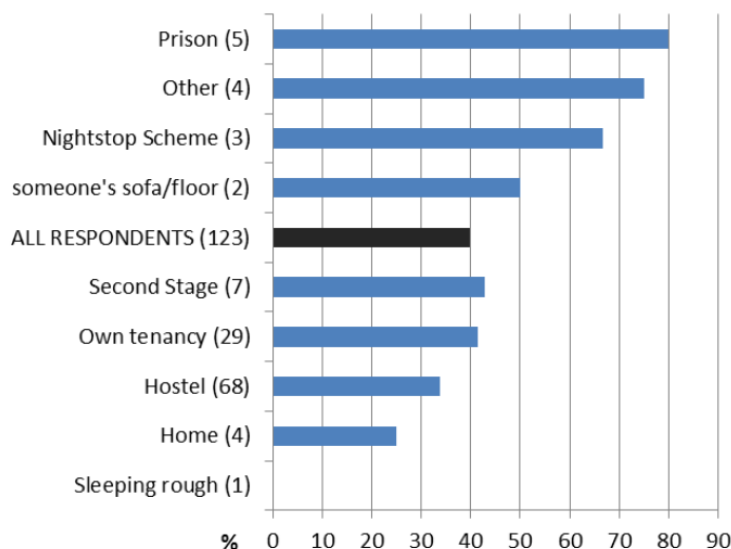
In the Homeless Link Health Audit a slightly different question was asked around self-reported mental health need (rather than a mental health need which had been diagnosed by a health professional). This estimated that 61% of 16 to 25 year old homeless people had one or more mental health needs.

For those homeless young people known to Depaul UK who had a diagnosed mental health need or condition, only two people (6%) had experienced it just in the last year, whilst the majority (63%) had experienced it for more than a year (31% either did not know or could not remember).

There was little difference by gender (41% male; 39% female) for those 'very likely' to be suffering from depression. Those who were employed (30%) or in training (30%) were less likely to be suffering depression, whilst a much higher proportion of those in education (55%) were very likely to be suffering depression.

There were also differences in terms of the current sleeping arrangements of respondents to the survey (see Figure 1). The base number of respondents was very low in some categories; however, there does appear to be a lower prevalence of depression amongst homeless young people who are living in hostel accommodation compared to other categories. Four-out-of-five respondents who were currently in prison were 'very likely' to be suffering from depression.

Figure 1 Percentage of homeless young people 'very likely' to be suffering from depression (figure in parenthesis denotes base number of respondents)



Self medicating and self harm

Just over a third (**35%**) of respondents reported that they used illegal drugs or alcohol to help cope with their mental health ('self-medicating'). This is another way in which substance misuse is normalised within the lives of homeless young people. Some young people discussed self-harm as a result of their mental health issues or as a way of coping with them:

“When the arguments started between me and my mum, I wasn’t really very close to my sister, and I did feel the only way I could cope with the stress and with the pressure that I was under from my mum was to self-harm.”

(Female, NE Ethnographic study).

““Have you ever self-harmed?” They must get sick of hearing that question, and it’s not a nice thing to ask from someone you’ve never met before when you’re not a health professional.” (Staff focus group, NE)

Support for mental health issues

Just over a third of the homeless young people from Depaul UK (**35%**) wanted more help/support either because they were not getting any or were not getting enough support. A similar proportion (**37%**) felt they were getting all the help/support that they needed and just under a third (29%) stated that they did not need any support.

Survey respondents were also asked about the type of support which helps them now and that which they would like in the future⁵. Figure 2 (below) shows that talking to their key worker, support worker or mentor was the type of support which currently helps most young people with a mental health condition now (**38%**). This was much higher than those who are currently supported by a specialist mental health worker, or who wish to be.

Figure 2 Type of support that young people with a mental health condition currently receive, or would like to receive

| | helps me now | | would like | |
|---|--------------|----|------------|----|
| | n | % | n | % |
| talking to others - key worker/support worker/mentor | 48 | 38 | 5 | 4 |
| talking to others - friends & family | 45 | 35 | 10 | 8 |
| activities to do like arts, volunteering & sports | 27 | 21 | 19 | 15 |
| practical support to help me with my day-to-day life | 27 | 21 | 9 | 7 |
| talking therapies (e.g. counselling, psychological therapies) | 21 | 17 | 14 | 11 |
| a specialist mental health worker (e.g. community mental health team) | 16 | 13 | 14 | 11 |
| services to address dual diagnosis | 15 | 12 | 11 | 9 |
| Other | 2 | 2 | 0 | 0 |

5. Respondents to the questionnaire were routed only to answer the question on the type of support received/wanted if they had previously indicated that they had a mental health need/condition diagnosed by a doctor or other health professional. However, a higher number of respondents completed this question so the percentages quoted have been calculated using the base for all respondents to the questionnaire (127).

When interviewed, Depaul UK key workers reported that due to long waiting times for mental health services, or to young people not wanting to access such services, they were often left to support young people who were suffering from mental health issues until they could receive professional support. However, staff sometimes reported feeling that they lacked confidence in their ability to do so. This was identified as a key area for development, due to the crucial role and influence that a trusted key worker.

The second most common type of support which helped young people with a mental health condition was talking to their friends or family (35%). This supports the idea of developing a peer mentoring approach to supporting homeless young people. This was very popular amongst young people participants in the focus groups and interviews.

In the qualitative research young people were unanimously supportive of peer mentoring, not just with regards to mental health, but across a broad range of issues. All young people would be supportive of accessing support advice & signposting from their peers, where they knew that the peer mentors/advisers had themselves received training and support in that role. The vast majority of young people also expressed a keenness to take on a peer mentor/support role themselves.

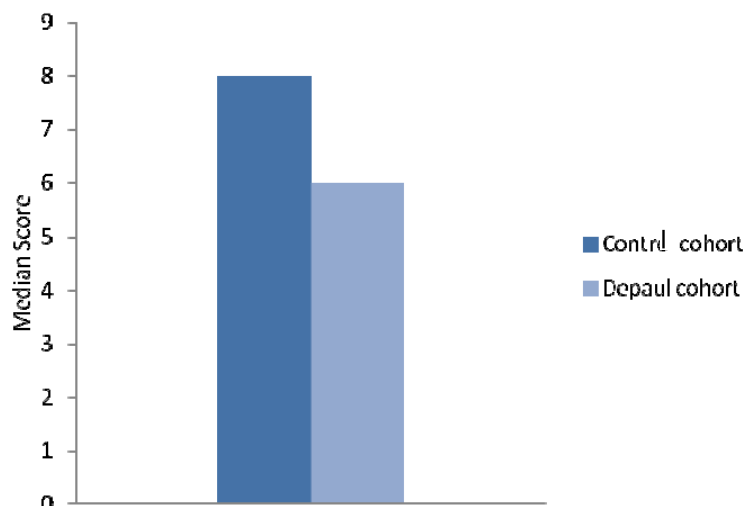
“Yes it would be good (peer mentoring) having advice from someone who has been through what I have been through and come out ok on the other side.”

“I’d prefer someone a bit older really who has more experience and some training to talk to, who understands from the inside.”

The peer researchers found that the mental health of young people is helped by exercise and eating well, group work and volunteering, talking to support workers or professionals, and socialising with friends or family, having a pet or having a child.

Wellbeing

Levels of self-reported happiness (general wellbeing score)



One section of the survey focused on the well-being of young people over a range of different aspects of their lives for which each individual scored themselves from 0 'very unhappy' to 10 'very happy'. Young homeless people reported significantly lower levels of happiness than other young people (6 compared to 8 on a wellbeing scale).

The average scores for homeless young people, and the control group, are shown in Figure 3 (next page). What is clearly evident from Figure 3 is that across all aspects of an individual's well-being, homeless young people are worse off (less happy) than other young people. A separate question on an individual's overall general well-being is included on Figure 4 and shows that the average well-being score for homeless young people is 6.3 compared to 7.9 for other young people (scores out of ten). As one young man in Newcastle said,

“Most days I am really feeling s**t and don't like going out at all.”

Looking at the different aspects of wellbeing (see figure 3 next page), the biggest difference between the scores of homeless and non-homeless young people was related to school/college work and school/college attended. However, this could, in part, reflect the much lower number of homeless young people in education/training who may have scored given a low score to this for that reason, rather than because they were less happy with how it was going⁶.

The gap was also large for issues such as an individual's family, their possessions and the groups they belonged to. Average scores were closest between homeless young people and their cohort for their appearance and for their communication with other people. One young man in Bradford stated that, ***“My family just bring me grief and I don't see them anymore”***. This was a fairly typical comment amongst interviewees. The majority of young people had experienced homelessness as a result of family breakdown and often that continued to be a source of unhappiness after they had left the family home.

As shown in Figure 4 (page 30), the self-reported well-being of female young homeless people was, on the whole, lower than that of male homeless young people. The biggest difference between the well-being of young, homeless males and females was for how happy they were with their family, with an average score (out of 10) of 6.9 for males compared with 4.7 for females. There was also a big difference for an individual's confidence level with an average score of 7.4 for males and 5.6 for females. One young woman in Newcastle commented that,

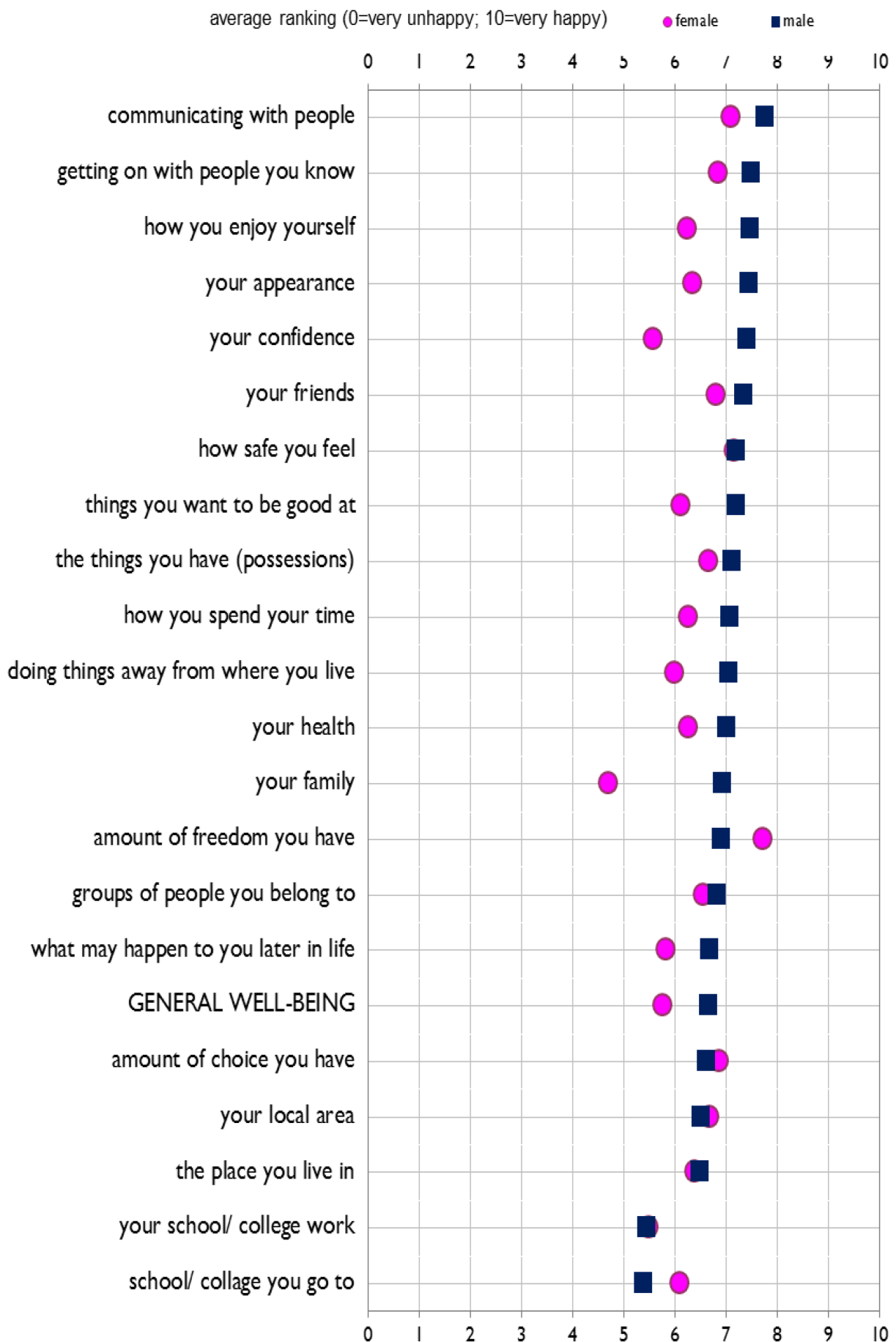
“I have absolutely no confidence at all really. People seem to be looking at me all the time, so I ignore them.”

6. The methodology of administering paper-based questionnaires to Depaul UK clients means that we are not able to determine the extent to which this is the case. This was a limitation of the methodology discussed at the design stage but other practical benefits outweighed it.

Figure 3 Average well-being scores of homeless and other young people (0=very unhappy; 10=very happy)



Figure 4 Average wellbeing scores of male and female homeless young people (0=very unhappy; 10=very happy)



The only exceptions, where females reported higher levels of well-being than males, were for the 'amount of freedom you have', the 'amount of choice you have' (where there is some similarity) and the local area and school/college they go to.

Staff concerns

Staff also identified poor mental health as the most pressing health issue for homeless young people. Their concerns ranged from low-level through to severe, including insomnia; low self-esteem; depression; trauma; ADHD; schizophrenia; self-harm; psychosis; and paranoia. Staff felt that low level mental health concerns are often the most endemic and time consuming as they can go undiagnosed, but affect day-to-day life. They found that a client's attitude and ability to manage or engage with a healthy lifestyle was determined by the state of their mental health. Due to the stigma that mental health holds, clients feared the label associated with it leading to issues going undiagnosed.

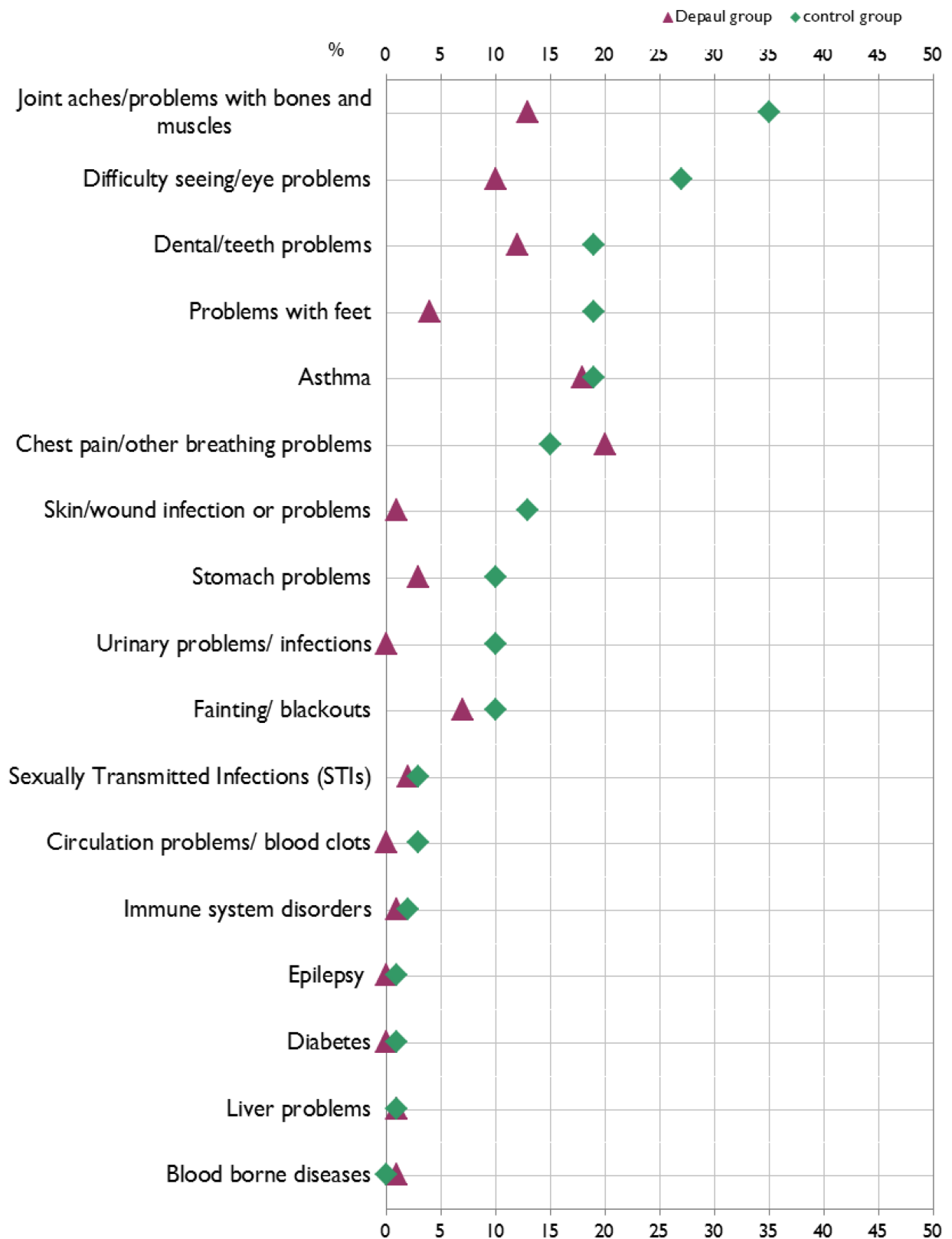
PHYSICAL HEALTH

Figure 5 (next page) shows the health problems experienced by homeless young people aged 16 to 25 years compared to the general population (same age group). Interestingly, this shows that, on the whole, there were lower reported levels of physical health problems amongst homeless young people, than there were for the equivalent age group who were not homeless.

For all of the categories listed in Figure 5 (next page), homeless young people reported lower or similar levels of prevalence compared to their cohort of a similar age. Exceptions to this were that homeless young people reported higher chest pain / other breathing problems, which were experienced by 20% of homeless young people compared to 15% of those not homeless, and a higher incidence of blood borne diseases – 1% of compared to 0% . These findings broadly concur with data from a similar cohort (16 to 25 year olds) drawn from Homeless Link's Health Needs Audit pilot project of 2009/10⁷. This study found that the most common physical health problems among homeless people were joint/muscular pain – which was experienced by around a quarter of respondents – followed by chest pain – experienced by around a fifth of respondents.

7. This information is based on a series of audits which took place as part of Homeless Link's Health Needs Audit pilot project. Clients were interviewed across nine areas (one per region) in England between October-April 2009/10. All data was provided anonymously. It is based on 233 individuals who fell into the 16-25 age group (49 aged 16-17, 184 aged 18-25). 88 clients were female, 143 male (2 didn't state). This data has been pulled off from the overall sample of 727 individuals for Depaul UK. It contains some of the key findings from the analysis. Please note this is based on clients self-perceived health needs. Most completed the survey one to one with a project worker, some individually. All were currently homeless.

Figure 5 Physical health problems experienced by young people (16 to 25yrs)



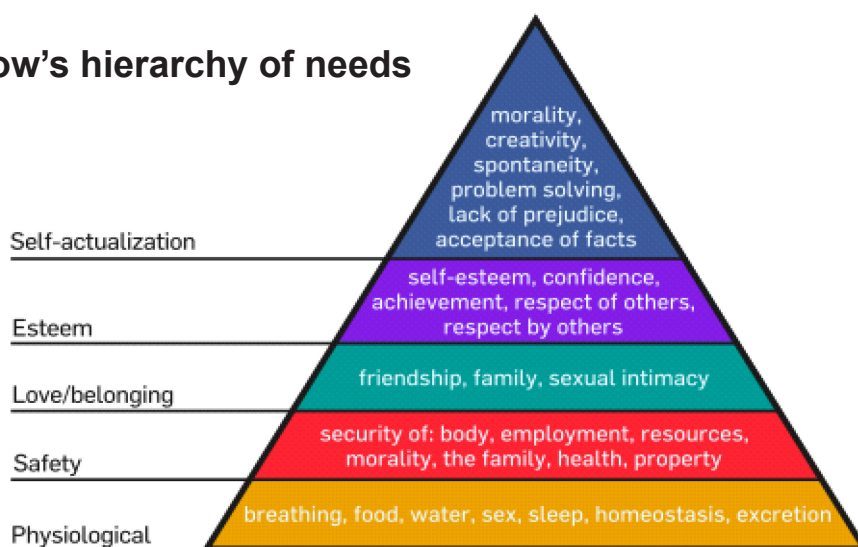
From the interviews and focus groups with homeless young people, it was clear that health needs, particularly physical health conditions, were not a high priority in these young people’s lives. When asked about ‘health’ issues, young people would usually start talking about lifestyle issues such as smoking, drinking and taking drugs. In some cases this was then related to future potential health problems, usually ‘cancer’ or ‘having heart attacks’. One young man told us,

“To be honest, I ain’t got time to worry about my health, have I? No money, no roof over my head, no job, no girlfriend and no fags”.

It was not common for young people to relate any of these aspects of their lifestyle or well-being to current health problems (physical or mental). Again, there is evidence of this in one of the ethnographic research studies, where daily smoking of ‘strong green’ skunk and emotional and behavioural problems were described, but without any acknowledgement of the possible relationship between them.

Here, substance misuse was described as *“an addiction, but an addiction I can manage”* without seeing any connection to any negative physical or mental health related outcomes. Another factor which may help explain this pattern of lower reported physical health problems among young homeless people is in reference to Maslow’s hierarchy of needs. Maslow described a hierarchy of human needs, most commonly described as a pyramid such as the one shown in Figure 6 (below), in which the most basic needs must be met first before an individual will strive to achieve higher needs.

Figure 6 Maslow’s hierarchy of needs



In the context of this study, the theory suggests that young homeless people are, understandably, pre-occupied with ensuring they have a warm place to sleep, food and drink etc, rather than seeking help with physical health problems such as joint-aches, difficulty seeing or health problems. There was evidence to support this theory from responses to the question regarding access to healthcare, which shows lower levels of access for homeless young people to paid services such as dentists and opticians. The lack of parental presence and influence in the lives of homeless young people may also be a factor in lower levels of reported physical health problems.

DISABILITY

A higher proportion of homeless young people – around one in six - considered themselves to have a disability than the general group of young people – just one in twenty. (17% compared to 4%).

Of the homeless young people who did consider themselves to have a disability, almost half said that it was a learning disability. The other most common categories of disability mentioned were mental health disability, and long term conditions.

SEXUAL HEALTH

Self-reported levels of sexually transmitted infections (STIs) were low in both groups (2% of homeless young people and 3% of young people generally). However, with regards to lifestyle, homeless young people may be at greater risk of STIs than other young people and, on the whole, reported levels of sexual activity were high. 52% of the homeless young people surveyed had had unprotected sex at least once in the last year, compared to 29% of the non homeless young people.

“I had 3 girls last week and two this week so far, so what am I going to do about diseases? I go to the clinic regular.” (Male, Interview, London)

However, staff said that it was easier to address sexual health issues with young people than mental health issues, as sexual health carries less of a stigma. They said that clients exhibit greater awareness around sexual rather than mental health, and consider it easier to access relevant support services.

DIET AND EXERCISE

Diet

On the whole homeless young people ate fruit and vegetables less often than other young people. The proportion of young people eating the [Government] recommended ‘five-a-day’ was low for the general population of young people – 11% – but even lower for homeless young people with only 2% eating five or more pieces of fruit and vegetables. The disparity was even more pronounced for those who never eat any fruit and vegetables, which was 6% of the general population, but 37% - over a third of all homeless young people. Staff observation was that diet and nutrition receives little attention from clients who are in the midst of chaotic lifestyles.

Eating ‘fast food’ was also much more common amongst homeless young people. One-in-ten homeless young people eat fast food at least once every day (11%), with a similar proportion eating it every other day (12%). This compares to much lower levels of 1% and 3% respectively among the general population of young people.

One young person described his local fried chicken take-away as “**basically my breakfast, lunch and dinner.**” (Male, London, Ethnographic film study).

This was also evident in the focus groups where young people regularly commented that fresh fruit and vegetables were too expensive. One young homeless person living in London commented that,

“It’s just too expensive [fresh fruit and vegetables]. I mean, what is it about a pound or something for an apple and that’s not going to fill you up, when I can get a massive bag of crisps for the same amount. So you get the crisps, don’t you?”

There was also evidence for this in the survey findings which showed that 27% of young homeless people eat less than 2 meals a day compared with 5% of the general population of young people. Young people participating in the focus groups and interviews felt nutrition to be secondary to budgeting while on limited income and benefits.

“We had quite a lot of weekends where we only really had one bit of food in the house to feed three people.” (Female, NE, Ethnographic film study.)

What also emerged from the focus groups was that most young people lacked the basic skills required to cook meals. One person said that “we just go to the chippy a lot, or sometimes we have a kebab”.

In one group several young people commented that they ‘don’t even know how to use the cooker’. On the other hand, another group described how some officers from the local police force would come into the hostel and cook them a meal (see footnote page 19) . This proved to be a highlight of the week for the young people and the respect and trust particularly for the local Community Support Officer who had initiated the scheme was both genuine and well meant. The hostel had many longer term residents, many of whom were known as young offenders and it was surprising that such barriers of resentment against the police had been broken down.

It was clear that some basic life skills such as cooking, managing – and food shopping – on a budget were still an issue for some young people living in hostels. Whilst, some provision had clearly already been delivered in this area, it was equally clear that some extra support in this area – either from workers or through a model of peer support/mentoring – could have a positive impact on young people’s health. Figure 7 (next page) shows some of the diet and exercise patterns of young people participating in the surveys.

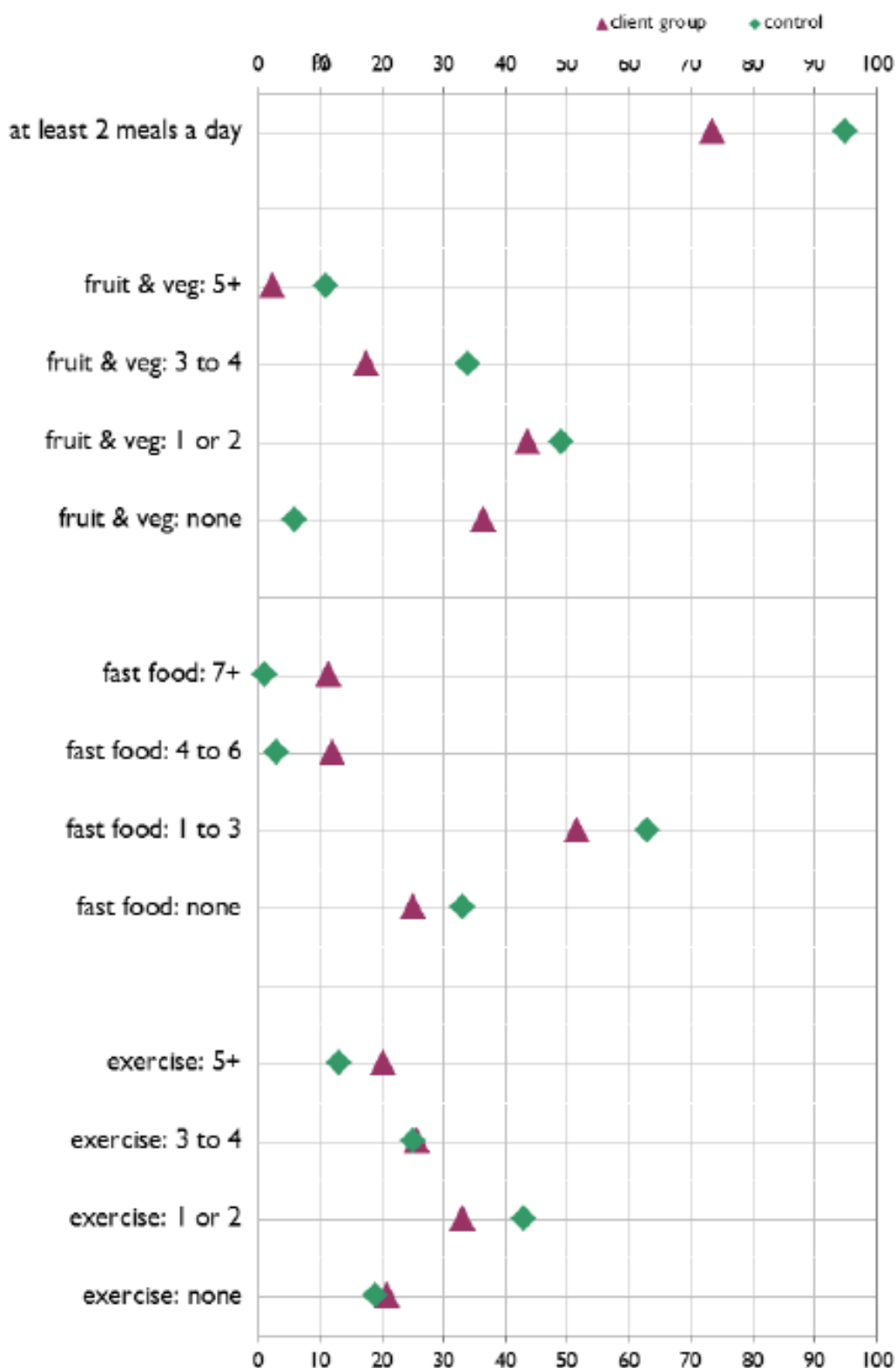
Exercise

With regard to exercise, responses to the survey indicate that there is little difference between homeless young people and the wider population of young people. There were a slightly higher proportion of homeless young people exercising five or more times a week.

However, this was not particularly evident in the focus groups and interviews. Many young people bemoaned the lack of facilities and activities related to physical exercise. Several young people cited access to a local gym as something which they would like to be provided with through a health programme and which was unavailable to them at the moment either due to a lack of access or financial constraints.

"I would go to the gym if I could afford it but everyone seems to be looking at you and I feel really useless at stuff like that" (Female, NW).

Figure 7 Patterns of diet & exercise



SMOKING, DRINKING AND SUBSTANCE MISUSE

Smoking

Smoking cigarettes was highly prevalent amongst the homeless young people, who were significantly more likely to smoke than the general population of young people. Almost two-thirds of homeless young people smoke every day (64%) whilst just 19% have never smoked. This compares to equivalent figures of 5% (smoke every day) and 74% (never smoked) amongst the general population of young people.

“I smoke, probably a 10 packet of cigarettes a day, probably more cannabis.”
(Male, London, Ethnographic study)

This disparity is supported by national research, with the 2009 survey of smoking, drinking and drug use amongst young people in England (2009⁸) finding that just 6% of 11 to 15 year olds smoked regularly. Whilst this is a slightly younger age group, the findings concur with our own. Data for 16 to 25 year olds from the Homeless Link Health Needs Audit (2009/10)⁵ shows a similar pattern with 74% of respondents reported that they were smokers.

As well as being more likely to smoke, those young people who do smoke are more likely to smoke more often if they are homeless. Homeless young people who smoked, on average smoked 63 cigarettes a week (9 a day) compared to an average of 28 cigarettes per week (just over 3 a day) for those young people who smoke but are not homeless.

The higher frequency and level of smoking amongst homeless young people has implications relating to poorer health and economic disadvantage. Assuming an average cost of £3 for a pack of 10 cigarettes (in UK, November 2011) the average smoking habit of around two-thirds of homeless young people costs around £21 per week. One exchange about smoking with a young girl during a focus group in the North East went as follows:

Girl: I've really cut down, I've had this packet of tabs [cigarettes] since Saturday [until Weds] and I've got one left so I'll get another packet (of 20) and that'll last me until next Saturday.

Interviewer: So how much will that cost you a week then? About 15 or 20 pound?

Girl: About that, aye.

Interviewer: And how much [money] do you have to live on a week?

Girl: 53 quid

Interviewer: So that could be something like a third of all your money on fags?

Girl: (shrugs) Aye, suppose so.

8. Smoking, drinking and drug use among young people in England in 2009. Edited by Elizabeth Fuller and Marie Sanchez. A survey carried out for the NHS Information Centre by the National Centre for Social Research and the National Foundation for Educational Research. Full report available here: <http://www.ic.nhs.uk/pubs/sdd09fullreport> last accessed November 2011.

In this case, not untypical of other similar conversation in other focus groups, the young person was not shocked or fazed by the amount they spent on cigarettes, nor did they think they could spend the money in a better way. In discussions about 'the cost of being healthy' several young people had said things such as the cost of 'healthy food like fruit & veg is too expensive' or that they 'can't afford gym membership' despite spending a large proportion of their income on smoking.

In focus groups and interviews, young people did not consider smoking a health problem without prompting and even then did not consider it a high priority for health. Smoking was not considered a danger, more a "soother"; an accepted part of life. Young people explained this by saying that 'everyone smokes' and it was clear that this was a normalised behaviour. It also seemed that this was in keeping with the self-perceptions of some of the homeless young people as 'an outsider'. In interview one young female who had said that she would like to get involved in peer mentoring commented that,

"I wouldn't say nowt about smoking though cos I do it myself so I'd be a hypocrite. Me nanna's 70 & she's smoked all her life and there's nothing wrong with her."

When probed about whether she thought cigarettes were bad for your health. She commented that,

"Well 'they' say everything's bad for you don't they?"

This represented what many young people who participated in the qualitative element of the research felt, that whilst smoking was bad for you other things were more important or could have a worse effect on your health.

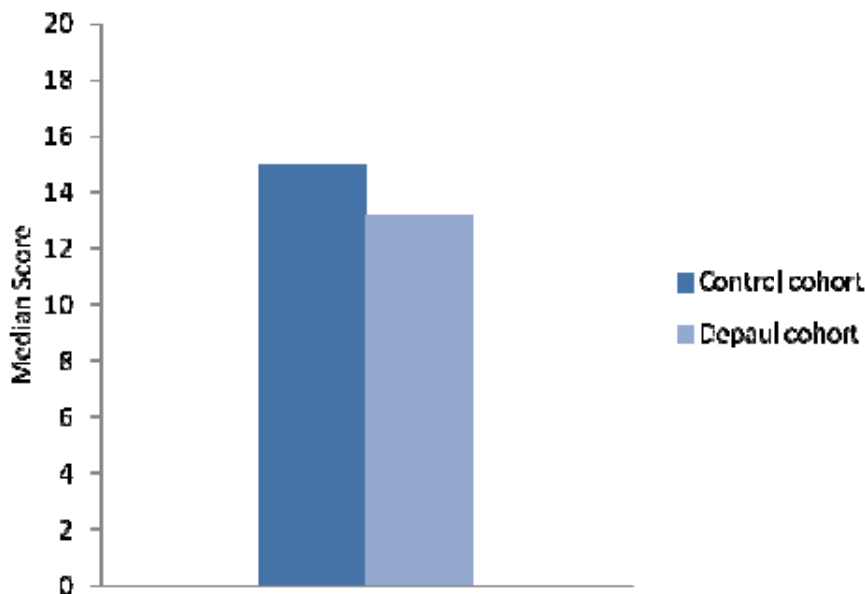
It was not the case that young people lacked information on the negative effects on health of smoking. Indeed when asked in interviews about information and advertising campaigns about health issues, almost all young people mentioned smoking first. For example when asked to recall advertising campaigns that they may you may have seen, heard or read about being healthier one young girl responded,

"...horrible pictures on your tabs (cigarettes), that advertise about passive smoking when the bairns are about."

As well as reinforcing their self-perceptions of being a bit of an 'outsider', smoking was also a source of enjoyment, something which relieved the boredom and helped them to socialize with other young people, particularly for those living in hostels. These issues are the ones which need addressing to support young people to give up smoking.

Drinking

Age at drinking onset was significantly lower for homeless young people than for the general population of young people. The average age of first alcoholic drink for homeless young people was 13 years 2 months, compared to 14 years 6 months for other young people.



Interviews with young people reveal that parental attitudes towards alcohol consumption and misuse are an important and influential factor in young people's drinking patterns. One young girl casually remarked that,

“I started drinking when I was little with my Mom, she used to give me some cider to help me sleep”.

Consumption of alcohol was higher for homeless young people than for other young people, particularly at the higher end of consumption. Half of the homeless young people had been drunk in the last four weeks (50%) an average of 3.7 times. This compared to 42% of other young people, drunk an average of 2.8 times in the last four weeks. The proportions of young people who drank alcohol every day were also higher (6.3%) among the homeless than for other young people (3.7%).

Substance misuse

Levels of illegal drug use were significantly higher for homeless young people (38%) compared to other young people (7% of the control group). This is also borne out in comparison to national statistics on drug use by young people.

The most common illegal drug use was cannabis (48%) followed by cocaine (19%). This concurs with data from Homeless Link's Health Audit which also found that cannabis (36%) and cocaine (9%) were the drugs most commonly used by 16 to 25 year olds, although estimated the prevalence at slightly lower levels. These figures are in comparison with the control group where only 6% of respondents reported using cannabis and 1% using cocaine.

“Um I had my first drink at eight years old and I was actually eleven years old when I had my first spliff.” (Male, NW, Ethnographic study)

In interviews young people demonstrated that they did not make any link between their lifestyle – in this case substance misuse – and how it might affect the rest of their lives, including their physical and mental health. It became apparent that regular (daily) use of cannabis was the norm and widely accepted as the drug of choice for many of the young people interviewed. Indeed, cannabis use was often referred to in relation to the positive effects it had; “it gets us through the day”.

Whilst many of the young people at least talked about wanting to quit smoking, there was no direct ambition or apparent energy to desist from the use of cannabis. What was said was that the smoking and drug use “relieved boredom” and “was cheaper than getting drunk”. Cannabis was both readily available and seen as comparatively harmless and cheaper than beer by the young people. Others commented that it “makes me calm not aggressive” or that it “helps with my art.”

It also reinforces the culture of resistance and an outsider mentality discussed previously for smoking. Whilst this may put the young people at risk from legal repercussions or gang bullying it does also give an identity and friendships.

The negative side effects on motivation and ability to adhere to any reasonable timetable or work based structure were also identifiable in the conversations. Staff interviewed also identified substance abuse as exacerbating the inability to manage whole lives effectively. In their experiences, many of the young people they had worked with had grown up in environments where substance abuse is ‘natural’ or endemic therefore did not recognise it as a possible concern. When asked about support for stopping their use of illegal drugs, few wanted this or thought it necessary. In the survey three-quarters of young homeless people (**75%**) stated that they did not need any support with regards to their drug use and only **13%** wanted help, or were already getting some help but wanted more.

USE OF HEALTHCARE SERVICES

Emergency Services

The homeless young people surveyed were significantly more likely to access emergency services than their peers in the non-homeless population. They were more than twice as likely to use walk-in-clinics (**46%** compared to **22%**); more than twice as likely to have visited A&E in the last twelve months (**37%** compared with **14%**); they were eight times more likely to have used an ambulance (**24%** compared with **3%**); and more than four times as likely to have been admitted to hospital (**27%** compared with **6%**).

These findings are supported by data from Homeless Link's Health Audit⁵ which found equivalent figures of 39% for using A&E, 18% for using the ambulance service and 25% who have been admitted to hospital.

Reasons for using ambulance, A&E or hospital admittance

Those who had used A&E, hospital or an ambulance in the last 12 months were asked to indicate the main reason for using those services. The responses are collated in Figure 8 (below). Most commonly A&E, hospital or ambulance were used due to a violent incident or assault, or due to an accident.

Figure 8 A&E, hospital or ambulance services used 5 or more times in the last 12 months (%)

| Reason | n |
|--------------------------------|----|
| violent incident or assault | 15 |
| accident | 15 |
| breathing problems/chest pains | 12 |
| stomach pain | 12 |
| self-harm | 8 |
| relating to mental health | 7 |
| relating to alcohol use | 6 |
| relating to drug use | 4 |
| seizure/fitting | 2 |

One young person explained the visits she had made to hospital,

“When I was fifteen I was in hospital ‘cos I had to get my stomach pumped after I drank a bottle of vodka, one of those 75cl bottles. Second time was for a motorcycle accident, nearly lost my leg so was in hospital for a while that time. Felt comfortable ...scary at first but once people started talking to us I knew what was going on and felt OK”.

Given the high usage of emergency and flexible services, it is perhaps unsurprising that significantly less homeless young people are registered with a GP than other young people. Eight-out-of-ten homeless young people are registered with a GP (80%), compared with 92% from the general population of the same age. This finding was almost identical to that of Homeless Link's 2009/10 Health Audit⁵ which found that 82% of 16 to 25 year olds who were homeless were registered with a GP.

For those homeless young people who were not registered with a GP the reason given was most commonly because they only moved to the area recently (67% of those not registered with a GP). Very few (less than 3) young people were not registered with a GP because they did not know how to, where to or had tried and been refused.

Staff working to help young people register with GPs said that this could be difficult due to background, house moves, temporary addresses and chaotic lifestyles which leads to missing records or being 'lost in the system'.

In line with the high usage of emergency services, responses to the survey, shown in Figure 10, show that homeless young people who are registered with a GP are also more likely to have seen their GP in the last 12 months (87% compared to 75%) compared to other young people of a similar age, indicating their high health needs. Around one-in-ten homeless young people also accesses a homeless health or no fixed abode (NFA) service. Some homeless young people also commented that a walk-in clinic or hospital was 'somewhere to go if you've got nowhere to go'. The implication here was that a clinic / hospital was somewhere warm and dry to spend some time and might get some attention.

Figure 9 Healthcare services used in the last 12 months (%)

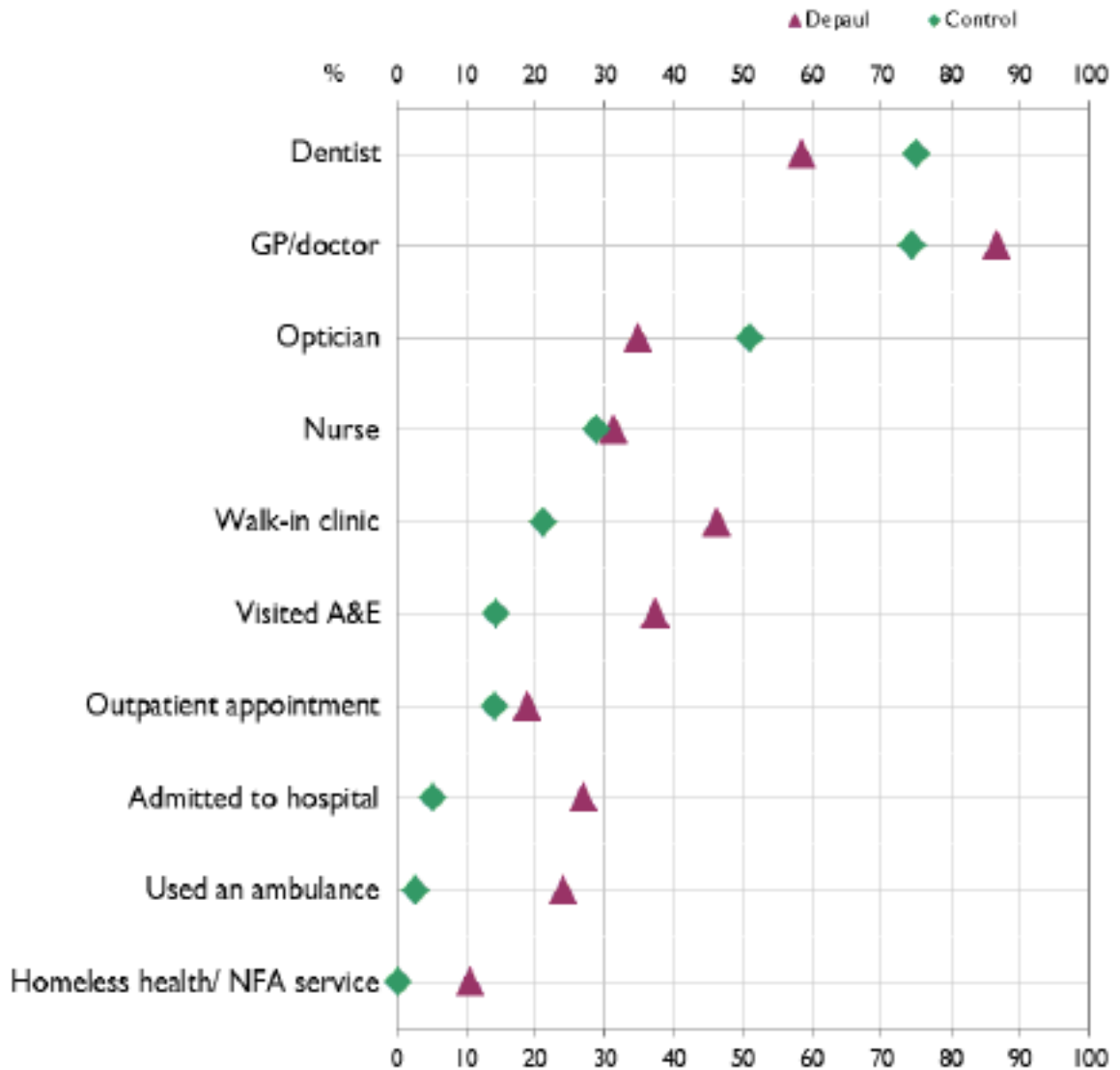


Figure 9 (previous page) shows that far fewer homeless young people access health services which may require payment such as opticians and dentists, when compared to other young people. It is also evident that as well as a higher proportion of homeless young people accessing services, they also have higher frequency rates, and this is true for almost all services. Figure 10 (below) shows the percentage of respondents who used health services five or more times in the last 12 months.

Figure 10 Healthcare services used 5 or more times in the last 12 months (%)

| Service | Depaul Group | Control Group |
|------------------------------|--------------|---------------|
| GP/doctor | 38.1 | 14.8 |
| Nurse | 8.6 | 0.9 |
| Visited A&E | 3.7 | 0.3 |
| Walk-in clinic | 3.7 | 0.5 |
| Dentist | 3.6 | 0.7 |
| Optician | 2.8 | 0.0 |
| Used an ambulance | 1.9 | 0.3 |
| Outpatient appointment | 1.0 | 1.8 |
| Homeless health/ NFA service | 1.0 | 0.0 |
| Admitted to hospital | 1.0 | 0.3 |

Prescription medication

All respondents were asked whether they were currently on any prescription medication (e.g. anti-depressants, tablets for epilepsy, inhaler for asthma). Similar proportions of homeless young people and the control group reported being on prescribed medication: around a third (**34%** and **32%** respectively). However, an issue highlighted by both the Depaul UK staff, and the homeless young people is the difficulty adhering to courses of medication. Reasons suggested for non-adherence were chaotic lifestyles as well as motivational issues. A limited understanding of medical conditions was also suggested by the qualitative research.

“Since I’ve actually had to take medication I think I’ve taken one course of tablets which was four weeks. I took that course, I felt absolutely fine after that, but I stopped taking my tablets and I think that it’s actually opened back up again which is why I need to go to the hospital again to get more tablets to close my heart up.” (Male, London, Ethnographic study).

It was suggested by staff as well as the young people that sometimes the very short GP appointment times contributed to homeless young people not taking medication, or not being adequately diagnosed, as they did not have adequate time to feel comfortable enough to open up and discuss their problems.

“The doctors had been telling us I was depressed, stuff like that, but obviously, they’ve given us tablets before, and, I’ve never taken them when they’ve given us them. I didn’t feel at the time that I needed to take them; I didn’t feel like I was depressed. I think sometimes I think that’s just the easy way for them to deal with somebody that is upset and asking for help.”
(Female, NE, Ethnographic study)

Women’s health services

For females responding to the survey the proportion that had accessed women’s health services for a cervical smear (14%) or for a breast examination (8%) were exactly the same for both groups. This may reflect the fact that the homeless young people taking part in the survey were already receiving a service from Depaul UK and staff encourage take up of these services. A young woman in Newcastle commented that, ***“staff here are really nice and take me to my appointments.”***

Accessing Healthcare Information

Very few of the young people had either noticed or taken any action from posters or advertising campaigns. The campaigns which could be recalled were around smoking cessation or the ‘five-a-day’ fruit and vegetable healthy eating promotion. It was apparent that on the whole the young people Depaul UK are working with do not read posters or leaflets unless someone goes through it with them.

There was a very mixed response to using the internet to access information or support for health services. Some young people described this as the first thing they would do if they wanted to find out any information: ‘just Google it!’ However, others were less convinced about the level of access homeless young people would have and whether or not you could trust the information you got back. One young person commented on the usefulness of using the internet to access information:

“...depends if you’ve got access at home or not. Won’t reach every one. Have used it before but didn’t give me that much information so I had to phone up as well and ask them. Loads of writing [on websites] & I just get bored of looking at writing so don’t really ...obviously you get information but get bored of reading a load of paragraphs.”

Depaul UK staff felt that whilst factual and educational information on many health-care issues is widely available, it does not produce inability to promote true engagement with or a lasting impact with health issues.

BARRIERS TO ACCESSING SERVICES

Waiting times

A common experience of the homeless young people seeking help for their mental health was having to wait a significant time in order to see a counsellor or mental health specialist. Both staff and the young people themselves recognised in the qualitative research that by the time the young people admit they need help it is normally because they are at crisis point, and so need help immediately.

“Two years for a psychologist to get back to us...It took about four to five months to get referred to an alcohol service for my drinking.” (DPUK Female Client, peer Interview)

Young people are not aware of the possible length of the waiting list, and may be unprepared to wait for help, leading to them self medicating in order to cope. It is this waiting period that staff also struggle to support.

“With mental health for instance, you can get a young person to say that they’re going to start accessing the service... you’ve got the hurdle of trying to get a diagnosis in the first place which can be really hard, then they get it and because they’re transient, because they’re bouncing around hostels and then they have workers who haven’t got enough information and then you’ve health services that won’t stay with them, they bounce them and bounce them and bounce and then they get worse again because there’s no follow through” (Depaul UK Staff member)

“I think it’s more how quick they can access the services... that’s when they start to disengage, cause they think, well what’s the point in going there, cause all you’ve done is refer me to somewhere that I can’t go for the next four weeks. And then something else happens in between.” (Depaul UK Staff member)

Attending appointments

Relevant factors raised by young people in interviews and focus groups (in relation to the higher access levels of flexible provision) related to homeless young people’s difficulty in keeping appointments.

“I do try and make an appointment but I always end up missing them. I keep forgetting about them or I won’t come in the night before.” (Male, London, Ethnographic study).

In some cases this was due to practical factors – such as lack of access/money for transport – but mainly was about a lack of motivation and organisational skills. Both staff and young people felt that the structure of the health system does not allow for appointment flexibility which is needed in the lives of young homeless people.

“I have to keep going up to the doctors every week to go and pick up a new prescription and it just seems very long to me, a lot of money wasted, jumping on the buses, it’s a lot of money, £2.20 now.” (Male, London, Ethnographic study).

A significant few of the young people did not feel listened to or taken seriously when they had reported health issues so they did not persist. Appointments systems seemed to them to be lengthy, off putting and if relying on the written word (form filling) extremely daunting. Several young people related negative experiences when seeking help with regards to mental health problems. One young man in London said that,

“Sometimes I hear voices telling me to do things but when I told my Mum she got me put in care and I had to see doctors so now I keep things to myself more.”

Interactions with professionals

There were mixed reports of interactions with healthcare professionals. In the experience of the young people interviewed by their peers, some GPs could be judgemental and did not always provide the support and compassion required in order for the young person to feel that they could be open.

“Quite patronising, the doctor, when I was trying to explain how I felt...I was trying to explain that I didn’t get on with the counsellor, and she just really didn’t understand.” (DPUK Female Client, peer Interview).

Some young people felt that some counsellors were condescending and others appeared to be clock watching. The experience of having to repeat one’s story due to changing GP or counsellor was felt to be a negative one, and one that deterred young people from accessing services.

“One of our young people, when she decided yes I’m going to go for counselling, she saw three different people, every time she went back there was a different somebody to assess her so she had to go through all her painful story again and then she said I’m not doing it any more and she just walked out.” (Depaul UK Staff member)

In the staff research there was also a perception that relationships and access to GPs was much more problematic for homeless young people than for other young people, namely because of a lack of empathy towards young homeless people’s poor communications skills and complex histories. Some young people felt that GPs had never helped them in the past, which deterred them from seeking help.

“Once they go back to the doctors having taken probably all their anti-depressants in one go and there’s none left, then they’ll tell the bloke “you shouldn’t have taken that all in one go” and re-prescribed, or if they’re not working and they say “oh it’s cause I’ve been drinking”, then they just get wronged for drinking because the anti-depressants don’t work. So they don’t feel like anyone’s exploring it with them, it’s just they’re getting told what they should and shouldn’t do and just sent off again.” (Depaul UK Staff member).

Other young people were far more positive about their interaction with their GP. Some GPs in particular were talked about in glowing terms as being “brilliant” or that “my doc always gives me a hug” One young person commented that she liked her GP because

“She listens to me and I can trust her, I can tell her (my G.P.) anything and I have known her years.”

“Dead friendly, help you and everything, know how to treat you when you need help.”

This was not the case for all young people. One young woman remained suspicious when her new GP was very talkative and friendly,

“...she asked me loads questions and seemed to be really interested but then at the end she gave me a form to fill in on how well she had treated me! That made me very suspicious that she had only done it to get good marks!”

GP Survey

An online GP community survey involving 750 GPs was carried out as part of the research done by the Insight Research Group. The GPs surveyed identified mental health issues and substance misuse as the main health issues for the young homeless population. Poor nutrition and physical health problems featured also, but were felt to be more minor.

Overall the GPs who responded reported that they did not find treating ‘the young and homeless’ satisfying because they can be difficult to engage, hard to treat, require more counselling rather than medical attention. It was a shared feeling that young homeless people can have a “do not fit with the system” attitude (i.e. they want healthcare on their own terms), which results in a lack of empathy from the healthcare professionals. However, some of the GPs did report having empathy for, and understanding of the chaotic nature of the homeless people’s lives, i.e. poor family backgrounds, transient nature and lack of stability.

Moving from paediatric to adult services

An issue identified by staff as creating difficulties for homeless young people in accessing healthcare was the breakdown when young people move from paediatric to adult services. This was problematic for several reasons. Continuity of care and of practitioners was seen as one of the success factors in homeless young people persisting with treatment or medication, or having the confidence to seek help when needed. Having to repeat stories to a new healthcare professional was described as being traumatic and a reason that young people would choose not to access services. Having to wait for services due to switching to adult services was seen as damaging for young people who had been consistently receiving treatment from paediatric services.

“When I was moving from one house to another, I just started getting settled down to one doctors and then having to switch to another straight away to get used to another one, it was a bit confusing cos I was only little, so I didn’t really understand why.” (Female, NE, Ethnographic study)

Emotional and motivational

As discussed in the earlier section addressing Motivation and Aspirations, both staff and the expert advisory group felt strongly that homeless young people often lack motivation to access care. This was illustrated by the young people in the interviews, focus groups and peer research. In many cases, despite knowing that health care was available, and even knowing how to access it, young people appear to be unmotivated to do so. A number of different reasons were felt to be behind this, including a lack of confidence, very low self-esteem, previous negative experiences, and often a lack of guidance during their childhood.

Often young people lack the confidence to access a new, unfamiliar service, and need encouragement to do so, or need to be accompanied the first time that they attend. It is difficult however for frontline staff to travel with young people to appointments due to other work commitments (eg staff are often lone working). Homeless young people often have very low self-esteem or low feelings of self worth, which affect the likelihood that they will seek help, sometimes feeling that they are not worth it, or that no one will listen to them.

The chaotic lifestyles that homeless young people have, particularly due to heavy cannabis use, or a lack of routine mean that they often end up missing appointments. Their budget priorities may also mean that they lack the funds to travel to appointments. Young homeless people have often had chaotic upbringings, and may not have had the adequate parenting to equip them with the knowledge about when and how to access services.

Having to access a wide range of services for their health issues (eg, alcohol and drug services, mental health services, sexual health services etc) means not only a high number of appointments, but also having to repeat often painful stories to unfamiliar professionals. This factor was reported to be a high deterrent in the motivation of young homeless people to accessing services.

As discussed in previous sections, young people have often had negative experiences when accessing services, such as staff or professionals in those services addressing their issues with sensitivity, or allocating enough time to explore problems. This also affects the confidence of young people to access services and to resolve health issues.

“It took two years to be referred....I just can’t be bothered to chase things up anymore.” (Female, Peer research.)

HOW CAN WE IMPROVE THE HEALTH OF YOUNG HOMELESS PEOPLE?

SUGGESTIONS FROM YOUNG PEOPLE & DEPAUL UK STAFF

The following list of suggestions to improve the health of young homeless people is compiled from the different interviews, focus groups and meetings that took place as part of this research project, and so incorporates the views of young people, staff, experts and researchers. It is not an exhaustive list but a selection of the most frequently mentioned ideas for interventions.

Peer support and mentoring

It is clear from the research that there is an opportunity to mobilise the young people supported by Depaul UK as a resource for positive change. Whilst staff time is already stretched in a very challenging environment in the youth sector as a whole, the young people in accommodation or accessing other services provided by Depaul UK, generally, have time on their hands. Almost without exception young people taking part in interviews and focus groups were supportive of a peer mentoring scheme for supporting young people.

“I’d like to be a bit more useful really and help others by going into schools and talking to the kids about how easy it is to get kicked out and be on the streets.”

As part of its Comic Relief funded mental health project in the NE, Depaul UK is setting up a peer support group for young people with mental health needs, and it would be beneficial to make such opportunities available to more young homeless people.

Activities

Young people were very keen to do things - structured activities with a purpose. Whilst many young people acknowledged a lack of motivation within themselves and their peers, they were nonetheless keen to participate in activities provided they were accessible, relevant and – most importantly – linked in some way to supporting routes into employment. Giving young people new experiences, expanding their horizons and helping them to develop positive aspirations for the future would be of undoubted benefit. Activities that have worked so far and have had a positive impact on the health of Depaul UK clients include Depaul UK’s sports project in the NE and it’s writing group for young people with mental health needs (Write Yersel Well), accredited education qualifications, cookery classes, writing groups, and therapies addressing emotional needs, such as art therapy.

“It would be good if we had more stuff to do and visits, I have only ever been outside of Newcastle once on a school residential, never been abroad or had a holiday.”

Schools’ homelessness prevention programme

A preventive programme could be set up to try and prevent or reduce young people becoming homeless. This would be a generic intervention but would undoubtedly have a positive impact on physical and mental health outcomes. A schools programme could consist of: young people going into schools to share their stories; working with the school on producing material that is directly relevant and informative to local needs and resources; setting up with the school links to local crisis and housing support signposting services; establishing an early warning system for likely breakdowns that can be addressed by talking and supportive interventions; providing conciliation and family mediation at point of contact via the school referral process.

The provision of good prevention signposting and support would reduce the incidence of crisis breakdowns with all the accompanying psychological mental health and irreconcilable family conflicts that magnify over time and circumstance. As one young person commented:

“I remember our form teacher going on about homeless people but I thought that was like tramps”. (Female, London, Focus Group.)

Depaul UK currently provides family mediation and schools work in some areas, and there is clearly the potential for this to be upscaled in order to widen its reach.

Access to healthcare

It was apparent in the research that there were many real or perceived barriers to successfully accessing healthcare. Several suggestions were given to improve the access that young homeless people have to healthcare services, including: providing flexible health appointments and services for homeless young people; developing relationships between homeless services and healthcare services including awareness raising for healthcare professionals in the needs of the young homeless population; providing support for young homeless people to access services, including developing the communication skills necessary to describe their health needs; creating direct pathways for young homeless people to access the healthcare they need, particularly in the mental health sector; bridging the gap between paediatric and adult services for example by enabling continuity of staff.

Education, skills training & empowering: Providing opportunities for training can have a hugely positive effect upon mental health. Training can help young people to access education and employment and increase their life skills, whilst raising self-esteem and confidence. Training could include skills training for healthy relationships e.g. with partners / families and healthcare professionals; as well as apprenticeships and accredited training programmes.

Training in mental health issues and support for frontline staff

The research with staff highlighted the key role they have in supporting homeless young people with mental health issues, either before they admit they need help, or whilst waiting to access help. Whilst Depaul UK staff receive some training (CBT, Mental Health First Aid), it was felt that additional training could help support their key role. Some suggestions for this included: reflective practice which allows up-front training on mental health issues, and ongoing support so that skills are practiced, developed and maintained (the Psychologically Informed Environment model was recommended as one such appropriate model); simple interactive online training modules on the signs and symptoms of mental health issues; simple strategies that anyone can teach from helping young people with naming emotions to making simple suggestions for change.

Next Steps

Depaul UK and AstraZeneca are evaluating the suggestions to see which are possible to take forward into sustainable, effective health interventions for homeless young people. We anticipate that the intervention/s will be available in the second half of 2012.

ACKNOWLEDGEMENTS

Independent Steering Group

The problems faced by young homeless people in accessing health services are widely recognised and we are grateful for the thoughtful and passionate expert contributions of many organisations to this project. In particular we would like to thank the members of the independent steering group which led this work:

Una Barry, MBE – Depaul UK – Chair

Martin Gibbs – Department of Health

Dr Hannah Maiden – Royal College
of GPs Health Inequalities
Standing Group

Helen Keats – Department for
Communities and Local
Government

Michelle McPake – Centrepont

Nick Maguire – University of
Southampton

Chris Walker – Young Minds

Helen Mathie – Homeless Link

Ellie Lewis – National Children’s
Bureau

Kathleen Kelly – Joseph Rowntree
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Lucie Russell – Young Minds

Charles Fraser – St Mungo’s

Natasha Gregory – Young Health
Ambassador Programme

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Howard Pemble – HM Young Offenders
Institute Rochester

Rebekah Pope – Camden PCT

Jane Freeman – Depaul UK Mental
Health Resource Worker

Annie Crowley – Depaul UK

Alison Williams – AstraZeneca

Nicole Lambie – AstraZeneca

James Munday – AstraZeneca

Paul Tomlinson – AstraZeneca

Jeremy Fazal – AstraZeneca

Depaul UK young people and staff

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Research and communications agencies

Thank you to the agencies who carried out the different pieces of research, and upon whose reports this full report is based:

Community Research Company <http://www.community-research.co.uk/>

Naked Eye: <http://nakedeyeresearch.co.uk/>

Insight Research Group: <http://www.insightrg.com/>

Contributors to the research analysis and report writing:

Omega Scientific: <http://www.omegascientific.co.uk/>

The Open Road: <http://www.theopen-road.com/>

Department of Psychology, University of Southampton

APPENDICES

Appendix 1 – Focus Group Schedule

A total of 8 focus groups were held as per the schedule below. As the clients at the Women@theWell project are older than 25 the information was not summarised with the other data for this report, and has been analysed and written up separately (contact annie.crowley@depauluk.org for more details).

| Date (2011) | Location | Project/group | Attendees |
|----------------------------|------------------------------|---|--------------------|
| 20 th June | London - IRG offices | Staff from Depaul UK London projects | 3 female, 2 male |
| 22 nd June | Stockport - Aspect offices | Staff from Depaul UK NW projects | 3 female, 3 male |
| 23 rd June | Copthorne Hotel, Newcastle | Staff from Depaul UK NE projects | 4 female, 3 male |
| 6 th August | Resource Centre, Whitley Bay | Attendees from Drive Ahead & Creative Writing Group | 7 female; 1 male |
| 14 th September | Willesden Hostel, London | Accommodation project | 6 female; 1 male |
| 26 th September | Kings Cross, London | Women @ the Well (older age group) | 10 female |
| 28 th September | Resource Centre, Whitley Bay | Young parents | 4 female |
| 29 th September | Aldo House, Bradford | Accommodation project | 7 male 2 female |

Appendix 2 - Questionnaire – Control Group

Dubit Limited is a partner research organisation of the Community Research Company UK who specialise in the youth research market, with a particular focus on online research. Dubit Limited maintains a database of around 37,000 young people who have registered their details and agreed to be contacted about participating in research. Young people are recruited through social media (e.g. Facebook), viral marketing and via word of mouth. The company was originally set up by young people in response to organisations regularly asking them to take part in research but feeling that they gained little from doing so. In return for agreeing to be contacted about research, young people are rewarded for their participation. For example, completion of a questionnaire will be rewarded by £2, taking part in an online focus group might be rewarded by £10.

The system used by Dubit Limited has the strong advantages of being able to turn-around large quantitative surveys in a short space of time at low cost. These were key factors in using this approach for the control survey for this research project, something which was not included in the original scope of the research brief. The limitations of this approach are that the sample may be biased towards those young people with online access and that participants may be affected by their regular participation in different research projects.

For the purposes of this project, and this report, the control group is assumed to be broadly representative of young people aged 17 to 25 years old and to provide a useful comparator of the context of findings from the Depaul UK client group.

Appendix 3 - Ethnographic Film Descriptions

Film 1 - Kerry

- Used to live in a hostel – film revisits it and shows how improvements have been made
- When Kerry first moved in, her mum visited and asked her to move back home, but arguments with her mum had caused unhappiness all round
- Kerry stood up to her mum & defended her choice. Although she was upset to see her mum go, she knew it was the right thing for her.
- Hostel staff supported her to be strong. Advise her to see the night through. The hostel was noisy and scary to Kerry but she knew it was right.
- Kerry thought that if she went back home she would “go back to same old place.” There would always be another argument – she would not make progress
- She made friends at the hostel and felt optimistic – saw a new life without needing to return home where her family relationships decline into fighting
- Kerry has an enlarged liver and spleen, pains in her legs and stomach. She is troubled walking long distances & climbing lots of stairs.
- Kerry has bouts of severe fatigue; she takes painkillers every day on top of her other medication.
- Kerry has also been diagnosed with depression partly caused by her physical condition.
- Kerry has been prescribed anti-depressants but feels they are not the way to deal with someone who’s unhappy and is seeking help / support.
- Kerry has often been prescribed anti-depressants but has never taken them.
- She is on means tested benefits due to condition, but a medical examination declared fit for work so she had to appeal the decision.
- She won, but it was difficult because the doctors can’t clearly pin point what is going on in her body. She didn’t want people thinking she was faking.
- Always wanted to have one home and a career; her goal has never been to live on benefits.
- Now has her own flat, loves knowing it’s hers and she has her independence.
- But, a neighbour complained that she was making a nuisance (noise nuisance).
- Kerry received a letter (written in legalese) informing her that her tenancy would be withdrawn due to noise nuisance.
- Kerry was oblivious to noise – she was quiet and often out of the house – but the letter scared her.
- Her care worker visited the housing office with her – this elicited a significant shift of attitude once they saw that Kerry was supported by a professional from within the public services.
- Kerry works hard and stays positive – learns from her experiences

Film 2 - Daryl

- Daryl sleeps rough, is scared of animals at night and has often been intimidated and beaten up by gangs
- Feels the police did not want to know
- Ended up on the streets because the relationship with his parents broke down.
- He smoked from young age and sold drugs. His familial relationships became increasingly violent when he reached 13–14 years resulting to him being kicked out
- Daryl moved into hostel but felt very alone
- His main meal each day is something from the fried chicken shop
- He still smokes, but typically more cannabis than cigarettes
- Faced sexual health worries after sleeping with three girls in one week. Was tested for sexually transmitted diseases and got the all clear.
- Receives some family support from his grandparents, but does not like to involve other people in his problems
- Depaul gives him access to a phone so he can phone the job centre and Social Security, sort out his benefits and job seeker's allowance. Daryl feels this can a frustrating process as it can be difficult to get through to the right people.
- Found out he had a hole in his heart when he was 13-14 years old. This scared him but he does not take regular medication.
- He experiences debilitating pain every couple of weeks and often self-medicates with pain killers, ignorant of the appropriate doses. He lacks the necessary language to speak properly about his condition (e.g. thinks the hole has 'opened up again').
- Daryl struggles to keep hospital appointments - perhaps because of lack of routine, forgetfulness, fear of finding out something he does not want to hear.
- His girlfriend keeps him on the straight and narrow and is encouraging him to make and keep appointments.
- Daryl tries to budget his money and uses a shopping list to help the process. His food purchases are budget driven with limited awareness of diet and nutrition.

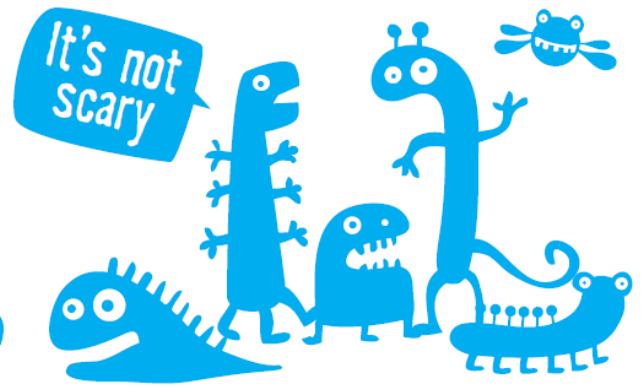
Film 3 - Paul

- Experience pains in his head when he feels “wound up”. These pains would calm down when he expressed his anger and hurt someone (e.g. he once threw someone through a window)
- Knew his violent behaviour was not right and would try to walk away, but sometimes he just could not help himself. He would often scare himself.
- When he found out about anger management and strategies for coping with his aggressive feelings he engaged with the process for help
- He is very close to his girlfriend and she helps make him feel more positive about life and keeps him calm
- Grew up with brothers and sisters and moved to Manchester when he was two-years-old. He started drinking young and first used cannabis when he was eleven
- Admits he is addicted to skunk, but believes he can control the addiction
- He is currently at a Depaul hostel and finds his time with his key worker very helpful. Key worker is the only adult outside of family that he trusts. She listens to him and gives him good advice
- His key worker explains that she offers advice on employment, education, housing, budgeting, signposting to counselling, drug and alcohol and anger management services. She believes education could turn Paul’s life around and help him to look at the world differently
- Paul and his girlfriend are trying for a child. They hope to be in their own flat by the time the baby arrives. His key worker suggests he focuses on sorting himself out and takes some more time before having a child, but he is committed to starting a family.

Film 4 - Debbie

- Her mum and dad divorced when she was two-years old
- Her mum did not have much support and seldom had money for rent. They kept being evicted and never had a permanent home. The longest time she spent in one house was five years, but every week she was there she expected to be evicted.
- Seldom had enough food, or gas or electricity to cook whatever food they did have
- Lived in two shelters with her mum and sister for a year
- Debbie attended eight different schools because of the amount of moves and was sometimes bullied at school
- One home was set on fire, she thinks because of a grudge against her mum. Her mum used to create tension, which led to Debbie and her sister being bullied
- Her mum and her sister fought a lot so her sister no longer lives at home. Debbie feels it is her responsibility to build bridges and help everyone to get along
- Her sister was diagnosed with depression a year ago and Debbie takes it upon herself to visit her to help her get up in the mornings, encourage her to be sociable and to motivate her. This puts strain on Debbie.
- When her mum and sister used to argue, she felt the only way she could deal with things was by self-harming. She would nip her skin with her nails and scratch it until it bled
- She eventually moved out and moved in with her sister. Living with her sister did not work and Debbie felt upset not to be living with her mum any longer
- Debbie found a room and home through the Depaul Supported Loggings project (where people offer spare rooms to young homeless people as a stepping-stone to independent living). She no longer feels upset and pressured and has stopped self harming
- Since having the support of Depaul UK, Debbie has become more confident and her support worker helps with emotional counselling and making sure she gets the benefits she is entitled to.
- Since getting back in touch with her dad two years ago, they have grown very close and he offers her real support.
- Has asthma and had to switch between doctors whenever she had to move. She never got used to her doctor and medication before she would have to change to another. She now has a doctor she is happy with and would not change anything about her current asthma management.
- Wants to work with disabled children and have a family of her own so she can provide them with the supportive, stable environment that she missed out on as a child.

Health Questionnaire



This questionnaire asks you questions about things which affect your health.

We are asking you these questions to try and work out how Depaul UK (and other similar charities/organisations) can improve the services they provide to young people who are homeless.

*The answers you give here will be completely anonymous and will **NOT** be traced back to you.*

Depaul UK asked the Community Research Company to design this questionnaire and analyse the findings. The individual answers you give will not be shared with anyone else and the questionnaires will be destroyed after the project has been completed. AstraZeneca (a company that makes medicines) is also working with Depaul to design and collate this research.



If any of the questions in this survey have raised questions or worries about your health, or the health of someone you know, please discuss this with your key worker or another member of staff at Depaul UK.

The questionnaire should take around 20 minutes to complete. Your support worker will assist you to complete it. You can miss out any questions you don't want to answer and you can stop answering questions at any point.

Client worker details

Date: (DD/MM/YYYY) _____

Name of staff member / volunteer: _____

Project: _____

Location: _____

About you

First we'd like to know a little bit about you to make sure that we are capturing the views of all the groups of people Depaul UK work with.



Are you: Male Female How old are you now? Put number in box

When were you born? (DD/MM/YYYY) _____

Where were you born? _____

Do you consider yourself to have a disability?

YES NO

If YES, please indicate the type of disability:

Mobility Learning disability Mental disability

Sensory impairment (e.g. sight or hearing problem) Developmental disability

Long term condition Other (please state)

At the moment are you in:

Education Training Employment None of these

Are you currently on a conditional discharge community order, bail or suspended sentence?

YES NO

About you cont.

Have you left prison or remand in the last 12 months?

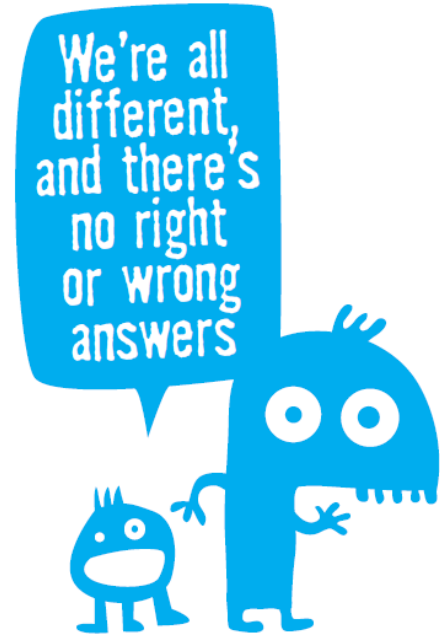
YES NO

Have you left Care Services in last 12 months?

YES NO

In the last 12 months have you moved any of the following...

| | No | Yes | If yes, number of times... |
|----------------|--------------------------|--------------------------|----------------------------|
| Where you live | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| School/college | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| Local area | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |



How would you describe where you are currently sleeping? (if this changes frequently, please say where you slept last night)

| | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Sleeping rough on streets/parks | <input type="checkbox"/> Hostel | <input type="checkbox"/> Nightstop Scheme |
| <input type="checkbox"/> Second stage or supported accommodation | <input type="checkbox"/> Squatting | <input type="checkbox"/> Own tenancy |
| <input type="checkbox"/> Sleeping on somebody's sofa/floor | <input type="checkbox"/> Nightshelter | |

Other – please specify _____

How would you describe your ethnicity?

| White | Mixed | Asian | Black | Other |
|--------------------------------------|--|--------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Irish | <input type="checkbox"/> White & Asian | <input type="checkbox"/> Bangladeshi | <input type="checkbox"/> Black African | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> British | <input type="checkbox"/> White & Black African | <input type="checkbox"/> Pakistani | <input type="checkbox"/> Black Caribbean | <input type="checkbox"/> Other |
| <input type="checkbox"/> Other white | <input type="checkbox"/> White & Black Carribean | <input type="checkbox"/> Indian | <input type="checkbox"/> Other Black | |
| | <input type="checkbox"/> Other mixed | <input type="checkbox"/> Other Asian | | |

Approximately, how long have you been involved with Depaul, if applicable?
(approximate length of time in months and years)

Your Physical Health

1. On average, do you eat at least two meals a day?

If this is difficult, please think about the meals you ate yesterday.

YES

NO

2. How many pieces of fruit and vegetables do you usually eat per day? If this is difficult to answer think about what you ate yesterday. For small fruit or veg (e.g. peas or grapes) a handful counts as one.

None

1 or 2

3 to 4

5 +

3. On average, how many times do you eat fast food in a week? (e.g. McDonalds, KFC, Pizza, chip shop) If this is difficult to answer think about what you ate last week.

None

1 to 3

4 to 6

7 +

4. On average, how many times do you exercise in a week? (e.g. play sport, swim, cycle, dance for at least 30minutes each time) If this is difficult to answer think about what exercise you did last week.

None

1 or 2

3 to 4

5 +

5. Do you experience any of the following health problems?

| | YES, in last 12 months | YES, for more than 12 months | NO, never |
|---|--------------------------|------------------------------|--------------------------|
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain/other breathing problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint aches/problems with bones and muscles | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty seeing/eye problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin/wound infection or problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Problems with feet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/blackouts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Urinary problems/infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Circulation problems/blood clots | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental/teeth problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood borne diseases | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Immune system disorders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually Transmitted Infections (STIs) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other...

Your Wellbeing

6. For this question, we would like you to imagine a ladder.

The top of the ladder '10' is very happy and the bottom '0' is very unhappy.

In general, where on the ladder do you feel you stand at the moment?

Write the number in this box:

7. For the list below please indicated how you feel on a scale from 0 to 10 (where '0'=very unhappy, to '10'=very happy). If any of the options do not apply to you just put 'n/a' in the box.

- about the place you live in
- with your friends
- with your family
- about the groups of people you belong to
- about getting on with the people you know
- about how you enjoy yourself
- about the things you have (your possessions)
- with your health
- about doing things away from where you live
- with the things you want to be good at
- about communicating with people
- about the amount of freedom you have
- about how safe you feel
- about the amount of choice you have in life
- about how you spend your time
- about what may happen to you later on in your life
- about the school/college that you go to
- with your local area
- with your confidence
- about your school/college work
- with your appearance

Remember
to put NA
in a box if
it doesn't
apply to you



Your Mental Health

8. The following questions are about mental health.

Please tick the relevant box to show your response.

| | No, not at all | On some days | On more than half the days | Nearly every day |
|--|--------------------------|--------------------------|----------------------------|--------------------------|
| Have you found little pleasure or interest in doing things? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you found yourself feeling down, depressed or hopeless? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had trouble falling or staying asleep, or sleeping too much? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been feeling tired or had little energy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a poor appetite or been overeating? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you felt that you're a failure or let yourself or your family down? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had some trouble concentrating on things like reading the paper or watching TV? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been moving or speaking slowly, or very fidgety, so that other people could notice? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you thought that you'd be better off dead or hurting yourself in some way? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

YES NO Don't know

9. Do you have a mental health need or condition which has been diagnosed by a doctor or other health profession?

If you answer 'NO' please GO TO QUESTION 14

YES NO Don't know

10a. If you answered yes to the last question (Q9), do you know what your mental health condition is called?

Depression Schizophrenia Bipolar disorder Post-traumatic stress disorder
 Dual diagnosis with drug or alcohol problem Obsessive Compulsive Disorder (OCD)
 Attention Deficit and Hyperactivity Disorder (ADHD) Borderline/ personality disorder
 Asperger's Other mental health condition (please state)

10b. If you answered yes to the last question (Q10a) how long have you experienced it for?

Just in the last 12 months For more than 12 months Don't know/can't remember

11. Do you get support with your mental health, e.g. from Depaul workers, a medic or support service?

yes, and it meets my needs yes, but I'd still like more help no, but it would help me no, I don't need any support

Your Mental Health cont.

12. We would like to know about the type of support that helps you and/or that you would like.
Please tick boxes in both columns where relevant.

| | Helps me now | Would like |
|---|--------------------------|--------------------------|
| Talking to others – friends and family | <input type="checkbox"/> | <input type="checkbox"/> |
| Talking to others – key worker/support worker/mentor | <input type="checkbox"/> | <input type="checkbox"/> |
| Talking therapies (eg counselling, psychological therapies) | <input type="checkbox"/> | <input type="checkbox"/> |
| A specialist mental health worker (eg Community Mental Health team) | <input type="checkbox"/> | <input type="checkbox"/> |
| Services to address my dual diagnosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Activities to do like arts, volunteering or sport | <input type="checkbox"/> | <input type="checkbox"/> |
| Practical support to help me with my day to day life | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |

13. Do you use illegal drugs or alcohol to help you cope with your mental health?
This is sometimes called 'self-medicating'.

YES NO



Drinking alcohol

The next questions are about drinking alcohol. Remember that your name is not on the questionnaire, so no one will know it was you that gave these answers.

14. How old were you when you had your first proper alcoholic drink?

Write in the box your age then, in numbers not words.

15. How often do you usually have an alcoholic drink?

- | | | |
|--|---|--|
| <input type="checkbox"/> Every day or almost every day | <input type="checkbox"/> About twice a week | <input type="checkbox"/> About once a week |
| <input type="checkbox"/> About once a fortnight | <input type="checkbox"/> About once a month | <input type="checkbox"/> Only a few times a year |
| <input type="checkbox"/> I never drink alcohol now | | |

16. During the last 7 days how much of the following drinks have you drunk? Please write the number of the types of drinks you have had.



Beer, lager or cider
Number of pints?



Wine, Martini and Sherry
Number of glasses?



Alcopops
(e.g. Reef, WKD)
Number of bottles?



Spirits and Liqueurs
Number of shots?

17. Have you been drunk in the last 4 weeks? YES NO

18. (If yes) How many times have you been drunk in the last 4 weeks?

Write the number in box.

Smoking cigarettes

The next questions are about smoking cigarettes.

19. Which of the following statements best describes you (tick one box only):

- | | |
|--|--|
| <input type="checkbox"/> I have never smoked | <input type="checkbox"/> I used to smoke sometimes but I never smoke now |
| <input type="checkbox"/> I smoke every day | <input type="checkbox"/> I smoke every week but not every day |

20. If you do smoke, please write in the box how many cigarettes you smoke in an average week. Write the number in box.

Nice one,
only a few
pages left
to do!



Illegal drugs

The next questions are about drugs (apart from cigarettes and alcohol). Remember that your name is not on the questionnaire, so no one will know it was you that gave these answers.

21. Do you take any illegal drugs? If NO, go to QUESTION 26.

YES

NO

22. If you answered yes to the last question, in the last month, have you used any of the following (please tick all that apply):

Heroin

Crack

Cocaine

Cannabis/weed

Amphetamines/speed

Ecstasy

benzodiazepines/ benzos

prescription drugs

Other drugs (please state) _____

23. Do you get support to help you with your drug use?

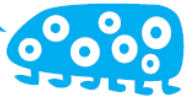
YES, and it meets my needs

YES, but I'd still like more help

NO, but it would help me

NO, I don't need any support

All your answers
are anonymous!



24. We would like to know about how the support you get now helps you with your drug use and what support which you would like:

Helps me to better control my drug use

Would like

Helps me to reduce my drug use

Helps me to use drugs more safely

Helps me to stop using drugs

Helps me to better control my drug use

Other

Sexual health

25. Have you had a sexual health check in the past 12 months?

YES

NO

26. Have you had unprotected sex in the past 12 months?

YES, once

YES, more than once

NO

27. FEMALE CLIENTS ONLY Have you had access to the following women's health services?

Cervical smear:

YES

NO

Breast examination:

YES

NO

Access to Health Services

28. Are you currently registered with a GP/health centre in this area? YES NO

29. If you are not registered with a GP/health centre in this area, please tell us why? (tick all that apply)

- Only moved to the area very recently
 Not had time
 Don't see any need to register
 Can't be bothered
 Didn't know how to register
 Didn't know where to register
 Tried to register and was refused

Other reason (please state)

30. Are you currently on any prescription medication? YES NO
 (for example, anti-depressants, tablets for epilepsy, inhaler for asthma)

If YES, do you know what the medication is called?

Please write the name(s) in the box.

If YES, do you know what the medication is for?

Please write in the box.

31. Which of these services have you used in the past 12 months? Please tick the box which corresponds to the number of times used.

| | Not used | 1- 2 times | 3-5 times | 5 or more times |
|------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| GP/doctor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dentist | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Optician | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nurse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walk-in clinic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Outpatient appointment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Homeless health/ NFA service | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Visited A&E | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Used an ambulance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Admitted to hospital | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Access to Health Services cont.

32. If you have used ANY of A&E, HOSPITAL or AMBULANCE in the last 12 months, please could you indicate below the main reason (tick all that apply, if you have used these more than once, please write the number of times in the box)

- Violent incident or assault
- Accident
- Breathing problems/chest pains
- Seizure/fitting
- Stomach pain
- Relating to mental health
- Self-harm
- Relating to drug use
- Relating to alcohol use



33. Is there anything else you would like to tell us about your health and the support you do receive or would like?

Thank you!

Yeah, thanks so much.
Your help on this will
help improve services!



Thank you for taking the time to complete this questionnaire. **NONE** of the answers you have given will be traced back to you but they **WILL** help Depaul to improve the support it provides. If any of the questions in this survey have raised questions or worries about your health, or the health of someone you know, please discuss this with your key worker or another member of staff at Depaul UK.

Prize Draw!

There will be a prize draw for everyone who completes a questionnaire with the following prizes: 1st £100; 2nd £75; 3rd £50. If you would like to enter the prize draw just tell us your name and contact details below.

Join our group discussions - receive a £20 high street voucher.

We are also planning to carry out some short interviews and group discussions with young people. Interviews will probably last around half an hour and group discussions no more than an hour and a half. As a thank you, those people who take part will be given a **GUARANTEED £20 high street voucher** which can be spent almost anywhere!

We will contact a selection of young people for interviews shortly.

FREE £20
voucher?
Yup, it's all
yours if you
want one.



If you **DO NOT** wish to be contacted about group discussions please tick this box:

Name: _____

Date of birth: _____

Email : _____

Phone number: _____

Contact Address _____

Post code: _____

This page (with your name contact details on it) will be separated from your answers to the survey, so your answers will remain completely anonymous.

**For more information on this report,
contact Annie Crowley:
Annie.Crowley@depauluk.org**

**Registered Charity No.802384 Company No. 2440093 (England and Wales)
Depaul UK is part of Depaul International, a group of charities working to
support homeless and marginalised people around the world.**