APPENDIX 5

Chapter 1 Young People's Supported Housing Service (Kingsley House)

Profile.

This service provides supported housing to 16-25 year olds who have been homeless or at risk of homelessness. The service offers a range of accommodation to best suit the skills & circumstances of the individual. These comprise of hostel places, rooms in shared housing & studio flats, totalling 67 bed spaces. The service also manages 5 transition houses in the private rented sector with a further 26 bed spaces. Our aim is to promote healthy, well balanced independent living.

One of the primary roles of this service is to prevent the need for entry into adult services. Where we are successful the savings to local spending can be significant.

Overall we find that in terms of general healthcare the provision in the city for our client group is available & of good quality. At Kingsley House we have a good relationship with our local surgery and have examples of them going above & beyond to accommodate the needs of our tenants.

In general we find that access to providers offering specialist services such as mental health, substance misuse, sexual health, health trainer guidance, smoking cessation, dentistry, emotional support (inc. self harm, anger management) etc. are accessible, although there may be a waiting list.

Main Issues.

The main areas where we fail to find an appropriate co-ordinated response are with clients with more complex issues (see case study- Martin). This young man failed to 'fit' the criteria for mental health services as his psychoses are drug induced, and arguably self- inflicted. He also fails to 'fit' into drug programmes because his drug use is sporadic & variable in terms of substances used. The frustration for us as a service is that without specialist support this client won't be stabilised. His self harming is significant, disturbing & sometimes public. We have been unable to keep housing him because of his impact on staff & other tenants. He has been referred to an adult service, where the issues will continue if not worsen. Martin is not his real name, but I could give several real names for whom this story is accurate.

Another difficulty we have is getting the right support for those with a border-line learning disability, particularly when they also display high risk behaviours. The service is an unsafe environment for this group- they are often at risk of violence & exploitation from other clients. We have experienced sexual &, more regularly, financial abuse of these clients. In our safeguarding review of the past year- half of the 13 serious safeguarding logs we have been running involve a client with border line LD (half also care leavers, interestingly). If the client has been assessed to have an IQ score of 70 or less, a diagnosis of LD can be made & the client qualifies for specialist support. Ours sit at or just above 70, so do not qualify & come into mainstream provision. My team are trained to give tenancy support, as per our commission, and are not specialised to support these clients. EVERY client in this

group has failed to hold a healthy tenancy, even if this highly supported environment, and has been at higher risk of harm from being placed here.

Barriers.

The barriers for these groups of young people are that they don't fit into the criteria of services best placed to support them. Our service would have more success in housing these groups if additional specialist support was available where needed.

Another barrier is that my team are not specialists, and the service doesn't have the finance to pay for specialist staff. Our commission is tenancy support.

The complex, dual & poly-diagnosis clients will usually have been involved with services previously. As these services are so stretched- and the client may have missed many booked appointments- they, quite fairly, will insist that the client comes to them. It is our experience that this group is unable to commit to attending appointments. Even when we are resolved to take them, we have to find them first and usually their chaotic lifestyles have taken them elsewhere. We have no power to stop young people coming & going at will- nor would we want it.

A significant issue for us as a voluntary sector service is being taken seriously by, and achieve good engagement with, the statutory services our complex clients need support from. It is incredibly frustrating to work with the borderline LD clients, who may have been assessed as able to decision make- when the decisions they do make are dangerous & irresponsible. We know that we cannot keep these clients safe, nor will we prevent them from entering adult services.

For clients generally, limited income leads to lack of good diet. Many live on packets of noodles & microwave meals. The service does teach cooking, nutrition & budgeting skills, but young people rarely prioritise diet- and never consider future health issues as a result of poor diet now. At this service we do not provide meals.

Cannabis use is prevalent among our client group. Other drugs are used, but mostly the use is experimental & short lived. We have strict rules around cannabis use & work closely with the police, but cannabis use is 'normalised' within the family groups & communities around our clients, so they rarely take our messages seriously. Those with more serious drug use will always fail in their tenancies as they will not prioritise rent payment.

Successes.

There have been a couple of occasions where our commissioner has stepped in to open a pathway to the LD service for us and two clients have been placed into specialist LD housing. Neither client has come back into the service which would indicate successful placement.

Access to general health care is strong for our client group.

We are successful in promoting healthy independence with a large proportion of the young people we house- those without complex needs.

Solutions?

Widen the criteria for existing statutory services? This would potentially close the gaps that complex clients fall through, but with these services already stretched this could only impact the quality of provision unless more funding were made available.

Create new services for these groups? A very costly exercise.

Invest in more training for existing housing support services? I would suggest that the supported housing environment would no longer prove a suitable place for young people without these issues if services specialised.

Utilise current housing stock differently to create more specialist housing? This would prevent the more vulnerable, at risk clients from entering mainstream services, allowing these services to do what they were designed to do- tenancy support. With strong partnership work with the necessary providers it would be possible to create safer, appropriately supportive environments for these groups.

Stronger partnership work between existing providers? This is essential regardless of any other solution. The gap between voluntary & statutory services is still too wide. When a provider who spends hours each day observing behaviours from a client then reports issues to other services, this needs to be taken seriously and assessed.

Change the rules around ineligible service charges so that more complex clients can at least secure their housing while they are supported to address their issues? This may go some way to addressing the 'revolving door' issue of clients being evicted due to non-payment of rent, but having nowhere else to go. These clients will come back through the service again & again, accumulating debt and a history of evictions, making future secure housing difficult. These people *will* go into adult services because private landlords are understandably risk averse with this group.

Wider context.

Please see the attached report. This study was undertaken in 1997 but the conclusions ring true today. There are significantly higher instances of mental health issues & drug use among homeless young people as opposed to young people who are provided with a safe and consistent home life.

Young people not getting appropriate care & support can bring long term health issues into adulthood which will significantly impact the economy in the future.

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A comparison of homeless and domiciled young people

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Abstract

There is growing concern about the welfare of the substantial number of young people who are homeless in the UK. A sample of young people living in homeless hostels in Birmingham is compared with one derived from a private household survey carried out in the same city. Sociodemographic details along with information on mental health, substance use and service uptake were ascertained. The homeless sample were younger and more likely to be male than their domiciled counterparts. They had more often spent time in institutional child care and had worse educational records and lower levels of employment. Young people who were homeless had greater involvement with the police, more frequently used illicit drugs and reported worse physical and mental health than those in private households. They were equally likely to see a general practitioner and more often consulted for 'nerves' as well as having a higher rate of contact with mental health professionals. The bearing these findings have on how to tackle youth homelessness are discussed.

Introduction

The report of the national enquiry into preventing youth homelessness estimated that almost a quarter of a million young people became homeless in the UK during 1995 (Evans, 1996). The reasons proposed to explain this high level of youth homelessness have predominantly stressed structural antecedents and highlighted the need for better access to accommodation, improved opportunities for employment and enhanced social security benefits (Harvey, 1999). Shortcomings in these areas leave young people vulnerable to becoming homeless when they have to move out of their childhood homes (Smith *et al.*, 1998). However, while not denying their impact, it is difficult to ignore the reality that many young people exposed to these factors do not become homeless. This lends support to the argument that personal characteristics make a significant contribution to the risk profile for youth homelessness.

Smith & colleagues (1998) reported that two thirds of the young homeless people they interviewed came from 'disrupted' families and ended up homeless because of conflict with their parents, often in the context of abuse. For the remaining third, from 'non-disrupted' families, their own behaviour was most likely to be the trigger for them having to leave home. These results are echoed by Craig & Hodson (1998) who found that both childhood adversity (69%) and childhood conduct disorder (43%) were more prevalent

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in homeless compared to domiciled young people. They also identified significant associations between early adversity and later mental illness and between conduct disorder and subsequent substance misuse. High rates of both mental illness and substance misuse have been consistently reported in populations of young people who are homeless (Blaire & Wrate, 1997; Sleegers *et al.*, 1998). However, the pathways by which these and other individual factors mediate the experience of homelessness remain uncertain. The aim of the present study is to compare young people who are homeless with those living in private households in Birmingham, UK in order to explore the role of personal characteristics in youth homelessness. The findings should inform the debate about how best to help this disadvantaged section of the population (Evans, 1996).

Methods

Sample

A domiciled sample of people aged 16–25 years was obtained from a random sample of west Birmingham residents registered with a general practitioner (GP) drawn from a database held by the Family Health Service Authority. West Birmingham is consistently ranked in the top ten most deprived health districts in England (Smith *et al.*, 1996). The sample forms part of a wider study examining psychiatric morbidity rates and service utilisation in this catchment area (Commander *et al.*, 1997). Permission was sought from all GPs with potentially eligible patients to access their practice lists and to invite people to participate in the study. All the subjects identified were contacted by letter and subsequently approached for interview. The survey was completed between December 1994 and May 1995.

The homeless sample consists of people aged between 16–25 years drawn from homeless hostels in Birmingham accepting people within this age range. Twelve hostels were eligible to take part and of these 10 agreed to participate. Two hostels were specifically for men, six for women and two mixed gender. Four hostels confined themselves solely to people aged under 25 years. People in the hostels on a designated census day and all those subsequently using these facilities during the following 5 months were eligible for inclusion. The study took place between June and October 1997.

In both surveys subjects were interviewed in their accommodation by trained researchers. Each subject completed a written consent form prior to proceeding with a semi-structured interview. All completed interviews were reviewed by a senior member of the research team. A payment of £10 was made to each subject who participated.

Measures

The survey of the domiciled population in west Birmingham was completed before the homeless survey was conceived and limited the range of factors available for comparison. Where possible, identical items were included in the homeless survey. Sociodemographic details and information regarding the use of services were elicited.

Mental health was assessed using the UK version of the 5-item mental health dimension of the SF-36 (MHI-5; McCabe *et al.*, 1996). This instrument is short and easily administered. It consists of five questions rated on a six point scale from none to all of the time (item score 1–6); How much of the time during the past month have you (1) been a very nervous person? (2) felt down in the dumps that nothing could cheer you up? (3) felt calm and peaceful? (4) felt down hearted and low? (5) been a happy person? This

inventory gives a total score ranging from 5–30 and raw scores can be transformed onto a scale of 0–100, higher scores indicating better health. In addition, subjects were asked the question; Have you taken an overdose or attempted in any other way to deliberately self harm (DSH) in the past 6 months?

General health was examined using items from the UK version of the SF-36 (Jenkinson *et al.*, 1993). Two questions were asked; (1) In general would you say your health is: poor, fair, good, very good or excellent? (2) Compared to one year ago how would you rate your general health now: much worse, somewhat worse, about the same, somewhat better or much better? In addition, a question from the List of Threatening Experiences was utilised (Brugha *et al., 1985*); Have you suffered from a serious illness, injury or assault in the past 6 months?

Alcohol use was assessed by a general question asking whether the person drank alcohol and subsequently by the CAGE (King, 1985). The latter instrument requires the following four questions to be answered yes or no; (1) Have you felt that you ought to cut down on your drinking? (2) Have people annoyed you by criticising your drinking? (3) Have you felt bad or guilty about your drinking? (4) Have you had a drink first thing in the morning to steady your nerves or get rid of a hangover? The conventional threshold of two or more affirmative replies was used to distinguish a case from non-case. Drug use was assessed using the checklist criteria from SCID/DSM IIIR (Spitzer *et al.*, 1992) with the exception that 'heroin' and 'other opiates' were merged into one group.

Analyses

The characteristics of homeless and domiciled young people were compared. The data were analysed using SPSS (1993). Levels of significance were determined using χ^2 where appropriate. The *t*-test for independent samples and analysis of variance were used to compare the MHI-5 scores.

Results

Response

In the homeless sample, 70/119 (59%) young homeless people agreed to be interviewed. The response rate did not differ significantly for men (43/72, 60%) and women (27/47, 57%). In the domiciled sample 111/147 (76%) people who were contacted agreed to participate. The response rate did not differ significantly by gender (47/68, 69% men and 64/79, 81% women) but was greater overall for the domiciled than the homeless sample (p<0.01). Of those in the homeless sample, 36/70 (51%) had been homeless (defined as the time they were last resident in a private household for 6 months or more) for more than 6 months and 38/69 (55%) had a history of sleeping rough.

Comparison of homeless and domiciled young people

A higher proportion of the homeless sample were male and aged 16–17 years compared to the domiciled sample (see Table 1). The latter included a higher percentage of young people self-identified as Asian whereas the homeless sample included more people within the 'other' ethnic group. A similarly high proportion in both domiciled and homeless samples were born outside Birmingham. A quarter of the young people who were homeless compared with none of those in private households had spent time in institutional child care. They were also less likely to identify someone whom they 'felt particularly close to and could turn to and share their troubles'. Young homeless subjects had more often left full time education before the age of

Table 1: Sociodemographic details (%)

	Domiciled		Homeless		
	n	(%)	*n*	(%)	
Gender: Male	47/111	(42)	43/70	(61)	p=0.01
Age16–17 years	7/111	(6)	26/70	(37)	p<0.0001
Ethnicity					p=0.000
Asian	44/111	(40)	11/70	(16)	
Black	13/111	(12)	11/70	(16)	
White	50/111	(45)	36/70	(51)	
Other	4/111	(4)	12/70	(17)	
Born in Birmingham	76/111	(69)	40/70	(57)	*NS*
Time spent in local authority care	0/111	(0)	18/66	(27)	p<0.0001
Identify person they are close to	107/111	(96)	60/69	(87)	p=0.02
Left full time education < 16 yrs	12/111	(11)	23/69	(33)	p=0.0002
Any qualifications	79/111	(72)	33/68	(49)	p=0.002
Work in past week	54/111	(49)	5/67	(7)	p<0.0001

16 years, were less likely to have any qualifications and far less likely to be in work than their domiciled counterparts. They had also more often been charged by the police in the past six months (13/70 (19%) v. 3/111 (3%); p=0.0003).

Young people who were homeless were significantly more likely than their domiciled counterparts to have used illicit drugs during the previous 6 months (with the exception of ecstasy and solvents) as well as using two or more drugs and injecting (see Table 2). A higher proportion reported drinking alcohol although the level of problematic alcohol use, determined by the CAGE, did not differ significantly between the two groups. Homeless subjects had more often deliberately harmed themselves during the past 6 months and experienced a serious illness, injury or assault. They also reported worse general and mental health (see Table 2).

Although permanent registration with a GP was lower than for the domiciled sample (who were all necessarily registered), young people who were homeless had a similar level of contact with a GP in the previous 6 months and were more likely to have seen their GP for 'nerves' during this time (see Table 3). They also had greater involvement with mental health professionals both during their lifetime (including in-patient care) and in the past 6 months.

Discussion

Methodological issues

The definition of homelessness is fraught with difficulty (Sleegers *et al.*, 1998). The sample in this study is restricted to people using homeless hostels and is likely to reflect a marginalised group of young people who have exhausted other avenues of support. The hostels included represent those identified by key local agencies but other establishments, especially smaller privately run facilities, may have been omitted. The generalisability of the hostel sample to other sections of the homeless population including the 'hidden homeless' and people sleeping rough is uncertain. Also, in both surveys, but especially the homeless, the refusal rate was not inconsiderable and encourages cau-

Table 2: Health details (%)

	Domiciled		Homeless		
	n	(%)	*n*	(%)	
Drugs used in past 6 months					
Cannabis	16/111	(14)	36/66	(55)	$p<0.0001$
Amphetamines	5/111	(5)	10/66	(15)	$p=0.01$
Opiates	1/111	(1)	9/66	(14)	$p=0.0004$
Ecstasy	4/111	(4)	7/66	(11)	*NS*
Cocaine	0/111	(0)	6/66	(9)	$p=0.01$
Hallucinogens	3/111	(3)	3/66	(5)	$p=0.04$
Solvents	0/111	(0)	0/66	(0)	-
Any drug use	17/111	(15)	38/66	(58)	$p<0.0001$
Using two or more drugs	8/111	(7)	18/66	(27)	$p=0.0003$
Injecting drugs	0/111	(0)	6/66	(9)	$p=0.00$
Alcohol in past 6 mths	51/111	(46)	56/69	(81)	$p=0.0006$
CAGE caseness	4/92	(4)	8/65	(12)	*NS*
Deliberate self-harm in past 6 mths	1/111	(1)	8/70	(11)	$p=0.002$
Serious illness, injury or assault in the past 6 mths	12/111	(11)	34/70	(49)	$p<0.0001$
General health fair to poor	11/96	(11)	20/69	(29)	$p=0.004$
Health worse than 1yr ago	13/95	(14)	17/68	(25)	*NS*
	mean (SD)	*n*	mean (SD)	*n*	
MHI-5 transformed score *	72 (19)	95	61 (19)	65	$p<0.0001$

* Blaire & Wrate, 1997; mean 60, SD 19.

tion in interpreting our results. The conceptual problem defining mental illness represents a further hurdle to be overcome in undertaking research in this area. In contrast to Craig & Hodson (1998), no attempt was made to generate clinically meaningful diagnoses in this study. There are doubts about the performance of screening instruments developed in other populations. The homeless condition itself may lead to ratings that are not necessarily indicative of underlying pathology but may reflect demoralisation or unhappiness (Sleegers *et al.*, 1998). There is evidence to support the reliability and validity of the MHI-5 in homeless populations (Wood *et al.*, 1997). Less confidence can be placed in the CAGE (King, 1985) but comparative data from the domiciled sample dictated that this measure be used. Likewise in order to retain comparability, the checklist items for drug use in SCID (Spitzer *et al.*, 1992) were utilised even though it was not feasible to complete the full SCID substance use section in the homeless sample.

There are limitations to the use of a private household survey for comparison, especially as in this study it was not obtained with that purpose in mind. The young people in the west Birmingham sample were not asked if they had ever been homeless when this may have been the case for a substantial minority (Craig & Hodson, 1998). Also, had those living in private households become homeless they would not necessarily have been included in the homeless sample as many did not originate from the city. Likewise, almost half the homeless sample were born elsewhere. The distortions introduced into the analyses as a consequence are revealed in comparisons relating to ethnic group and

Table 3: Service use details (%)

	Domiciled		Homeless		
	n	(%)	*n*	(%)	
Permanent registration with GP	111/111	(100)	34/67	(51)	$p<0.0001$
Contact with a GP in last 6 months	85/111	(77)	44/69	(64)	NS
Seen GP for nerves in past 6 months	3/111	(3)	9/69	(13)	$p=0.007$
Ever been psychiatric in-patient	0/111	(0)	7/70	(10)	$p=0.0007$
Ever seen a mental health professional (*)	2/111	(2)	19/70	(27)	$p<0.0001$
Seen a mental health professional in the past 6 months	0/111	(0)	6/70	(9)	$p=0.002$

*= psychiatrist, psychologist or community psychiatric nurse

place of birth. The stark finding that almost half the young people who were homeless identified their ethnic group as 'non-white' is masked by the substantial proportion of people from ethnic minorities living in west Birmingham (14% black and 23% Asian, 1991 Census). When contrasted with the population of Birmingham as a whole (21% 'non-white', 1991 Census) it becomes transparent that young people from ethnic minorities are probably over represented in the homeless population. The greater likelihood of their being brought up in deprived areas with prominent overcrowding and high unemployment as well as their exposure to racism and discrimination have been tentatively proposed as reasons for this disparity (Julienne, 1998). More certainty can be attached to evidence regarding the unacceptability of much existing homeless provision to ethnic minorities and credence given to demands that specific attention be paid to interventions to tackle homelessness in this group (Davies & Lyle, 1996, Julienne, 1998). The similarly high proportion of homeless and domiciled young people who were born outside the city conceals the considerable mobility of the homeless sample almost half of whom did not originate from Birmingham. This too is important for service development as it suggests that strategies targeted on the city alone are likely to have only a partial impact unless combined with measures to address the problem countrywide.

Key findings

The homeless sample included a larger proportion of very young people, aged 16–17 years, than those living in private households. This may be an inevitable consequence of the fact that as they get older young people tend to exit homeless settings. It is also likely to reflect a period of high risk for becoming homeless. A breakdown in the relationship with one or both parents is the precipitant of homelessness in over two thirds of cases (Craig & Hodson, 1998, Smith *et al.*, 1998) and around a third of young homeless people have spent time in institutional child care settings (as compared to none of our domiciled sample). The development of family mediation services (Randall & Brown, 1999) and improvements in leaving care services (DoH, 1999) link into these early experiences and have been identified as offering potentially valuable contributions to preventing youth homelessness (Bruegel & Smith, 1999). Both antecedents are likely to result in lower levels of support being available to young people as they attempt the transition to adult life. Our finding that almost nine out of 10 young people who were homeless could

identify someone they could turn to for support was more optimistic than the 64% reported in a survey in Edinburgh (Blaire & Wrate, 1997). However, many of these relationships are likely to be with young people in similar circumstances (Randall & Brown, 1999). Such contacts may hinder moves away from homelessness as young people are understandably reluctant to disrupt fragile social networks. Loneliness has been repeatedly identified as a key factor undermining attempts at resettlement (Fitzpatrick *et al.*, 2000). Services are likely to be more effective if they intervene promptly when young people first become homeless and so avoid them drifting away from their local area and established friendships (Fitzpatrick, 1999). Young people who were homeless were far more likely than their residentially stable counterparts to have left school before the age of 16 years and were less likely to possess any qualifications. This is consistent with reports from previous UK studies (Blaire &Wrate, 1997; Craig & Hodson, 1998) and is corroborated by Breugel & Smith (1998) finding that over half the homeless young people in their sample had been excluded from school. Along with early aversive experiences at home, poor educational attainment provides a marker for people at high risk of becoming homeless (Craig & Hodson, 1998; Breugel & Smith, 1998) and should draw attention to the need for additional support, not least in school. Their weak academic performance also helps explain why less than one in 10 young homeless people were in work and underlines the importance of schemes to facilitate access to training and meaningful occupation (SEU, 1998).

The present study reinforces concerns regarding the well being of young people who are homeless (Blaire &Wrate, 1997; Craig & Hodson, 1998). When compared to the domiciled group, the homeless sample experienced worse general health including a greater likelihood of having suffered a serious illness, injury or assault within the previous six months. They scored lower on the MHI-5, had more commonly deliberately self harmed and reported more extensive illicit drug use, including polydrug use and injecting. Young people who were homeless were also more likely than their residentially stable counterparts to have been charged with an offence by the police during the previous 6 months. This may be at least partly accounted for by higher rates of conduct disorder (Craig & Hodson, 1998). It is not possible to unravel the temporal order of events in a cross sectional survey but Craig & Hodson (1998) found that mental health problems (mental illness, substance misuse and conduct disorder) predated the onset of homelessness in the majority of cases. This strengthens the argument for the early identification of those at risk and for prompt intervention to avert any corrosive impact on home life and schooling and subsequently support networks and employment. But what about the requirements of those young people who are presently homeless? Overall contact with GPs was comparable with our domiciled sample and consultations for 'nerves' higher in the young people who were homeless. The latter were also more likely to have had contact with a mental health professional and a significant minority had been in a psychiatric hospital. These findings contradict suggestions that young homeless people have difficulty negotiating their way around an unco-ordinated care system (Evans, 1996). The obstacle appears to be with the services provided rather than simply to do with access. The quality of services available to homeless people has often been poor and the attitude of service providers frequently negative (Fisher & Collins, 1993). Where dedicated and enthusiastic specialist psychiatric services have

been initiated they have proven unattractive to young people perhaps sensitive to the disparaging images associated with mental disorder (Blaire & Wrate, 1997). Agencies concerned with young people who are homeless should consider training their own staff to be better able to tackle common mental health problems and either develop 'in-house' services or close ties with other providers targeting young people in order to offer more specialist psychotherapeutic interventions (Commander *et al.,* 1998).

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Notes

This information is based on domiciled and homeless young people aged 16-25 like KH.

- This study was written in 2002 based on young homeless people. Evidence has come from 1995-1998. This shows a comparison of how much services have or have not changed between then and now.
- Although this has been sampled through West Birmingham it still gives a good representation on young people and mental health.
- Table 1: talks about age, ethnicity and gender. This gives statistics of those with mental health who were domiciled and homeless. This is a comparison of health between the two groups and how great the difference is or is not.
- Table 2: illustrates the health details of those who are domiciled or homeless and also gives statistical information. This table is based on those who consume have consumed. (like *Martin*)
- Table 3: Shows the type of contact or how frequent the contact is with the health services.

This shows that access to health services was not great in 1995-1998. Now in 2014 access for those with mental health and who are domiciled or homeless access to health services is not that much better.

Chapter 1 Case Study

Martin is a 21 year old male in supported hostel accommodation. He previously had lived in a more independent self contained flat. When he was originally assessed for housing Martin had few support needs. It was known that he had a previous drug addiction to an amphetamine but he hadn't used in the last month before the assessment date. He had also previously taken MDMA and smoked cannabis. In these circumstances Martin had not had professional support to stop his addiction; he had done this by himself with nothing but willpower. In his initial assessment, Martin disclosed that he used to self harm and had only on one occasion entered hospital for treatment of wounds. He had also disclosed trying to commit suicide by overdosing on sleeping medication on two different occasions. Martin had previous connections with the local mental health team and had been diagnosed with having a Borderline Personality Disorder and had been prescribed two different forms of medication one of which was an anti-psychotic drug and the other an anti-depressant.

Martin had previously coped in the self contained flat until he felt unable. At his first review he felt that he had not managed to budget well and had mostly spent his benefit money on drugs, amphetamines again. This lead him to neglect buying food and topping up his electricity and gas meters. Martin was often found sat in the dark with no electricity, heating or food. He was still taking medication for his mental health needs. The second review showed little to no improvement; Martin still struggled with budgeting for food and utilities and would spend his money mostly on drugs. Martin was no longer involved with the local community mental health team, so had not been taking his regular prescription. He disclosed that he was still regularly taking amphetamines, and was open to discussions of making contact with local drug services to help him with his addiction. When he lived in the self-contained flat he was in contact with an Early Intervention in Psychosis (EIP) team worker due to his drug use leading to drug induced psychosis. This psychosis had worsened and he eventually was admitted to stay in the local mental health unit. The stay lasted nearly a month, Martin's well being had improved greatly. He had a discussion with his worker within the project and his EIP worker and agreed to move into the more intensive support unit of the hostel accommodation.

About a month after moving into the hostel accommodation Martin showed signs of further deterioration and had been abusing his medication prescribed for his mental health and psychosis. He had asked a member of staff to look into entering a detox facility due to the effects of taking drugs. Martin often presented to staff in the reception area of the building stating that he had thought about self-harming, and a want to take morphine. He was receptive with having conversations with staff. There was an occasion where Martin presented with psychotic symptoms as previous, but this time they were more serious and worrying as he was threatening to self harm or possibly attempt suicide and had also made threats of harming other people. Emergency services were contacted and he was admitted to hospital and then admitted onto the mental health unit, but he was not sectioned. When Martin had left the unit and returned to the hostel, it was decided by management that due to the risks posed by Martin not only to himself but also to the other young people around him, that the project was no longer prepared to house him. A referral was made to adult services and he is to move on to accommodation provided by adult services.

Being in a hostel situation and in supported housing had a major effect of Martin's health and well-being as well as his stability in maintaining a tenancy. The housing and how it affected him mentally lead to an increase of drug use, meaning that he often had little to no money to feed himself and maintain utilities in his flat. Martin's drug use eventually lead to drug induced psychosis which affected his current mental health needs. This then lead to a further breakdown in his housing situation.