Patterns of Substance Use & Support Needs of Residents in Young People's Hostels & Foyer Accommodation in Liverpool: Final Report June 2010

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Acknowledgements

The authors would like to thank the following for their assistance with and participation in this research: the staff, representatives and residents of the hostels and foyers. Thanks to those who provided funding, advice and support: Comino Foundation (Dr Diana Burton & Stephanie May); Liverpool DAAT Addiction & Offender Health Commissioning (Susan O'Looney & Sue Neeley); Irene Buick at Liverpool City Council; Conrad Foote and Vivien Arnold at Young Addaction; and, Terence Whinnet.

The image for the front cover was provided by the Hollywood Homeless project, which was organised by Urban Strawberry Lunch with the assistance of the FAB Collective and funded by the Employable Communities Fund. The authors would like to thank Michelle Edgar and Liz Carlisle for contributing the image. If anyone would like more information about the front cover images, please contact Simon Russell (s.j.russell@ljmu.ac.uk) or the Urban Strawberry Lunch (usl@uslbunker.demon.co.uk).

Also, thanks to our colleagues at Centre for Public Health for their assistance with data collection, and proofing of this report: Geoff Bates, Layla English, Dave Seddon and Katrina Stredder.

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Vulnerable groups of young people include those who are homeless or living in temporary accommodation. Young people residing in temporary accommodation (i.e. hostels, bed and breakfasts or foyers), or who are sleeping rough, are often considered to be a homogenous group and their substance use patterns and support needs are generally not investigated discretely despite high levels of diversity. The aim of this research was to identify the patterns of substance use amongst those residing in young persons' hostels and foyer accommodation in Liverpool, and to explore explanations for these patterns and support needs in order to provide in depth understanding of the needs of this vulnerable group.

There are four hostels and one foyer that provide temporary accommodation for young people in Liverpool. In total, there is accommodation for 108 young people. During the fieldwork stage of this project (January and February 2010) 99 'beds' were occupied.

Methodology

Mixed-methods were employed using both quantitative and qualitative techniques; including a resident survey, resident focus groups and key stakeholder interviews.

The resident survey included items relating to: The respondent, their hostel/foyer residency, personal relationships, health, substance use (including tobacco, alcohol and drug use), contact with support services and perceptions regarding their accommodation. A response rate of 55.6% was achieved for the survey.

A residents' focus group was held approximately three weeks after completion of the survey data collection sessions in each hostel/foyer. The aim of the focus groups was to further explore substance use, contact with support services, education and socialising among young people resident in hostels and foyers. Four focus group sessions were conducted with a total of 14 participants.

Key stakeholder interviews were also undertaken with a representative of each hostel/foyer management team and a local substance misuse service, which provided outreach services at the residencies. The aim of these interviews was to gain an insight into the provision of hostel/foyer accommodation, how substance use issues and support needs are addressed and links with local services. In total, six interviews were undertaken.

Resident's Survey & Focus Group Findings

About the Residents

- Fifty-five residents completed the survey and 14 participated in the focus groups.
- 55.6% of all hostel/foyer residents completed the survey (56.4% were male; 69.1% were White; and the average age was 19.3 years). 14 residents attended the focus groups.
- 47.3% were not in education, employment or training (NEET). Residents felt there was no incentive to find employment due to the high rent costs which would be payable should they stop claiming benefits.
- Males were more likely to have been in contact with the Criminal Justice System (CJS).
- 46.9% became resident in a young persons' hostel/foyer due to a breakdown of family relationship.
- 40.0% demonstrated potential psychiatric morbidity.

Substance Use

- 81.8% smoked tobacco, 70.9% drank alcohol and 40.5% drank at least once a week.
- On average 47.5 units of alcohol were consumed in the previous week, mostly at the weekend.
- 83.3% had tried at least one illicit drug; females were more likely than males to report having tried illicit drugs.
- 48.1% reported lifetime use of at least one Class A drug.
- Cannabis and cocaine were reported to be the most commonly used drugs.
- 27.5% reported daily cannabis use (mostly males); it was reported that cannabis use could relieve *'stress'* and help with *'emotional problems'*.
- 33.3% of those who reported illicit drug use described first using illicit drugs after becoming a resident at a young persons' hostel/foyer.
- The majority of participants had received substance use awareness education; however, there were low levels of contact with substance use support and treatment services.

About their Residency

- Participants expressed positive views about residency at the hostel/foyer with many regarding it as *'home'*; supervision, available assistance and support from staff were positively reported.
- Positive peer influence was reported and participants indicated they could rely on their fellow residents for support.

Key Stakeholder Findings

- Six key stakeholder interviews were conducted with a representative of each hostel/foyer and of a local substance misuse service.
- All hostels/foyer accommodation complete resident assessments at the beginning of a residency, which is followed up with structured support plans.
- Hostels/foyers reported contact with external organisations to provide additional information and support to residents.
- All hostels/foyer provided support and encouragement for residents to engage in education, training or employment; in some cases it was a condition of tenancy.
- Stakeholders commonly suggested that the negative financial implications of becoming employed were greater than remaining on benefits.
- All hostels/foyer accommodation described policies and procedures in place to respond to problematic alcohol and drug use; often involving external support services.
- Cannabis and alcohol were noted as the most commonly used substances among young hostel/foyer residents; stakeholders expressed concern that while these substances may have negative impacts upon the young persons' lives/tenancies, often the young person does not consider their use to be a problem.

Conclusions and Recommendations

This research found that young people resident in hostels/foyer accommodation in Liverpool have similar trends of substance use as those in the general population. However, this cohort use increased amounts of drugs and alcohol and with greater frequency. The young people were also more likely to have been excluded from school, have been in contact with the CJS, be NEET and require support than those in the general population. Identified support needs related to; substance use; education and employment; mental health; and engagement with support services and agencies. In general, residents held positive opinions about their hostel/foyer residence, the staff, their fellow residents and the support they received. The recommendations made include potential areas for further harm reduction and social re-integration for this group. Initiatives, such as integrated training with staff and residents, will increase opportunities for ongoing and long-lasting impact for the residents and accommodation providers beyond an individual's residency.

A summary of the research recommendations are detailed in the box below. For more detail see Section 4.

Box 1: Summary of recommendations

- Consider the potential for provision of indicated prevention initiatives (i.e. targeting those showing signs of substance use) with regard to cannabis use amongst hostel/foyer residents, with a particular focus on male residents.
- Open consultation (both internally and externally) with a view to developing targeted reduction and alcohol awareness sessions, particularly for female residents. Include information on health effects, sexual health, alcohol and pregnancy, mental health and binge drinking.
- Support those who are NEET (not in education, employment or training) to enrol in relevant college courses, training or find employment; with a particular focus on males who are more likely to be excluded from school and be in contact with the CJS.
- Examine the potential to conduct further research into the types of offending that young people are involved in and consider employing appropriate prevention initiatives based on the research findings.
- Ensure residents' mental health is discussed at the needs assessment conducted at beginning of residency. Monitoring mental health needs of residents at sensible intervals; with particular focus on younger and female residents (who may be more vulnerable).
- Ensure hostel/foyer staff are trained to recognise potential mental health issues.
- Continue to promote safe sex practices, provide sexual health advice and condoms within the hostels/foyer accommodation.
- Consider conducting peer education training with residents in order to establish a number of peer advocates amongst residents in each hostel/foyer. Such advocates may be able to deliver 'front line' advice and support, especially to residents who may not feel comfortable accessing mainstream services or confiding with authority figures.
- Consider conducting integrated training with both residents and staff of a young person's hostel/foyer in order to improve knowledge of both groups. Training could focus on mixed topics such as substance use and sexual health.
- Ensure the links established between the hostels/foyer accommodation and substance use support services are maintained. Consider developing the remit of hostel/foyer accommodation staff(s) roles to incorporate drug and alcohol expertise; facilitating referrals to treatment or support services where necessary.

1. Introduction

Young people may be vulnerable to experiencing a range of detrimental health and social consequences; however, it is widely recognised that young people within certain socio-demographic groups are particularly vulnerable (such as those who leave home prematurely or suddenly, those who have a mental health problem and looked after children[1]). Literature indicates that vulnerable groups of young people are at increased risk of poor health, lower educational attainment and progression into substance use than non-vulnerable young people (EMCDDA, 2008). Vulnerable groups of young people include offenders, those who are looked after and those who are homeless or living in temporary accommodation (Edmonds et al., 2005).

There is considerable debate about the definition of homelessness with disagreement regarding whether someone residing in temporary accommodation or at risk of losing their accommodation constitutes being 'homeless' (Crisis, 2003; Reid & Klee, 1999). Definitions of homelessness may include those who do not have, or are at risk of, losing stable accommodation; such as those who are 'sleeping rough', those residing in bed and breakfast accommodation and those living in hostel or foyer[2] accommodation.

Young people residing in temporary accommodation (i.e. hostels, bed and breakfasts, foyers) or who are sleeping rough are often considered to be a homogenous group and their substance use patterns and support needs are generally not investigated discretely despite high levels of diversity. This research focuses upon the patterns of substance use and support needs of those residing in young person specific hostel and foyer[3] accommodation in Liverpool in order to provide in depth understanding of the needs of this vulnerable group.

1.1 Background

1.1.1 Policy and Prevalence

Homelessness was experienced by approximately 75,000 young people under 25 years of age in 2006/07 (Quilgars et al., 2008). This figure is a minimum estimate

[1] A term introduced by the Children Act in 1989 and refers to children who are subject to care orders and those who are accommodated outside of the family home.
[2] During the 1990s, foyer accommodation was established in an attempt to provide secure supported accommodation (typically where a young person, aged under 25 years old, can live for up to two years) with assistance for resettlement, training and employment.
[3] There are four hostels in Liverpool which provide services specifically for young people (aged 16-25). There is one foyer which provides accommodation for those aged 16-25. Both hostels and foyers are staffed 24 hours a day and provide a support package for their residents. Hostels and foyers are referred to as 'accommodation based providers' by Liverpool City Council.

taken from the number of young people registered as both statutory and non-statutory[4] homeless, although this does not take into account young people who are not in contact with any services and are therefore the 'hidden homeless'[5]. It is estimated that between 200-299 of under 25s are homeless in Liverpool, the highest number compared to other Merseyside districts. However, the rate of homelessness per 1,000 population of under 25s is higher in St Helens and Knowsley at 5.5-8.3; compared to 2.4-3.5 per 1,000 population in Liverpool (Quilgars et al., 2008). From the most recent data available for statutory homelessness, between July and September 2009 (CLG, 2009) there were 76 households accepted as homeless and in priority need within Liverpool, equating to 0.4 per 1,000 households, compared to Knowsley who accepted less households as homeless (68 in total) but had an increased prevalence of 1.1 per 1,000 households.

Since the development of the *Homelessness Act* (2002) and the *Children's Act* (2004) there has been a governmental commitment to improve services for children, young people and, vulnerable young people in particular. The focus on holistic approaches and multi-agency working in order to support children and young people generally underpins advisory documents (HM Government, 2004; DfES, HO & DH, 2005)[6].

The 2005 Social Exclusion Unit Report (Office of the Deputy Prime Minister, 2005) documented the need to concentrate policy and public services on a transitional age range (16-25 years), in order to improve assistance for those with 'complex needs'[7], at this 'critical stage'. Since 2002, 16 and 17 year olds and care leavers aged 18 to 20 have a priority need for accommodation if they become homeless through 'no fault of their own'. In 2006 a commitment was made that: by 2010 no 16 or 17 year olds should be placed in bed and breakfast accommodation, except in an emergency; and that supported lodging schemes, accommodation, advice and mediation services should be provided to those young people who can no longer stay at home (CLG, 2007). Supporting People programmes were devised as part of a package of measures to help prevent and challenge homelessness amongst young people. These aimed at enabling vulnerable people (including young people) to continue in their accommodation or to move to more suitable independent living conditions.

[4] Statutory homeless refers to households who qualify for housing assistance, become unintentionally homeless or have a priority need and therefore there is a legal obligation to provide appropriate accommodation. Non-statutory homeless is households to whom no duty of housing is owed i.e. those who become intentionally homeless, have no priority of need (typically single people and couples with no children).

[5] Those temporarily staying with friends/family or in other informal situations.

[6] Since the writing of this report there has been a change in national government, resulting in the formation of a coalition government on 11th May 2010, therefore this may not be reflective of current policy.

[7] "Complex needs – those who face particularly severe disadvantage. They may have interlocking problems where the total represents more than the sum of the part, or those with a depth or breadth of particular problems. These can make people particularly vulnerable and challenge effective delivery of service" (Office of the Deputy Prime Minister, 2005).

Foyers were also further developed to assist and support young people in making the transition into economic and social independence. It is estimated that foyer accommodation supports over 10,000 young people each year in the United Kingdom (Quilgars et al., 2008). In addition to new initiatives, traditional hostel accommodation[8] for young people who are homeless continues to exist throughout the country.

The *Staying Safe: Action Plan* (DCSF, 2008b) addressed the need to improve the safety of children and young people, as per the *Children's Act* (2004) and *Every Child Matters* (DCSF, 2004). This cross-government strategy suggested three levels of multi-agency safeguarding; universal, targeted and responsive. Universal safeguarding, involves working to keep all children and young people safe and create safe environments; targeted, includes targeting policies and services to those groups of children and young people who are more at risk, to help keep them safe from harm; and responsive, involves responding quickly and appropriately to those children and young people who suffer harm. Liverpool City Council (2009a) addressed the safeguarding of children and young people within their *Children and Young People's Plan 2009-2011*, which reports the aim to have an inclusive service culture for those who work with vulnerable and disadvantaged young people. They also outline the aim to narrow the gap between the most vulnerable and disadvantaged and the majority of young people via early intervention and specialist support services for those in need and by improving the provision of universal services. The efforts performed in this area have already increased the amount of care leavers in suitable accommodation and the range and quality of suitable accommodation for young offenders (Liverpool City Council, 2009a).

Liverpool City Council (2009b) outlined objectives to prevent homelessness whenever possible, including developing protocols for teenage parents who become homeless and for those discharged from prison. The Council promotes joint working with children's social services and the homeless support teams, therefore ensuring homeless assessments are completed consistently and on time, whilst screening for joint working at an early stage. The Council also aims to develop information leaflets regarding housing advice specifically for young people, by September 2010.

The 2008 drug strategy (HM Government, 2008) proposed targeted interventions to those children, young people and families most at risk of harm from substance misuse; specifically, earlier interventions with young people to prevent the immediate harms and, in the longer term, problematic drug use. Within Liverpool, the Drug and Alcohol Action Team (DAAT) work with the Supporting People team to provide housing services for vulnerable young people redressing their unequal access issues and develop assertive outreach for the homeless (Liverpool DAAT,

[8] Hostels are temporary shared accommodation. Residents usually have their own room and share kitchen and bathroom facilities with the other residents.

2009). The common theme underpinning all documents relating to reducing harm, and increasing the safety and wellbeing of children and young people is the need for multi-agency communication and working, combined with rapid and effective access to tailored services.

1.1.2 Substance Use, Young People and Homelessness

According to the results from the British Crime Survey 2008/09 (Hoare, 2009), 42.9% of young people aged 16 to 24 years had ever used illicit drugs, 22.6% had used one or more illicit drugs in the last year and 13.1% had used illicit drugs in the last month. Cannabis was the most commonly used illicit drug amongst young people, 18.7% used it within the last year; although, there was an increase in last year use of cocaine powder (from 5.1% to 6.6%) and ketamine (from 0.9% to 1.9%) from 2007/08 to 2008/09.

A recent report into non-opiate substance use in the North West of England reported that the use of alcohol, amphetamines, cannabis, cocaine and ecstasy (AACCE) is more prevalent amongst younger individuals (aged under 30 years) in structured treatment than those aged over 30, and that patterns of drug use are changing with a decrease in problematic opiate use amongst the under 30s (Hurst et al., 2009). Cannabis was stated as the most common primary problematic substance amongst under 18s in contact with structured drug treatment, with cocaine use steadily rising amongst 18 to 29 year olds. In Liverpool, cocaine use (61.8%) was more frequently reported by AACCE clients (of all ages) in structured treatment, than cannabis use (51.1%).

In the findings from the General Lifestyle Survey[9] (Robinson and Bugler, 2010), smoking and drinking behaviour of adults was discussed in detail. Tobacco was estimated to be used by 21% of the population in Great Britain, compared to 23% of the population in the North West of England in 2008. In 2008, the prevalence of cigarette smoking in the 16 to 19 year olds was 22%, compared to 30% of those aged 20 to 24; since 1990 prevalence of tobacco use has been highest amongst the 20 to 24 year olds compared to other age groups. The average weekly consumption of alcohol for adults in Great Britain (those aged 16 years and over) was 12.2 units in 2008[10]; in the North West of England the average weekly consumption was higher at 13.5 units. There was very little variation in the units of alcohol consumed weekly between age groups: (13.1 units amongst 16 to 24 year olds; 12.9 units amongst 25 to 44 year olds; 13.6 units amongst 45 to 64 year olds). However, there was a noticeable gender split; in 2008 males aged 16 to 24 drank an average of 16.3 units per week, compared to 10.3 units consumed by females. Findings amongst the 25

[9] Previously the General Household Survey.
[10] In 2008 a wine glass size question was added and used to calculate the number of units of wine consumed.

to 44 year olds were similar; males drank 16.8 units, compared to 9.6 units by females. When considering those who drank over 21 or 14 units weekly (the sensible drinking recommendations for males and females, respectively) in 2008, 25% of male and 22% of female 16 to 24 year olds were drinking above the weekly sensible drinking recommendations for their gender; 7% of males and 7% of females consumed more than 50 or 35 units weekly respectively[11].

Factors that have been associated with the increased substance use of young people include a lack of educational involvement, absenteeism and truancy from school; offending behaviour; living in government care; having parents who misuse drugs; and being homeless (Edmunds et al., 2005). According to a youth survey (MORI, 2004), those young people who had been excluded from school were significantly more likely to admit to alcohol use, were more likely to report smoking tobacco and having ever used Class A or Class B drugs, when compared to those in mainstream education. Similarly, McCrystal et al., (2007) report from their longitudinal study in Northern Ireland that those excluded from school were more likely to use drugs and be involved in antisocial and criminal activities and have less communication with their parents or guardians than those in mainstream education. In 2005, the results from the *Offending, Crime and Justice Survey* report that those young people who had used drugs in the last 12 months were significantly more likely to have committed an offence than those who had not (46% compared to 19%, respectively), and 26% of those that had committed an offence and used drugs in the last 12 months, committed a serious offence (Wilson et al., 2006). It has been reported that up to 30% of looked after children have been described as either potentially or existing problematic drug users (Edmunds et al., 2005). McVie and Holmes (2005) found that, when utilising the results of the *Edinburgh Study of Youth Transitions and Crime*, there was a relationship between parental drug use and young persons' drug use. Specifically, that at 15 years of age, those who had a parent who used drugs in the last year were around twice as likely to have also used a drug in the same time period, to be weekly smokers or weekly alcohol drinkers than those whose parents had not used a drug. Parent-child relationships were also found to influence substance use; Kristjansson et al., (2009) found that parental monitoring and time spent with parents were both protective factors for alcohol use and smoking in adolescence. Children raised in high conflict families are said to be vulnerable to both illegal drug use and delinquency (Hawkins et al., 1992).

It has been suggested that homelessness can be influenced by a variety of housing, economic and social factors that have led to people being isolated to the fringes of society (Fitzpatrick et al., 2000). A recent study found that young homeless people generally have poorer health than housed young people, with the likelihood of

[11] Consumption of more than 50 units of alcohol per week by males or 35 units per week by females is defined as 'harmful drinking'.

depression and mental health problems, as well as substance misuse issues, becoming more prevalent (Quilgars et al., 2008). The vulnerability that homelessness may cause regarding developing or worsening drug use in young people was highlighted recently by the European Monitoring Centre for Drug and Drug Addiction (EMCDDA) (2008). Homelessness and substance use have been linked in the literature (Commander et al., 2002; Fountain et al., 2003; Neale & Kennedy, 2002). Young, homeless people have reported high rates of illegal drugs and illicit use of prescribed medication, with some indicating risky behaviours including poly-drug use (Wincup et al., 2003). Further to this, Wincup et al., (2003) state that the majority of the young homeless people interviewed smoked cigarettes, on a daily basis. Compared to housed young people, homeless young people demonstrate much higher levels of tobacco use; in the 16 to 19 year olds, 93% of homeless young people smoked, compared to 29% of housed young people; in the 20 to 24 year olds, 96% of homeless young people smoked, compared to 35% of housed young people. Regarding the alcohol use of young homeless people, only 18% of the sample had never drank alcohol or did not drink alcohol anymore, although 48% drank alcohol at least once a week. Of those that did drink alcohol, females drank a median of 6 units in their last drinking session and males drank a median of 11 units; both of which are above the sensible drinking levels as defined by the DoH (2008). Shaw et al., (2008) reported that from those young homeless or vulnerably housed people interviewed in Liverpool, the most frequently reported substances used were tobacco, alcohol, cannabis (both resin and herbal) and cocaine, similar to the trends amongst young people in contact with structured drug treatment services in Liverpool (Hurst et al., 2009). The particular stressors involved in a homeless lifestyle can increase the likelihood of young people to self-medicate (with alcohol or illicit drugs) (Thompson et al., 2010); especially when other coping strategies are perceived to be less effective and self-medication is considered a social or bonding activity (Klee & Reid, 1998; Thompson et al., 2010). Research conducted with young homeless[12] people has shown that having a peer group of homeless people can increase an individual's likelihood of drug use and injecting (Rice et al., 2005). Further to this, Shaw et al., (2008) reported that young people interviewed described attending gatherings in young person specific hostels which involved drugs and alcohol.

1.1.3 Substance Use and Young Hostel Residents

There is relatively little evidence in the literature which relates to the impact of hostel residence on substance use and the reverse, and the impact of substance use on securing and maintaining hostel residence, specifically in relation to hostels for young people. Frequently, evidence relating to young homeless individuals and

[12] Homeless was defined as those aged under 17 who had spent two or more nights away from home without parent/guardian permission or those aged over 17 who had been asked to leave their home.

substance use combines data of young people sleeping rough, accessing drop-in support centres and residing in temporary accommodation (Fountain et al., 2003; Rachlis et al., 2009; Rice, Stein & Milburn, 2008), which can create difficulties in understanding the impact of residence in hostels and foyers, the reverse, and the support needs of this particular group of individuals.

There were 9,125 under 25 year olds resident in hostel[13] accommodation in 2001 in England and Wales, of which 30% (n=2,742) were aged under 18 years old (ONS, 2001) (this figure is now almost ten years old and is an under-estimate when compared to that reported by Quilgars et al., 2008 which estimates that 10,000 young people are supported in just foyer accommodation per year). A comparison of young people aged 16 to 25 living in private residences with those resident in a homeless hostel in Birmingham reported that the hostel-resident young people were significantly younger, were more likely to be male, had poorer levels of educational achievement, had higher levels of involvement with police, were more likely to have been in care, used more illicit drugs (including higher rates of polydrug use and injecting) and overall had worse mental and physical health (Commander et al., 2002). Similarly, Votta and Manion (2004) reported that homeless young people were at an increased risk of high-risk behaviours, including drug, alcohol and tobacco use and mental health issues, compared to non-homeless young people. When focussing specifically on foyer residents, three-quarters (75.5%) of those that were referred to mental health professionals reported having used illicit drugs and 84.7% reported having smoked (Taylor et al., 2006). Of those young people that did use substances whilst homeless, the persistent use of illicit substances was associated with poorer accommodation outcomes compared to those who did not 'abuse' substances or who had 'recovered' (Craig and Hodson, 2000).

1.1.4 Homeless Young People Not in Education, Employment and/or Training

The education, training and employment of young people has become an increasing priority for local and national governments in recent years (CLG, 2008; DCSF, 2008a). The Department for Children, Schools and Families[14] (DCSF) proposed a strategy for reducing the numbers of young people not in education, employment or training (NEET) nationally, in 2008. It was aspired that all young people would remain in education until the age of 18, but, along with increased participation, and the government aimed to reduce the number of 16 to 18 year olds who are NEET. Within England, the percentage of 16 to 18 year olds who are NEET reduced from 10.4% of the population in 2006 to 9.7% in 2007, with an estimated figure of 10.3% for 2008 (DCSF, 2009). However, within Liverpool, the amount of 16 to 18 year olds

[13] Including youth hostels and hostels for the homeless.
[14] Renamed the Department for Education after the formation of a new coalition government on 11th May 2010.

who are NEET (estimated figures taken from those provided by Connexions[15]) reduced from 13.2% in 2006 to 10.4% in 2008 (Connexions, 2006; 2008); higher than the national estimates.

Pleace et al., (2008) report that those 16 to 17 year old homeless people surveyed were more likely to be NEET than those in the general population. Commander et al., (2002) report that young homeless people were more likely to have left full time education before 16, have fewer qualifications and were more likely to be unemployed more often than those who were residentially stable. Unemployment has also been suggested as a trigger for homelessness along with socioeconomic marginalisation (Pleace & Fitzpatrick, 2004). Although a recent report (The Salvation Army, 2009) suggests that only 8% of homeless respondents cite unemployment as the main reason for their homelessness, even though 96% were unemployed (it should be noted that these data were collected from those aged from 18 to 65+ years). When specifically surveying young people aged between 16 and 17, Pleace et al., (2008) found that 57% were not in education, employment or training, which is approximately five times that of the general population; and that 34% had stopped attending education, employment or training since leaving their last settled accommodation. Further analysis revealed that being NEET had an independent influence of increasing the likelihood of a current substance misuse problem. Of those homeless young people who were identified as NEET by Pleace et al., (2008), 37% reported that the disrupted lifestyle of being homeless was a barrier to participating in education, employment or training and 30% cited that they would be 'worse off' financially if they were to attend a course or commence work. Similar results were found by Randall & Brown (1999), who reported that accommodation problems made it difficult for homeless young people to secure or maintain a job; and that those in hostels reported that the rent was a disincentive to finding employment as their housing benefit would be withdrawn. Within Merseyside, sofa surfing and being NEET was indicated as a key issue by Pemberton (2008) who also recommended that interventions are targeted at those who are NEET, their families and those young people who are experiencing family breakdown, in order to provide suitable and stable accommodation and improve the likelihood of returning to education, employment or training.

1.1.5 Accommodation provision in Liverpool

There are four hostels and one foyer that provide temporary accommodation for young people in Liverpool (for more detail on the capacity of each hostel/foyer see section 2.1). Each accommodation provider provides supported accommodation specifically for young people. Each hostel operates within its own philosophy and the policies and practices vary. The foyer belongs to a national network of foyer

[15] Includes all 16, 17 and 18 year olds known to Connexions on these dates and excludes those on gap years or in custody.

accommodation and operates within the Foyer Federation[16] mission to 'turn young people's experiences of disadvantage into solutions that support their transition to adult independence'.

In addition to the hostel/foyer accommodation, support is provided for 16 and 17 year olds in Liverpool via the Merseyside Accommodation Project (MAP). MAP provides supported lodgings within family homes in the city. For the purposes of this report young people from the MAP project were excluded as they do not live independently.

1.2 Research Aims and Objectives

The aim of this research was to identify the patterns of substance use amongst those residing in young person's hostels and foyer accommodation in Liverpool, and explore explanations for these patterns and support needs.

The objectives of the research are:

- To identify patterns of substance use amongst young people residing in the hostels/foyer including substances used, frequency of use, risky substance using behaviour and initiation practices.
- To explore reasons and causes of for substance use patterns.
- To explore substance use support provision and requirements.
- To investigate how other factors (family, relationships, health) impact upon substance use and hostel residency.
- To explore substance use policy and implementation in hostel/foyer accommodation.
- To investigate hostel/foyer resident's opinions about the hostel/foyer accommodation provided in Liverpool.

[16] For more information see http://www.foyer.net/

2. Method

Mixed-methods were employed using both quantitative and qualitative techniques. In brief, the research included a resident's survey, resident focus groups and key stakeholder interviews.

All young person specific hostels/foyer in Liverpool were included in the research, and efforts were made to include all young people resident during the study period.

2.1 Young Person's Hostel/Foyer Accommodation in Liverpool

In Liverpool there is accommodation available in young person specific hostels/foyer for 108 young people; a breakdown of the accommodation provision is provided in Table 1. Fieldwork took place during January and February 2010 and the hostel/foyer occupancy changed throughout this period; 99 beds[17] (91.7% of the total available) were occupied at the end of February 2010.

Table 1: Young person accommodation in Liverpool

Name	No. available 'beds'	No. occupied 'beds' (Feb 2010)	Age range	Hostel/Foyer?
Homeground[18]	29	24	16-35	HOSTEL
Powerhouse Foyer	52	48	16-25	FOYER
The Elm House	10	10	16-25	HOSTEL
Anne Conway House	13	13	16-25	HOSTEL
Bethel House	4	4	16-18	HOSTEL

2.2 Residents Survey

A resident's survey[19] was designed by the research team and incorporated questions about: The respondent, their hostel/foyer residency, personal relationships, health, substance use (including tobacco, alcohol and drugs), contact with support services and their opinions about young person's hostel/foyer accommodation. Questions about tobacco, alcohol and drug use were adapted from the national

[17] A 'bed' refers to accommodation provision for one young person. This varied from a single occupancy room, to a small flat or a shared flat in the hostels/foyer.
[18] Homeground hostel accepts young people aged up to 35 years. However, only residents aged under 25 were resident during the fieldwork of this project.
[19] Copy available on request.

Smoking, Drinking and Drug Use among Young People, 2008 Survey[20] (The Health and Social Care Information Centre, 2009). The health section of the questionnaire included the *General Health Questionnaire 12* (GHQ-12; Goldberg, 1978), a short screening instrument which assesses an individual's ability to carry out normal functions and identifies potential psychological morbidity. Respondents are required to rate to what extent they have experienced a symptom or behaviour in the previous four weeks on a four-point scale (See Data Analysis section 2.5 below for more detail on GHQ-12 scoring).

All hostel/foyer residents were invited to participate in the residents survey (n=99). The survey and incentive was promoted by hostel/foyer staff and posters detailing the date and time of data collection sessions. In order to maximise the survey response and to account for the frequent change in residents, data collection sessions were arranged for a variety of different time slots (as advised by hostel/foyer staff) and at intervals over a number of weeks during the project fieldwork stage. Thirteen data collection sessions were conducted across the five sites.

Prior to survey completion each participant was given an oral description of the research by the researcher, provided with a participant information sheet and asked to sign a consent form (Appendices 1 and 2). It was also explained to participants that the research team members could act as an intermediary for contact with any support service or to the hostel staff should the participant have any worries, concerns or express a need for support. Participants were asked whether they preferred to self-complete the survey or have researcher assistance. In order to protect anonymity, participants were only required to write their initials and date of birth on the survey. The survey took approximately 30 minutes to complete and each participant received a £5 gift voucher in recompense for their participation. Details of the number of residents contacted and the response rate is detailed in Table 2.

[20] This is an annual school-based survey of young people (aged 11-15 years) in England investigating levels of smoking, alcohol consumption and illegal drug use.

Table 2: Residents survey completion rate

Name	No. residents (Jan/Feb 2010)	No. residents contacted	No. surveys complete	Completion rate (%)
Homeground	24	18	17	70.8
Powerhouse Foyer	48	30	24	50.0
The Elm House	10	4	3	30.0
Anne Conway House	13	8	8	61.5
Bethel House	4	3	3	75.0
TOTAL	**99**	**63**	**55**	**55.6**

Once the participant had completed the residents survey, the researcher provided them with a debrief sheet[21]; which included contact details for the research team, local support services (including a map showing the location of services) and details of national telephone helplines.

2.3 Resident's Focus Groups

Survey participants were invited to take part in a residents' focus group which was held approximately three weeks after completion of the survey data collection sessions in each hostel/foyer. The aim of the focus groups was to further explore substance use, contact with support services, education and socialising amongst the young people resident in hostels and foyers.

After completion of the resident's survey each participant was presented with a focus group invitation. The invitation included details of the purpose of the focus group and a cut-off slip where interested participants provided required details (name and telephone number). Those who indicated a willingness to participate in the focus group were assured that the details provided on the invitation would be stored separately to their survey and that their name would only be used in order to contact them regarding the focus group.

The research team planned to hold a focus group (with a maximum of eight participants) in each hostel/foyer. Up to 10 young people, who indicated a willingness to take part in the focus group were invited from each hostel/foyer to enhance participation rates. Where a hostel/foyer had less than 10 survey respondents (or residents), all who indicated an interest in the focus group were

[21] Copy available on request.

invited. Where a hostel/foyer had more than 10 interested participants, a random sample was selected.

Once the date of the focus group was arranged, posters detailing the date and time were placed in each hostel/foyer. Text message invitations were sent to participants who had provided mobile phone numbers approximately one week prior to the date; the remaining participants were invited through hostel/foyer staff. On the day before the arranged date, text message reminders were sent and hostel/foyer staff also were utilised to remind participants.

Each focus group was attended by two researchers, one to lead the discussion and the other to take notes. At the beginning of each focus group, the researcher gave a verbal description of the aim of the focus group, emphasised the confidentiality policy and discussed some basic protocols that participants should follow (for example speaking one at a time). Participants were also provided with a participant information sheet and asked to sign a consent form (Appendices 5 and 6). Verbal and written consent was obtained to digitally record each focus group session. Participants received the debrief sheet when completing the survey and therefore these were not re-distributed, however, participants were made aware that they were available for any participant who wanted one, and that the research team could contact support services or speak to hostel/foyer staff on their behalf if they wished. Discussion topics were guided by the lead researcher who utilised a discussion guide. Each focus group lasted approximately one hour and each participant received a £10 gift voucher in recompense for their participation.

In total, four focus group sessions were conducted. The participation in the focus groups is detailed below (Table 3).

Table 3: Focus group participation

Name	No. invited	No. attended
Homeground	9	5
Powerhouse Foyer	10	6
The Elm House[22]	-	-
Anne Conway House	7	1
Bethel House	3	2

[22] None of the survey participants of The Elm House indicated an interest in the focus groups and therefore the planned focus group did not take place.

The Anne Conway focus group was attended by only one participant, given the incentives, reminders and promotion of the focus groups it was decided that conducting an additional session would not necessarily produce higher participation rates and therefore was not arranged.

2.4 Key Stakeholder Interviews

Key stakeholder interviews were undertaken with a representative of each hostel/foyer management team and a local substance misuse service, which provided outreach services at the hostels/foyers. The aim of these interviews was to gain an insight into the provision of hostel/foyer accommodation, how substance use issues and support needs are addressed and links with local services. In total, six interviews were undertaken. Each participant was provided with a participant information sheet and required to sign a consent form (Appendices 8-11). Consent was also gained to digitally record each interview. A discussion guide was utilised by researchers, and topics included assessment and contact with local services, education/training/employment policies, substance use policies and contact with support services. Each interview lasted approximately one hour.

2.5 Data Analysis

Quantitative data collected during the residents survey was inputted and analysed using SPSS for Windows v.15. Descriptive and inferential statistics were conducted; the chi-square or Fishers Exact Test was used, as appropriate, to examine differences between two independent groups (i.e. males and females), and the Pearson correlation[23] was used to examine the relationship between two separate continuous variables (i.e. GHQ-12 score and total number of illicit drugs used).

For the purposes of this research GHQ-12 scoring was undertaken bi-modally (0,0,1,1) to facilitate comparison with other studies (Biddle et al., 2004; Fagg et al., 2008; Moran et al., 2006). Potential scores ranged from zero to 12. It is recommended that the mean GHQ-12 score of the sample should be used as a threshold indicator of psychological morbidity (Goldberg et al., 1998), with studies commonly using 3 or 4 as the cut-off value (Biddle et al., 2004; Fagg et al., 2008; Moran et al., 2006).

Qualitative data from focus groups and interviews was transcribed verbatim onto word documents and analysed using Nvivo v8. Thematic content analysis was undertaken to derive the qualitative themes (Krippendoff, 1980). The six-stage thematic analysis process as described by Braun and Clarke (2006) was employed.

[23] The data satisfied the assumptions for normality and therefore the parametric test was used.

Data collected on substance use from the residents survey was compared with data from general population studies of the same or similar age range, specifically the British Crime Survey (BCS) and General Lifestyle Survey (GLS).

2.6 Ethical Issues

Ethical approval from Liverpool John Moores University Research and Ethics Committee was sought and granted. All data was held in accordance with Liverpool John Moores University Data Protection Policy (LJMU, 2008). All participants received a participant information sheet and had the research explained to them verbally and written informed consent was obtained. All participants were 16 years or older and the principle of Gillick/Fraser competence was adhered to i.e. young people aged 16 and 17 years old will be able to consent for themselves providing they fully understand what is being asked of them (Department of Health, 2001). Furthermore, the Centre for Public Health's (CPH) Child Protection Policy was strictly adhered to (Woolfall, Wareing & Stredder, 2009). To ensure equal opportunity, the survey was designed for those with low literacy levels and the researchers assisted survey completion, where required.

This project included questions about sensitive topics to groups of vulnerable young people and therefore the protection of the participants was of great importance. Members of the research team met with staff from each hostel/foyer prior to commencement of fieldwork to discuss appropriate protection and support for participants. This included the inclusion of the local service map in the debrief sheet, a discussion prior to survey completion or focus group about the research team's ability to act as an intermediary to support services, the research team's contact with Young Addaction (a local substance use support service specifically for young people) and ensuring the research team were aware of the referral pathway for support in each hostel/foyer.

3. Findings

This section details the findings from the three strands of data collection employed in this research project: (1) Residents Survey, (2) Resident's Focus Groups and (3) Key Stakeholder Interviews.

3.1 Residents Survey Findings

Fifty-five young people completed the resident's survey. However, the tables presented below may be based on a response rate less than 55 as participants may have refused to answer particular questions or left the field blank whilst self-completing the survey. The response rate for each item is based on the number of valid responses to each survey item (missing data was removed).

3.1.1 Participant demographics

Fifty-four participants indicated their gender, of which 31 (56.4%) were male and 23 (41.8%) were female.

Table 4: Age and ethnicity of participants, by gender

	Average age (years)*		Ethnicity					
			White		Non-White[24]		Not stated	
			%	n	%	n	%	n
Male	19.1		74.2	23	25.8	8	0	0
Female	19.6		65.2	15	30.4	7	1.8	1
All	19.3		69.1	38	29.1	16	1.8	1

* SD Male = 2.25; SD Female = 2.18; SD All = 2.21

Approximately one-quarter of participants had previously been in the care of the local authority[25] (27.3%, n=15).

[24] Due to the small number participants from ethnic backgrounds other than White a Non-White category was created. The Non-White ethnicity category is a combination of the ethnicity categories of: Mixed; Black or Black British; Asian or Asian British; Chinese and other ethnicity.
[25] Foster care or children's home.

3.1.2 Education and employment status

Table 5 details the formal qualifications held by participants, approximately two-thirds of participants held GCSE qualifications (60.0%, n=33) and approximately one-third had completed NVQ/GNVQ qualifications (34.5%, n=19).

Table 5: Reported qualifications attained by participants[26]

	%	n
GCSE	60.0	33
NVQ/GNVQ	34.5	19
BTEC	12.7	7
A Level	9.1	5
Degree	1.8	1

Over half of participants indicated that they had previously been excluded from school or college (57.4%, n=31). Seventy percent of males and 39.0% of females reported that they had ever been excluded from school or college; this difference was statistically significant ($p<0.05$).

Approximately half of participants (47.3%, n=26) were not in employment, education or training (NEET).

Forty percent (n=22) of participants reported that they were currently attending school or college. Of these, over two-thirds had attended in the previous week (68.2%, n=15). A further seven participants reported that they were currently attending training (12.7%). There was no statistical difference in current school or college attendance between those who had ever been excluded from school or college and those who had not.

The vast majority of participants were not currently in employment (90.9%, n=50).

[26] Percentages add to greater than 100% as participants could indicate more than one type of qualification.

3.1.3 Contact with the criminal justice system

Table 6 details the proportion of participants who indicated that they had previous contact with the Criminal Justice System (CJS).

Table 6: Contact with the Criminal Justice System, by gender[27]

	Been in a Youth Offending Institute (YOI)		Been in prison		Been in contact with Youth Offending Team (YOT)		Had a Youth Rehabilitation Order[28] (YRO)	
	%	n	%	n	%	n	%	n
Male	22.6	7	-	-	41.9	13	32.3	10
Female	-	-	-	-	17.4	4	-	-
All	16.4	9	7.3	4	32.7	18	23.6	13

Overall males reported more contact with the CJS; with 45.2% reporting contact with at least one of the organisations mentioned in Table 6 compared with 26.1% of females; this finding was not statistically significant. Males were more likely than females to report having been in a Youth Offending Institute (YOI) and in contact with the Youth Offending Team (YOT); these findings were not statistically significant. The difference in males and females who reported having been subject to a Youth Rehabilitation Order (YRO) was found to be statistically significant ($p<0.05$).

Those who had been excluded from school were significantly more likely than those who had not been excluded to report contact with at least one CJS organisation (51.6%, n=16 compared with 21.7%, n=5; $p<0.05$) and the YOT (48.4%, n=15 compared with 13%, n=3; $p<0.05$).

3.1.4 Hostel/foyer residence

Participants had resided for an average of 4.7 months (SD=4.1) in their current hostel/foyer and had been living in hostel/foyer accommodation for an average of 6.5 months (SD=8.1) in total. Table 7 details where participants had lived immediately before becoming resident in the hostel/foyer where they were surveyed.

[27] Numbers less than four have been suppressed.
[28] For example Anti Social Behaviour Order (ASBO), Acceptable Behaviour Contracts (ABC), curfew, tag, caution or Community Rehabilitation Order.

Table 7: Where participants lived immediately before the hostel/foyer in which they were surveyed

	%	n
With parent(s)	43.6	24
With other relatives	16.4	9
With partner	7.3	4
With friends	9.1	5
Another hostel	7.3	4
Care home/Children's home/Foster family	9.1	5
Other (hotel, own flat, prison)	7.3	4
TOTAL	100	55

The main reason why participants came to reside in hostel/foyer accommodation is detailed in Table 8. The majority of participants indicated that family relationship breakdown was the main reason for leaving their previous residence (46.9%, n=23).

Table 8: Main reason why participants became resident in hostel/foyer accommodation

	%	n[29]
Chose to leave previous residence/to gain independence	16.3	8
Asked to leave previous residence	12.2	6
Family relationship breakdown	46.9	23
Death/illness of parent/guardian	-	-
End of/Left care placement	-	-
Other[30]	16.3	8
TOTAL	100	49

Participants were asked to select from a list which places they had lived in during the previous year (this did not include staying overnight somewhere for a few nights) (Table 9). The most common places that participants had lived in the previous year was with a parent(s) or guardian(s) (49.1%, n=27) and with friends (38.2%, n=21).

Table 9: Places where participants lived in the previous year

	%	n		%	n[31]
With parent(s)/guardian(s)	49.1	27	In children's home	9.1	5
With friends	38.2	21	In own home	9.1	5
With other relatives	34.5	19	With foster family	7.3	4
In another hostel/foyer	20.0	11	In prison	-	-
In B&B[32]/Hotel	9.1	5	YOI	-	-

In addition to the responses above, three participants (5.5%) stated that they had slept rough in the previous year. 'Other' places participants had resided in the

[29] Numbers less than four have been suppressed.
[30] 'Other' responses included domestic violence, getting into trouble with the police and overcrowding.
[31] Numbers less than four have been suppressed.
[32] Bed and Breakfast.

previous year included: at their partner's home; college residency; and Merseyside Accommodation Project (MAP) placement.

Approximately two-fifths of participants (41.9%, n=18) reported that they had previously spent some time 'sofa-surfing'[33].

Six participants (11.3%) reported that they had previously been banned or evicted from a hostel/foyer. Reasons for eviction included racism and anti-social behaviour.

Half of participants (50.0%, n=26) found it 'easy' to get a place at the hostel/foyer in which they currently lived. Four participants (7.6%) reported that it had been 'hard' to obtain a place at the hostel/foyer where they currently lived. Reasons for difficulties accessing accommodation included difficulties with paperwork and having to wait for a place to become available or made ready.

3.1.5 Family contact

The vast majority of participants had familial contact[34] in the previous month (92.7%, n=51). Of these, 54.5% (n=30) had contact with one parent[35]; 30.9% (n=17) had contact with both parent(s); 80.0% (n=44) had contact with a sibling[36]; and 30.9% (n=17) had contact with a grandparent(s). Of the eleven participants who had previously been in the care of the local authority (i.e. children's or foster home), 26.7% (n=4) had been in contact with foster parents in the previous month.

Ten participants (18.9%) reported having more contact with their family since coming to live in their current hostel/foyer residence and half of participants (50.9%, n=27) indicated they currently had less contact with their family. Approximately one quarter of participants (24.5%, n=13) reported that family members visited them at the hostel/foyer.

[33] 'Sofa-surfing' means moving from one house to another every day or few days.
[34] This included biological or adoptive parents, siblings, foster parents and grandparents.
[35] Biological or adoptive parent(s).
[36] Note that those who did not have contact with a sibling may have been an only child. Questions about family make-up were not included.

3.1.6 Participant's health

Participants were asked to rate their general health on a five-point scale from 'very good' to 'very bad'.

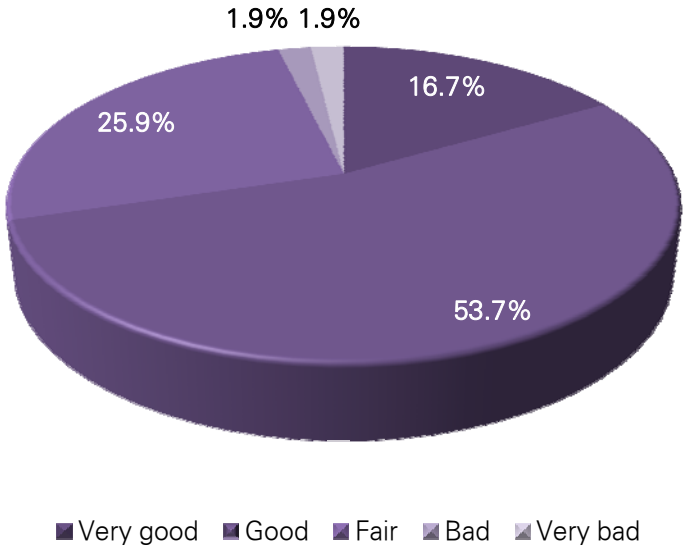

Figure 1: Participants self-assessment of their general health

Figure 1 shows that the majority of participants (70.4%, n=38) reported their general health as 'very good' or 'good', with only a minority reporting 'bad' or 'very bad' general health.

Nine percent of participants (n=5) reported that they had been diagnosed with a mental health condition. Specifically, ADHD[37], depression, anxiety and paranoia were specified by participants.

Participants completed the GHQ-12 as an indicator of psychiatric morbidity. Participants who had previously reported a mental health issue were removed from the analysis. The mean GHQ-12 score was 2.68 (n=40) and ranged from zero to 10. Forty percent of participants (n=16) had a GHQ-12 score above the mean indicating potential psychiatric morbidity. The mean GHQ-12 score amongst females was double that of their male counterparts at 4.89 and 2.44 respectively; this finding was not statistically significant[38].

[37] Attention deficit hyperactivity disorder. The authors recognise that ADHD is a neurobehavioural developmental disorder. However, all responses provided by participants have been listed.
[38] However, the p value (0.053) approached significance although did not achieve it.

Those aged under 20 years (n=25) had a higher mean GHQ-12 score than those aged 20 years and over (n=21) at 3.76 and 2.86 respectively; this difference was found to be statistically significant ($p<0.05$).

Those with a below mean GHQ-12 score were significantly more likely than those with an above average mean score to report contact with at least one CJS organisation (50.0% (n=12) compared with 12.5% (n=2); $p<0.05$) and the YOT (50.0% (n=12) compared with 6.3% (n=1); $p<0.05$).

3.1.7 Tobacco use

Approximately four-fifths of participants (81.8%, n=45) indicated that they smoked tobacco (at least sometimes); approximately three-quarters of participants were current smokers[39] (n=38, 74.5%); and 37 (72.5%) smoked more than six cigarettes a week. The reported age that participants first started to smoke ranged from eight to 23.

The majority of current smokers had been smoking more than one cigarette a week for more than a year (84.2%, n=32) and most reported that it would be 'very difficult' or 'fairly difficult' to go without smoking for as long as a week (86.8%, n=33). Half of current smokers (50.0%, n=19) reported that they had previously engaged in activities to help stop smoking. Of these, 31.6% (n=12) had spoken to family or friends for advice about quitting; 21.1% (n=8) had used nicotine replacement therapy; 18.4% (n=7) had consulted with their GP; and 15.8% (n=6) had used an NHS smoking cessation service (such as Fag Ends).

Almost all participants who had been excluded from school or college reported tobacco use (93.5%, n=29) compared to approximately half of those who had not been excluded (56.5%, n=15); this finding was statistically significant ($p<0.05$).

[39] Defined as smoking tobacco at least once a week.

3.1.8 Alcohol use

Approximately two-thirds of participants indicated that they drank alcohol (70.9%, n=39). Participant's age of alcohol initiation ranged from nine to 18 years old. The remaining discussion in this section refers to those who indicated that they drank alcohol (abstainers were excluded from the analysis).

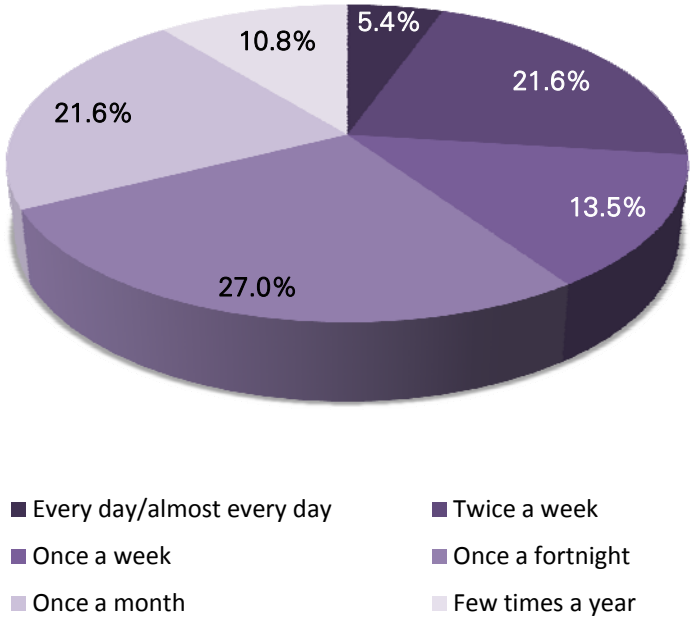

Figure 2: Usual frequency of drinking alcohol

Figure 2 shows that approximately one-third of participants drank alcohol once a month or less[40] (32.4%, n=12) and a small proportion were drinking every day or almost every day (5.4%, n=2). More than two-fifths (40.5%, n=15) reported that they drank at least once a week.

The majority of participants reported that when they drank alcohol they were usually with other people (94.6%, n=35). Of these, most indicated they were usually with friends of both sexes (58.3%, n=21).

[40] Based on the addition of those who responded 'Once a month' and 'Few times a year'.

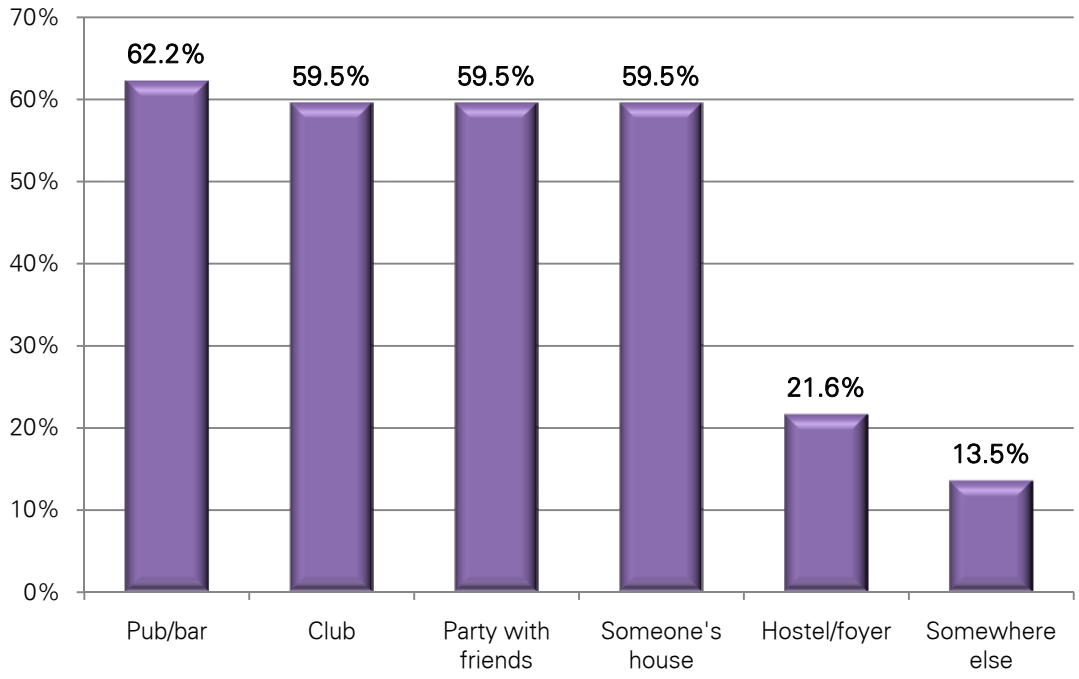

Figure 3: The usual places that participants consume alcohol

As displayed in Figure 3, the majority of participants reported consuming alcohol in licensed premises (pub/bar or club) or at a party or someone's house. One-fifth of participants reported consuming alcohol in the hostel/foyer where they lived (21.6%, n=8) and none reported drinking outside.

Forty-nine percent (n=18) of participants had consumed alcohol in the week prior to completing the survey. Five participants (13.9%) had last consumed alcohol more than one month previously. The proportion of females who reported consuming alcohol in the previous week was approximately three times greater than their male counterparts; 75.1% of females and 25.0% of males reported alcohol use in the previous week.

Of those who reported consumption of alcohol in the previous week, the most common days in which alcohol was consumed were Friday (61.1%, n=11) and Saturday (38.9%, n=7). The mean units of alcohol consumed in the previous week was 47.5[41] (range 2-120 units); 10 participants were drinking at hazardous[42] levels (six males and four females) and seven were drinking at harmful[43] levels (two males and five females).

[41] Approximately equal to 10.5 litres of average strength cider or 21 pints of average strength larger or 50 25ml measures of vodka.

[42] Consumption of 22-50 units of alcohol per week by males or 15-35 units per week by females is defined as 'hazardous drinking'.

[43] Consumption of more than 50 units of alcohol per week by males or 35 units per week by females is defined as 'harmful drinking'.

Of those who indicated that they drank alcohol, three-quarters (77.1%, n=27) reported that they had been drunk during the previous four weeks. The number of times that participants had been drunk during this period ranged from one to 15, with an average of four times. Of those who had been drunk in the past four weeks, 65.4% (n=17) reported that they had deliberately tried to get drunk.

Table 10 demonstrates that in the previous four weeks the participants experienced adverse consequences of alcohol consumption including losing money or other items (26.9%, n=7), getting into an argument (23.1%, n=6) and feeling ill or sick (23.1%, n=6).

Table 10: Consequences of alcohol consumption in the previous four weeks (n=27)

	%	n		%	n[44]
Lost money or other items	26.9	7	Got into trouble with police	15.4	4
Felt ill or sick	23.1	6	Vomited	15.4	4
Got into an argument	23.1	6	Clothes or other items damaged	-	-
Got into a fight	15.4	4	Taken to hospital	-	-

3.1.9 Drug use

Participants were asked if they had ever tried illicit drugs. The majority of participants had tried at least one illicit drug (83.3%, n=45) and almost half had tried a Class A[45] drug (48.1%, n=26). A higher proportion of females reported ever use of any illicit drug compared to their male counterparts (91.3% of females compared to 76.7% of males), however this difference was not statistically significant. The proportion of males and females who reported ever use of any Class A drug was similar (50% of males and 47.8% of females).
Less than five percent of participants had ever tried LSD, tranquillisers (non-prescribed), heroin, magic mushrooms, methadone (non-prescribed), crack cocaine, ketamine or khat. None of the participants reported use of anabolic steroids or volatile substances (glue/gas).

Figure 4 shows the proportion of participants who had ever tried a selection of illicit drugs.

[44] Numbers less than four have been suppressed.
[45] This includes heroin, crack cocaine, cocaine, ecstasy, hallucinogens (LSD and magic mushrooms), and methadone.

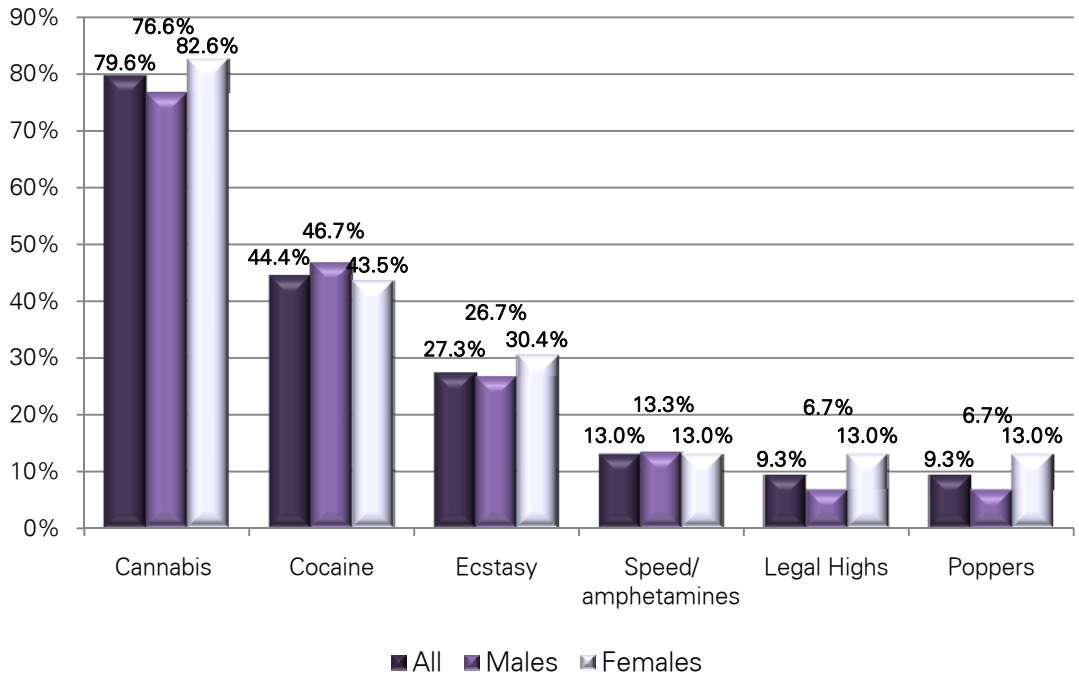

Figure 4: Percentage of participants who had ever tried illicit drugs[46], by gender

Over three-quarters of participants reported having ever tried cannabis (79.6%, n=43). Cocaine and ecstasy were the second and third most commonly reported substances which participants had tried, with 43.6% (n=24) and 27.3% (n=15) respectively reporting use.

Females were more likely to report ever use of cannabis, ecstasy, legal highs and poppers. Only in the case of cocaine were males more likely to have ever used the drug than their female counterparts. A similar proportion of males and females reported lifetime use of amphetamines.

Comparisons of those with above and below mean GHQ-12 scores indicated that those with a score above the mean were more likely to report use of cannabis (75.0% (n=12) compared with 17.4% (n=4)) and cocaine (62.5% (n=10) compared with 34.8% (n=8)); these findings were not statistically significant. However, there was a significant positive correlation between participants absolute GHQ-12 score and the number of illicit drugs that they had ever tried ($p<0.05$). This finding was also true for males and females separately ($p<0.05$).

On average participants were youngest when they first tried cannabis, at an average of 13.7 years old (n=42, range 5-19 years, SD=3.0). The average age of first use of ecstasy was 15.9 years old (n=16, range 12-21 years, SD=2.2) and first use of cocaine was 16.2 years old (n=24, range 12-21 years, SD=2.2).

[46] Only illicit drugs that had been tried by more than 5% of participants are included in the figure.

Table 11 illustrates the proportion of participants who reported use of cannabis, cocaine and ecstasy in the last year and last month. Almost half of participants (49.1%, n=27), reported use of cannabis in the previous month and 20.0% (n=11) reported cocaine use. Unlike the lifetime use (as shown in Figure 4), males were more likely to report recent (last year) and current (last month) use of cannabis than females. However, a greater proportion of females reported recent ecstasy use, and recent and current cocaine use.

Table 11: Last year and last month use of cannabis, cocaine and ecstasy, by gender

Drug	Time frame of use	All (%)	Males (%)	Females (%)
Cannabis	Last Year	58.2	67.8	47.8
	Last Month	49.1	58.1	39.1
Cocaine	Last Year	36.4	38.8	34.7
	Last Month	20.0	19.4	21.7
Ecstasy	Last Year	18.1	19.4	30.4
	Last Month	3.6	6.5	17.4

Note: Figures 5 and 6 refer only to those who indicated that they had ever used each illicit drug.

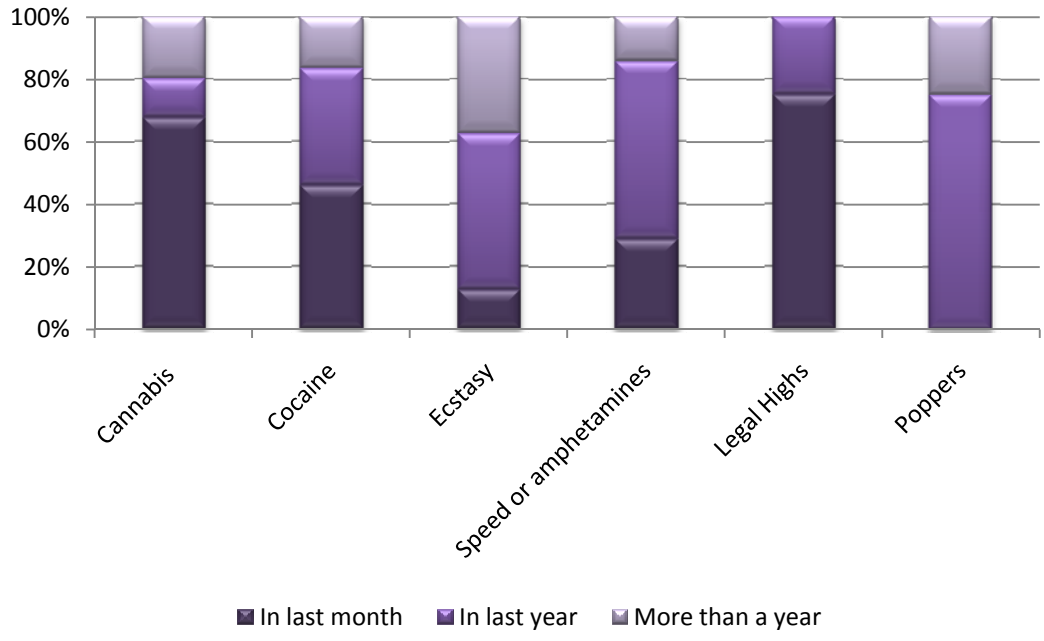

Figure 5: When illicit drugs were last used

Figure 5 shows, that of those who reported lifetime use of illicit drugs, the drugs most commonly used in the previous month were cannabis (67.5%, n=27) and cocaine (45.8%, n=11). Three of the four participants who reported use of legal highs had used them in the previous month. Reported use of ecstasy, poppers and

speed/amphetamines was less recent with fewer participants reporting last month use of these drugs.

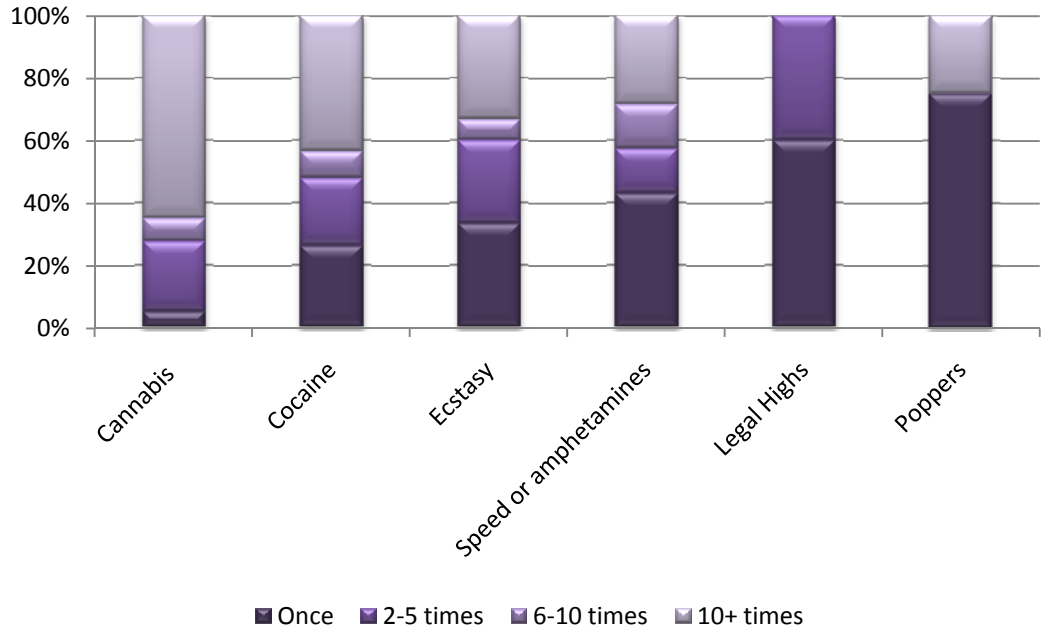

Figure 6: Number of times participants had used illicit drugs

Figure 6 indicates that of those who reported lifetime use of illicit drugs, participants were most likely to use cannabis or cocaine on more than one occasion. Use of cannabis and cocaine on more than 10 occasions was reported by 65.0% (n=26) and 43.5% (n=10) of participants respectively. Legal highs were used least frequently by participants (no more than five times).

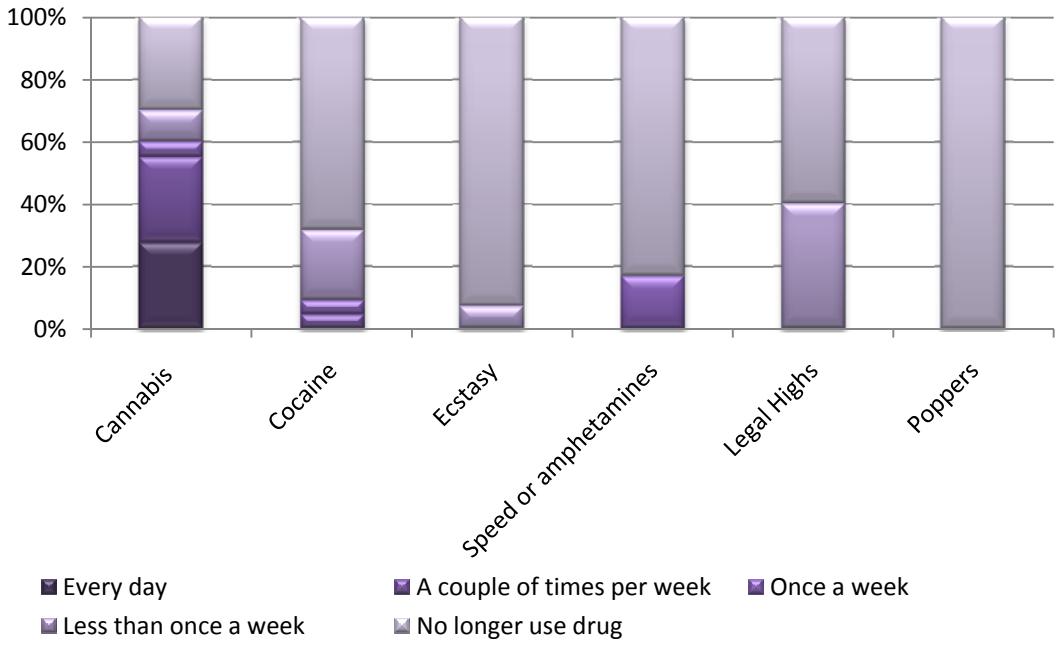

Figure 7: Current frequency of illicit drug use

Figure 7 illustrates, of those who reported lifetime use of illicit drugs, most no longer used many of the illicit drugs with which they had experimented, with the exception of cannabis. Daily use of cannabis was reported by 27.5% (n=11) of participants, with a further 27.5% (n=11) reporting cannabis use a couple of times per week.

Of those who reported use of at least one illicit drug (n=45); 53.5% (n=23) reported snorting or sniffing a powder substance and 28.9% (n=13) reported using equipment which someone else had also used to sniff or snort a powder (i.e. note or straw). None of the participants reported injecting any substances.

3.1.10 Changes in substance use

Participants were asked if their use of substances had changed since they had become resident in a young person's hostel/foyer. Changes in tobacco, alcohol and drug use were reported by 52.3% (n=23), 30.8% (n=12) and 40% (n=16) respectively.

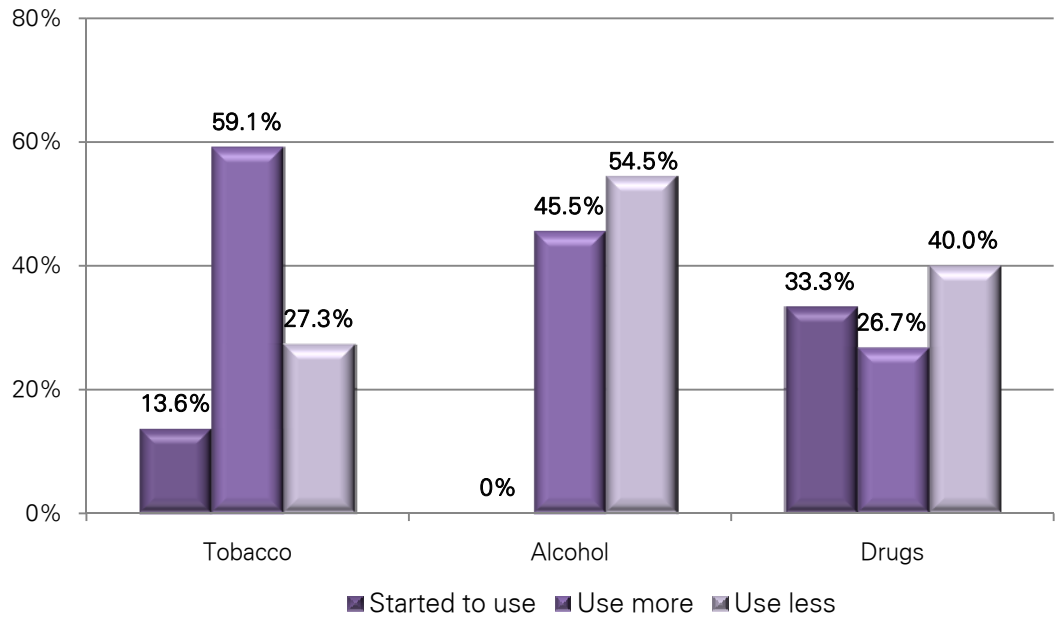

Figure 8: Reported changes in tobacco, alcohol and drug use whilst living in young person's hostel/foyer

Figure 8 shows that of those participants who reported a change in their substance use while living at a young person's hostel/foyer; 59.1% (n=13) reported an increase in tobacco use; the proportions of young people reporting an increase and decrease in their alcohol use were similar (45.5% reported an increase compared to 54.5% who reported a decrease); and one third (33.3%, n=5) initiated drug use and 26.7% (n=4) increased their drug use. Notably, 40% (n=6) of participants indicated that their drug use had reduced whilst living in a young person's hostel/foyer.

Two-thirds of participants (66.7%, n=30) indicated that they did not initiate use of any substances (tobacco, alcohol or drugs) since they became resident in a young person's hostel/foyer. Tobacco initiation was reported by 18.2% (n=8) and cannabis initiation was reported by 8.9% (n=4). Fourteen percent (n=6) of participants reported that they lived in a young person's hostel/foyer the first time they snorted/sniffed a powder drug.

When asked where they usually use tobacco, alcohol and drugs the most common responses were: 70.7% (n=29) reported tobacco use in their room; 50.0% (n=19) reported alcohol use at a friend's house; and 41.7% (n=15) reported drug use at a friend's house. *Usually* consuming alcohol and taking drugs on the hostel/foyer premises[47] was reported by 21.6% (n=5) and 16.7% (n=6) respectively.

More than 90% of participants indicated that they were aware of their hostel/foyer's rules regarding the use of alcohol, tobacco and drugs. Seventeen percent of participants (n=7) reported breaking their hostel/foyer's rules about tobacco and alcohol use, and 25.0% (n=11) had broken the rules about drug use.

3.1.11 Sexual experience and substance use

Approximately three-quarters of participants (78.7%, n=37) reported that they had had ever had a sexual experience[48]. There were no significant differences in the percentage of males and females who reported having had a sexual experience, 84.6% and 75% respectively. Approximately one-third of participants who had ever had a sexual experience (36.1%, n=13) reported that they had gone further sexually than they had wanted to, or planned to, after drinking alcohol, and approximately one-fifth reported this experience after taking drugs (22.9%, n=8). More females than males reported having gone further sexually than they wanted to, or had planned to, after drinking alcohol (40.0% compared with 33.3%). However, the reverse was true for drug use, 25.0% of males reported going further sexually than they had wanted to or planned to after taking drug compared to 20.0% of females.

[47] Either in their own room or someone else's room.
[48] A 'sexual experience' was defined as more than just kissing and included heavy petting, oral sex and sexual intercourse.

3.1.12 Experiences of substance use support services

Approximately, two-thirds of participants reported having received education or awareness session about tobacco (66.7%, n=34), alcohol (63.5%, n=33) and drugs (63.5%, n=33). Participants indicated that sessions were delivered by schools, colleges, YOT and professional support agencies (e.g. Young Addaction, Fag Ends). Participants expressed a variety of opinions about the sessions including: *'they covered things we already knew'* and *'they were very useful, made me understand more'*. One participant stated: *'I wish I was told earlier, it was too late. I was a kid and stupid'*. Approximately one in five participants reported that they had received awareness and information sessions about tobacco, alcohol and drugs since they came to live in the young person's hostel/foyer.

Participants were asked if they had ever received treatment[49] to reduce or stop their substance use: 11.8% (n=6) had received treatment for tobacco use; 6.0% (n=3) had received treatment for alcohol use; and 11.5% (n=6) had received treatment for drug use.

The participants were asked if they had ever received help, support or treatment from any local services. The most commonly accessed services are presented in Figure 9. Less than 5.0% of participants reported that they had been in contact with The Whitechapel Centre, Sharp and Young Runaways.

[49] Treatment was defined as one-to-one sessions with someone at a tobacco, alcohol or drugs service.

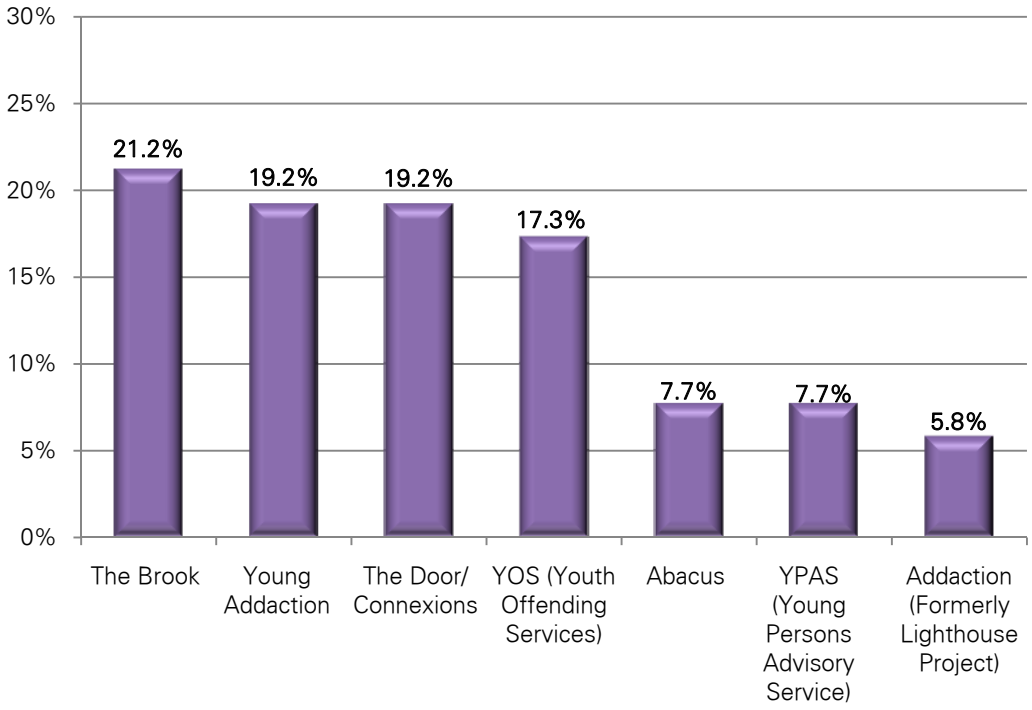

Figure 9: The most commonly accessed local services

Figure 9 shows that approximately one-fifth of participants had been in contact with a sexual health service, The Brook (21.2%, n=11). Nineteen percent (n=10) had accessed Young Addaction (young person's substance use service) and The Door/Connexions (an education, training and careers advice service), and 17.3% (n=9) had been in contact with the Youth Offending Services (YOS).

3.1.13 Opinions of hostels/foyers

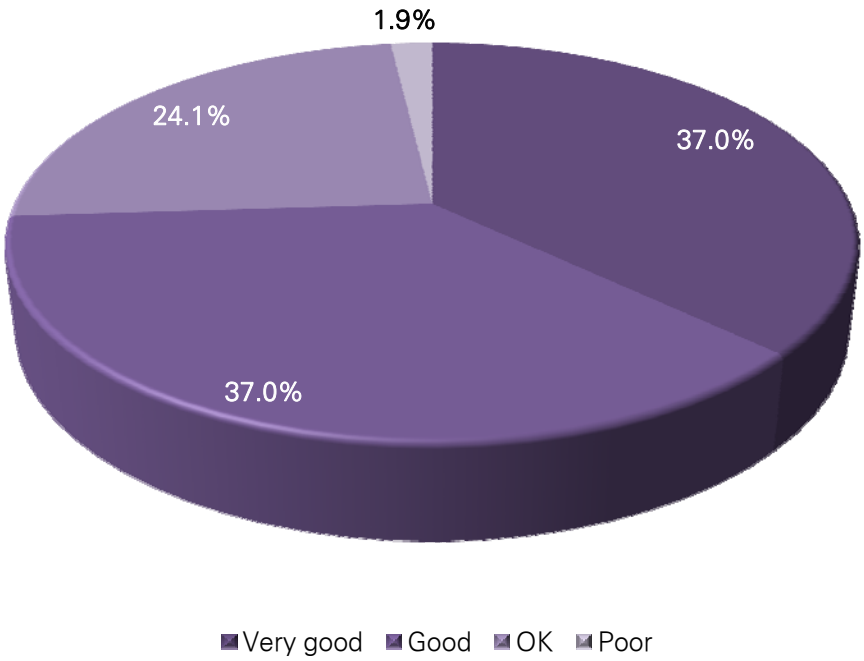

Figure 10: Participants ratings of their hostel/foyer[50]

When asked how they would rate their hostel/foyer approximately three-quarters of participants (74.0%, n=40) rated it as 'very good' (37.0%, n=20) or 'good' (37.0%, n=20) (Figure 10).

[50] None of the participants rated their hostel/foyer as 'very poor' hence it has not been included on the chart.

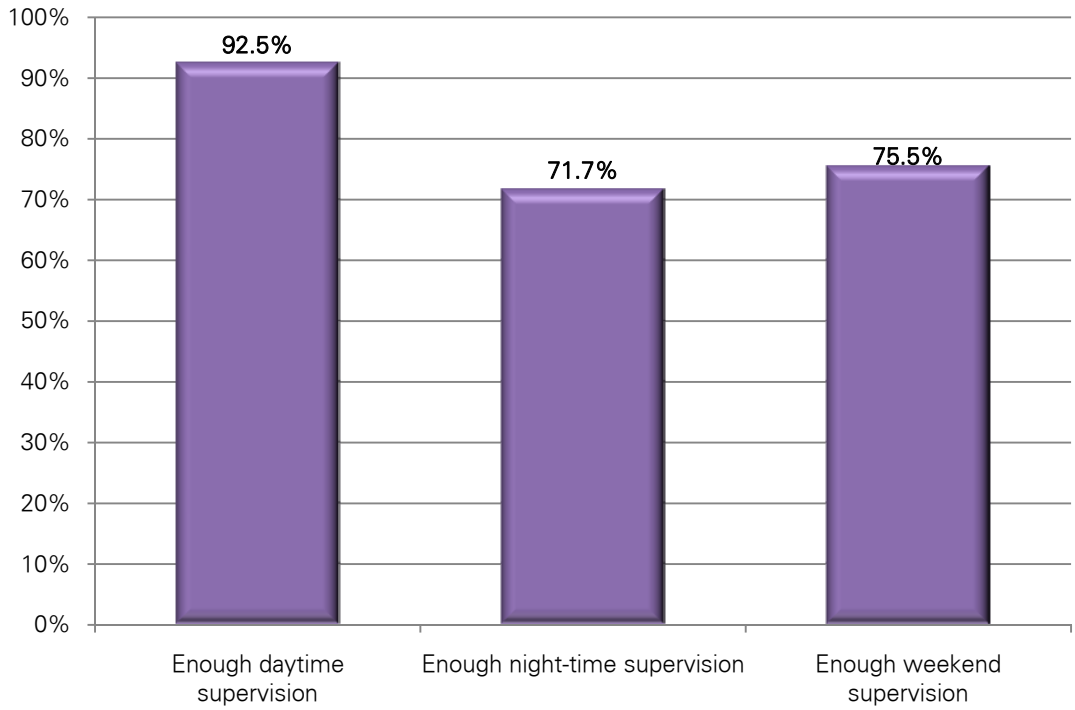

Figure 11: Participants opinions about supervision at their hostel/foyer (percentage who agree[51] with statements)

Figure 11 shows that generally participants agreed that there is enough supervision in their hostel/foyer. However, a greater proportion of participants agreed that there was enough staff supervision during the daytime (92.5%, n=49) compared to night-time (71.7%, n=38) and weekends (75.5%, n=40).

[51] A combination of those who 'strongly agree' and 'agree' with the statements.

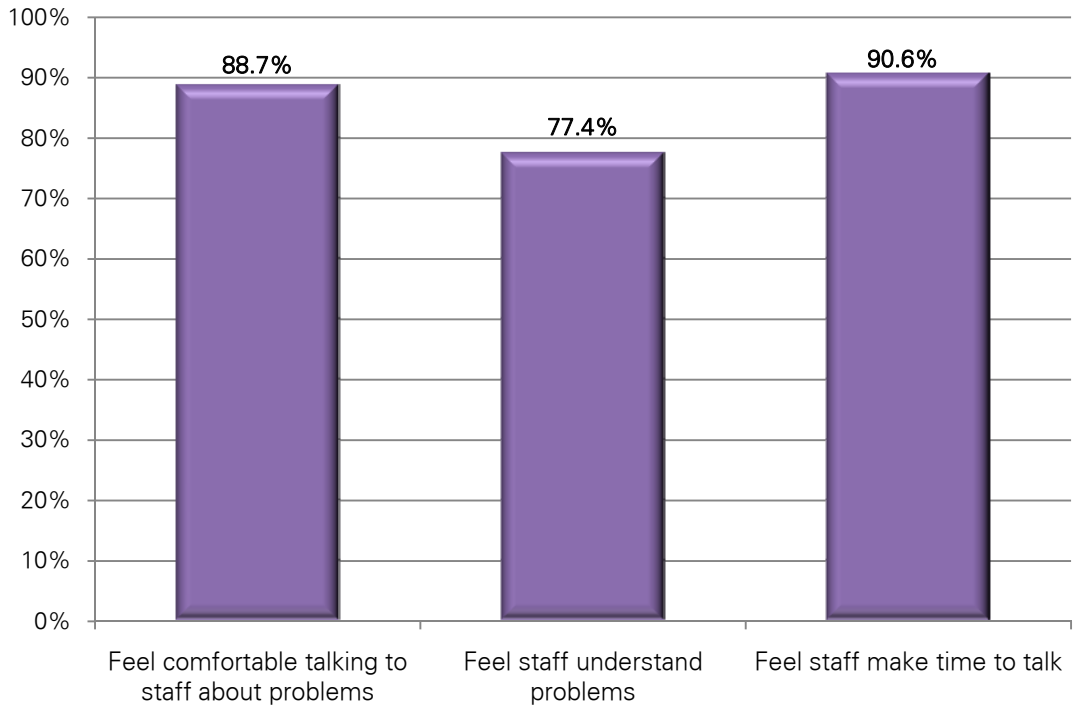

Figure 12: Proportion of participants who agreed with statements about hostel/foyer staff

When asked about how participants feel about interacting with staff at their hostel/foyer there was a high level of positivity; 88.7% (n=47) felt comfortable talking to staff about problems; 77.4% (n=41) felt that staff understand their problems; and 90.6% (n=48) felt that staff made time to talk with them.

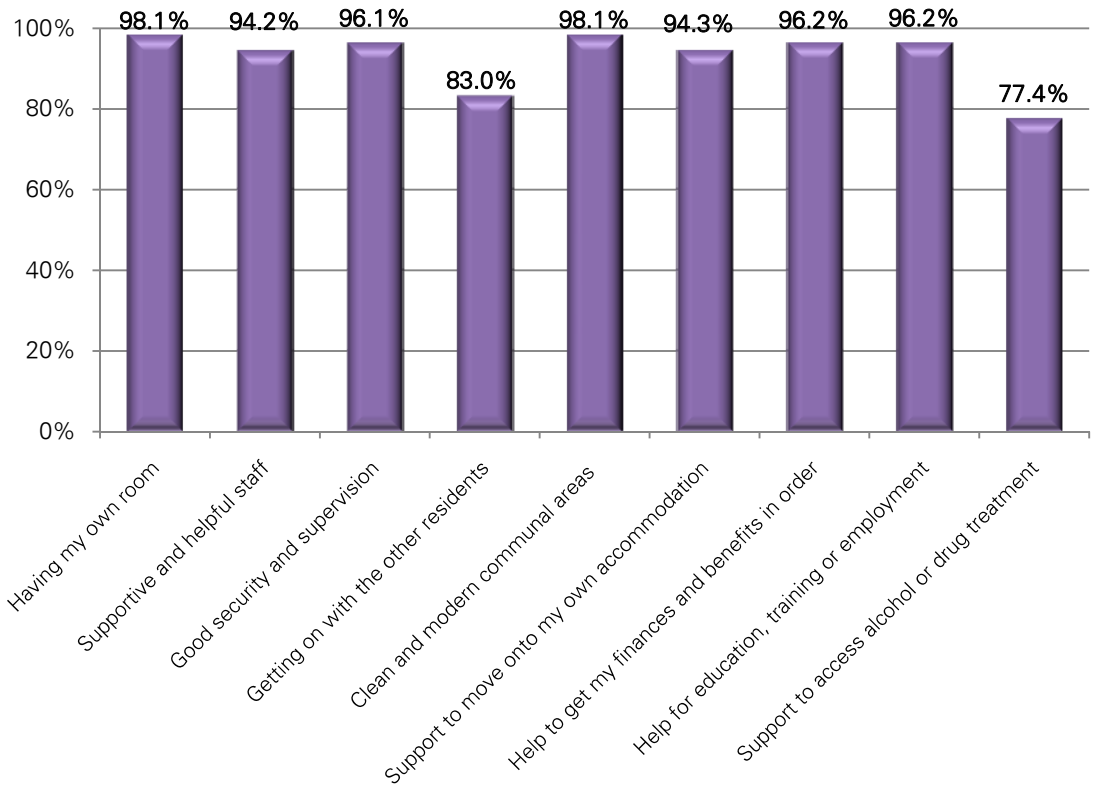

Figure 13: Proportion of participants who stated that various aspects of a hostel/foyer were 'important'[52]

Almost all aspects of a hostel/foyer were rated as important by over 90.0% of participants (Figure 13), with the exception of *getting on with the other residents* and *support to access alcohol or drug treatment* which were rated as important by 83.0% (n=44) and 77.4% (n=41) of participants respectively.

Figure 13 indicates that in-house support is considered more important and is potentially more appealing to the hostel/foyer residents.

[52] A combination of those who indicated that the aspect was 'very important' or 'important'.

3.2 Resident's Focus Groups – Qualitative findings

To gain further insight into the thoughts, behaviours and expectations of the young people resident in the hostels/foyer, focus groups were conducted. A discussion guide was utilised to guide each focus group. Twenty-nine young people were invited to attend the focus groups and 14 young people attended from four of the young person hostels (see Table 3 in section 2.3, for full breakdown).

Thematic analysis (Krippendoff, 1980; Braun and Clarke, 2006) of the discussions allowed the identification of six themes; accommodation issues, education/employment/training, service provision, socialising, substance use and support.

3.2.1 Accommodation Issues

Young people resident in the hostels/foyer spoke of accommodation issues involving their current residency in the hostel/foyer and/or prospective alternative accommodation.

Current Hostel or Foyer

Regarding their current accommodation a number of residents described their experiences in a positive way, although several made suggestions for improvements that would enhance their experience whilst residing in a hostel/foyer including environmental improvements and policy revision.

Six residents described their hostel/foyer as 'home' and spoke of their experiences positively.

"A good place to live and that it's a good environment like yeah."

However, four residents described their current accommodation in a neutral manner, as a necessary step towards gaining their own residency.

"Somewhere to come before you get a flat."

Twelve residents commented on improvements that could be made in order to promote their positive experience within hostel/foyer accommodation. These included reviewed visiting hours and related policies; building maintenance and facility improvement; and increased organised social activities.

Visiting hours and the rules surrounding visitors were mentioned by eight residents, specifically the proposed extension of visiting hours.

"6-9pm in the evening, I think they should have more."

Five residents commented on the maintenance of the building and facilities within their hostel/foyer. The decoration was criticised for not being maintained and the

cooking facilities available were also suggested for improvement.

"…I think it's the paintwork, to make it look like a home."

[Q: Any suggestions for improvements?]
"Toilets, bathrooms, kitchens."

Organised activities were also suggested by two residents in order to improve relationships both between residents of the hostel/foyer and between the staff and residents.

"More organisation for stuff [activities] *at the weekend."*

Alternative Accommodation

Five residents discussed their plans to obtain their own residency in alternative accommodation. The ability to search for their own flat was mentioned upon turning 18 years old, and resettlement support is available regarding obtaining, furnishing and maintaining tenancies.

"I'm trying to look for a flat as soon as possible like."

"Yeah, I get £100 when I leave and I'll use that to decorate. Once I've decorated the council'll come and look round and I'll get £150 decorating grant…"

3.2.2 Education, Employment and Training

The majority of the residents spoke about education, training and employment and their involvement with one or the other whilst residing in their hostel/foyer accommodation. For many being involved in some aspect of training, education or employment was a requirement for their continued financial and residential independence.

Education

Education, including course attendance and support was discussed by 14 residents during the focus groups. All were currently attending, awaiting acceptance or re-instatement on educational courses. Several participants (n=6) mentioned receiving encouragement from staff members in order to continue education and maintain attendance.

"Yeah, they get us up for college like."

"It's all about qualifications, for on your CV, the more qualifications you've got, the more likely you are to get a job, so…."

Two residents commented that continuing in education was a long-term financial necessity and one reported that in order to remain at the hostel/foyer some form of activity had to be undertaken during the day.

"Yeah, that's what I'm saying; have to stay in college to get paid. If I don't go to college like I don't get paid."

"No, like when I weren't in no college like, they started moaning at me in the end and you can end up getting kicked out of here."

Two residents also reported that they had been suspended from school/college in their educational history.

"No, I got suspended [from college] *this week."*

Employment

Some residents specifically mentioned currently looking for employment, but for many this was seen as the end goal after completing education or training. Three residents specifically reported that maintaining employment is made difficult due to the revision of benefits and rent upon securing a job.

"And you can't work when you're in here either. Cos the rents £130, if you get a job then you've got to pay £130 a month."

Three residents stated that the staff encourage the residents to actively seek employment.

"…kind of encourage you to find jobs…"

Training

Several (n=6) residents discussed their current training activities and the support received to attend courses. Similar to educational courses, residents are encouraged to attend any available and appropriate courses in order to improve their employability. However, one resident reported that attending training was a condition of benefit continuance.

"Me and him we do a course with the dole basically; we have to go there otherwise our benefits gets stopped."

Two residents mentioned that although course attendance is actively encouraged by hostel/foyer staff, some residents are permitted to refrain.

"But d'ya know where the say, getting up early and you've got to be up and out. Not many people actually do get up or nothin do they."

3.2.3 Service Provision

The services provided, including internally organised activities/events and external agency provisions and referrals were discussed by eight residents. Two residents stated that services including sexual health advice, budgeting and cooking advice are available within the hostels/foyer.

"Like condoms, sexual health, budgeting and stuff like that…"

One resident spoke of not needing any external service provision.

"I get all the support I need."

The majority of participants (n=10) spoke positively regarding the organised activities available within their hostel/foyer, including team activities, resident meals and days out.

"…there's gardening projects and they're meant to be setting up a football team and everything."

"…we went paint balling, a couple of months ago…"

Although, as previously mentioned, some suggested that there could be more staff organised activities.

"More activities would be nice, like going on a day out; Blackpool for a day."

3.2.4 Socialising

The influence of socialising with other residents, with staff and external friends was mentioned by 11 residents. Three residents also suggested staff organised events to promote cohesion within their hostel/foyer.

External Friendships

Five residents commented on their friendship groups from outside their hostel/foyer and their social activities, including substance use. Two spoke of their external friends substance use.

[Q: Do any of your friends outside the hostel drink or take drugs?]
"Yeah. A few of them does anyway, mostly just drink."

"Yeah, all me mates and that are on it [cocaine]."

A further two discussed their social activities with their external friendship groups, typically involving either staying in at their homes or going out to clubs and pubs with them.

"Just down to your mates and that innit."

Further to this, resident's discussed that finances play a part in their decision making process as to whether to stay in or not to socialise or 'party'.

"Depends how much money you've got! Comes down to that."

Hostel/Foyer Resident Friendships

A number of residents spoke about socialising with the friends they had developed whilst within their hostel/foyer. Similar to the activities undergone with external friends, this socialising took the form of either staying in the hostel or going out to bars and clubs.

"Just sit off and listen to music, have ciggies, watch films."

"Or go out to town, go clubbin like…"

Three residents mentioned the use of cannabis socially within their hostel/foyer.

"Yeah [smoke weed], *listening to tunes and that."*

The incidence of having parties within the hostel/foyer was also discussed; six residents reported that this does go on, although if it becomes too disruptive then the staff will intervene.

"There is parties that go on like, but if you're too loud and stuff like that then they'll come up and moan."

3.2.5 Substance Use

All residents were involved in the discussion of substance use, the discussion included alcohol and cigarette use, along with some illicit substance use (the most common substance being cannabis), the substance education available and the rules and policies within hostel/foyer accommodation.

Alcohol Use

Alcohol use was mentioned by 12 of the residents present in the discussion group. The majority of residents spoke of their own experiences of alcohol use both within the hostel/foyer accommodation and in external situations. Seven of the residents reported that they currently drank alcohol.

"Right my priorities, see been slacking the last couple of weeks, just been going to town and getting drunk…"

Whereas, four residents specifically mentioned that they don't drink alcohol currently.

"I just don't drink anymore cos when I was 12 I had my stomach pumped, tube down me stomach and all that and it was a horrible experience. Since then I've never really drunk, except like Christmas."

However, some of the residents (n=3) who stated that they no longer like to drink alcohol stated that they preferred to use cannabis, in fact one resident suggested that people use either alcohol or cannabis, generally.

"You do one or the other really [referring to cannabis or alcohol]*."*

Six residents mentioned the rules and policies relating to their hostel/foyer around alcohol use. Only one resident reported that alcohol use was allowed on the premises dependent upon the age of the resident, although it can only be consumed within the residents' room.

"…You're allowed a drink if you're old enough, but you're not allowed to show it on cameras or anything like that, just stay in your room with it."

The majority of residents reported that alcohol use was prohibited within their hostel/foyer, although it was suggested that it still occurs.

"…Drinking, you're not allowed to bring alcohol onto the premises, but if you're crafty you can sneak it in…"

All residents reported knowing what the current rules and consequences were surrounding alcohol use within their hostel/foyer, one having been recently reprimanded for alcohol related behaviour.

When the residents were asked their opinions about the alcohol consumption of their peers compared to the preliminary results obtained from this study, many reported that they may not be reflective.

"I think they were just saying that so that you didn't go back and tell…"

Although one resident suggested that there were a number of abstainers currently residing in the hostel/foyer.

"There is a lot of people in here though who don't drink though…"

Cannabis Use

Cannabis was mentioned by all of the residents in the discussion groups, although many (n=5) did not currently use this substance. Four residents reported that their cannabis use was a social activity.

"Rather just sit there stoned, with the tunes on, watching the telly or something…"

One resident reported upon the positive effects cannabis use provides for them individually.

"I've got problems and it takes the stress."

Conversely, one resident mentioned that reliance on cannabis can be counterproductive to solving emotional or any other issues.

"With emotional problems, when people do stuff like weed and that, it takes the problems away for like a while, until you come round from it and you sober up from being stoned and then….But then the problems still there, so cos its still there you'll smoke another green joint and then the problems just gets worse and worse."

All residents reported being aware of the rules and policies surrounding cannabis use (and therefore all illegal drug use) within their hostel/foyer; that it is prohibited. Although, it was recognised by the residents that the policies surrounding cannabis use are not as strictly adhered to as those regarding the use of other, illegal substances.

"You're immediately out, you don't even get to step back in your room, on some things [certain substances]. *If it's just weed, you get three warnings, if its smoking it in your room you get first warning on the conduct sheet and then manager will speak to ya…"*

Two residents mentioned that although there is a warning system in place regarding substance use on the premises, there was a lack of direct involvement from the hostel/foyer staff.

"They just slide them [warnings] *under your door; they don't even talk to you."*

Five residents reported that cannabis is a priority for them when considering the division of their finances, though generally not to the detriment of other necessities.

"I get paid right on a Tuesday every 2 weeks £75, joke [participant was indicating that their benefit payments were too low]*, I get £40 shopping (£20 each week) know what I mean, then have £35, I'll keep a £10-£20 for ciggies and then have like £15, I'll either get a £10 bud* [herbal cannabis], *or a £10 rocky* [cannabis resin]*…"*

When asked about the preliminary results from this study compared to the cannabis use of their peers, many reported that the findings may demonstrate confusion between the smoking of tobacco and the smoking of cannabis, specifically that more smoke cannabis than reported.

[Q: According to the survey 22% of residents smoke cannabis everyday, would you say that was accurate?]
"That is a bit low like."

Cigarette Smoking

Seven of the focus group attendees reported that they currently smoked cigarettes, with all stating that they knew the policies surrounding smoking on the premises; the use of tobacco was permitted in most of the resident's rooms, but not in communal areas of the hostel/foyer (one hostel did not permit the smoking of tobacco within resident's rooms). Some residents thought the preliminary findings, that the majority of young people resident in hostel/foyer accommodation smoked tobacco was an accurate depiction, although one thought that there may be a higher percentage smoking.

[Q: According to the survey 80% of residents smoke tobacco, ciggies and rollies, does that sound about right?]
"I'd say more than 80%."

It was also discussed that there may have been some misunderstanding between those who preferably smoked tobacco and those who preferably smoked cannabis. Some suggested that many people only smoke pure tobacco once they have no longer got access to cannabis.

"That's what every person in Liverpool does [smoke tobacco if they have no cannabis or money to buy cannabis] *"*

Stimulant[53] Use

Several residents spoke of stimulant use, although most stated that their use of stimulants was not current. Two residents reported past amphetamine use, three reported past cocaine use and five past ecstasy use (one reported ecstasy use whilst in hostel/foyer accommodation). Two suggested that the use of these substances had declined within their peer group due to limited finances and one suggested that, in reference to ecstasy, the trend was related to the changing music culture.

"Cocaine's a rich man's drug."

"To do with the music and all that [reduced ecstasy use]."

Other Substance Use (crack cocaine, heroin, legal highs, amyl nitrate)

There was only limited discussion regarding other substance use, i.e. crack cocaine,

[53] For the purposes of these findings amphetamines, cocaine and ecstasy have been grouped under the heading of stimulants.

heroin, legal highs and poppers. Only one resident reported past use of heroin, crack cocaine and legal highs; and two reported past use of amyl nitrate (poppers). The opinions stated about heroin and crack were generally negative; one resident reported a negative personal experience and another resident made negative comment about the use of these drugs.

"Dirty that mate [heroin and crack cocaine]."

Substance Use Education

Substance awareness education was mentioned by six residents, two of which spoke of education sessions that occurred prior to entering the hostel/foyer, three reported substance awareness sessions from external providers whilst residing in the hostel/foyer and one resident stated that staff members had discussed substance use with them. The external agencies that were mentioned by residents included Young Addaction, Arch Initiatives and Fag Ends, although no alcohol services were reported.

"Like Young Addaction and Fag Ends and all that come in and we got £60 for seeing all of them. There was about six people that we had to see over different weeks and then once we'd seen them we got a £10."

Two residents suggested that there were no other substance education agencies that they would like involvement with and a further two residents stated that they did not learn much that was new from the sessions with these providers, although reporting it was still useful.

"It is useful to know, there was things like that I didn't know like, but I knew most of it anyway. It's my own choice to smoke it innit, so."

3.2.6 Support

All of the residents spoke of the support received whilst in their hostel/foyer in a positive way; the majority reported that the support they received from other residents was encouraging and helpful, as was the support from the hostel/foyer staff.

Resident Peer Support

Six residents commented that they got on with the other residents in their hostel/foyer, four specifically stated that the other residents become like their family and are the best thing about living in their hostel/foyer.

"…full timers here become family…"

Participants suggested that the residents all support each other and promote a cohesive atmosphere.

"Everyone's there for everyone as well like, everyone's got different problems."

One resident reported that being placed in their hostel/foyer together helped to break down local social barriers.

"What's mad because we're all from different areas and we all get along with each other…"

"… cos everyone lives with each other, so would you be, rather be homeless and livin' on a park bench or get on with each other, know what I mean. When the odds are, when its stacked like that, know what I mean, most people'll just accept, well he's from Crocky [Croxteth] *but as long as he doesn't say nothin'."*

Four residents commented on their first meeting with other residents within their hostel/foyer, one suggested that it can be nerve-racking but not intimidating, three also spoke of the easy transition into residing in hostel/foyer accommodation; although participants reported that they were not formally introduced to other residents by the staff.

"Well, sometimes it's daunting, cos the second question out of someone's mouth is where are you from? Cos it's normally, 'what's goin on?', this is what I say to everyone that I've ever seen come in, 'what's goin on?', 'what's your name?' d'ya know what I mean and then erm, 'where are you from ?' know what I mean."

"Not really, just introduced myself me."

Staff Support

Seven residents stated that they felt supported by the staff at their hostel/foyer; many suggesting that the staff were similar to their parents regarding support provision.

"Naggin at ya, cos they love ya and they don't want…as half the staff tell ya, they see us as like their own children, cos they wouldn't give us any less advice than what they'd give do for their own sons or daughters…"

Also many reported that the hostel/foyer staff provided support to find alternative accommodation, attend education/training/employment, around substance use and with sexual health advice.

"…find like accommodation, or like a permanent accommodation…"

"If you get caught sleeping together, they pull you downstairs and they say to ya 'Have you got condoms? Have you got this…are you sure…' They talk it through with you."

Although one resident stated that there is a lack of staff support/intervention

surrounding substance use, specifically that it would be preferable if there was communication about the use.

"Nah, I'd rather they come and talk to me to check it out."

3.3 Key Stakeholder Interviews – Qualitative findings

To gain further insight into the accommodation provision, procedures and policies of the accommodation providers key stakeholder interviews were undertaken with representatives of the management teams of the hostels/foyer and one service provider. Interviews were guided by a discussion. Thematic analysis (Krippendoff, 1980; Braun and Clarke, 2006) of the interviews allowed the identification of four themes; assessment procedures, education/training/employment provision, substance use and the staff support.

3.3.1 Assessment Procedures

The stakeholders of the hostels/foyer detailed their assessment procedures upon the referral/entry of a new resident. All reported a comprehensive assessment procedure that included risk assessment and onward referral when necessary. Each hostel/foyer stakeholder stated that there were no outright behaviours that would deny a resident placement, although individual risk assessment took place in order to address any needs that could not be fulfilled within their hostel/foyer.

Referral and Protocol

In order to be referred to a young person specific hostel/foyer there are certain basic criteria that need to be met, the young person needs to fit within the age range of the hostel/foyer (16-25yrs, 16-35yrs or 16-18yrs) and they need to be homeless (or about to become homeless).

Following appropriate referral a needs assessment is completed. The protocol of when and where the needs assessment takes place differs from residency to residency; some complete the assessment prior to attendance at the hostel/foyer, whereas some complete this upon first interview; all interviewees reported use of a needs assessment process for discerning the suitability of their hostel/foyer to meet the needs of the prospective resident. The depth of information contained in the needs assessment varied, some receiving most of their information from the referral source and some undertaking a comprehensive assessment prior to acceptance.

"…we just read all the information that we're given, we make our questionnaire based on the information and what we want to know and what we need to know…"

"…it's a full assessment covering about 14 different sections…we start off by asking them to just explain who they are, some general information. So we get a little bit of a background of who they are, what they are, what they do, where they've been, what they've done before they've come in here. It covers substance misuse, and lifestyle. It covers family, where they've been past accommodated. It covers various aspects of risk assessments and criminality. It covers other agencies that they've been involved in. It looks at mental health issues, it looks at self-harming and if there's anything like that. So the interview lasts for round about an hour, it can take an hour and a half…"

Risk Assessment and Support Planning

Following the needs assessment and, dependent upon the level of risk identified within this, an assessment of risk is completed. This assists the hostel/foyer staff in their decision making process, regarding the offer of a residency.

"…so we will assess the risk to themselves, the risk from others, the risk to others, and we will assess their supported housing needs…"

"So you carry out that risk assessment and that's partly your decision making tool, so you're looking at do they meet your criteria, can we manage the risks, and that's where we make the decision as to whether to accept them or not."

Following the assessment of risks, if the decision is not to offer a placement within their hostel/foyer, the young person and their referrer is provided with suggested options.

"…after we interview, if we don't accept them, we write the reason why and ring the funder and tell them the reason why as well, so it's not just no. And they're told of the appeal procedure before they leave and they're given a copy of it to take with them, if they're unhappy with our decision. The whole interview is about assessing can we meet that individual's needs, what the risks to them are, what the risks to the other clients are and what the risk to the staff and general public is. And we say no sometimes to clients who we think that this environment would put them at too high a risk…So we might say to them, we think you're too vulnerable to move in. We might refer them onto somewhere else that may best meet their need, you know."

The needs assessment process is ongoing, as is the assessment of risks; therefore the hostels/foyer regularly reviews the young person's needs/risks as part of the support planning framework. The reviews are completed a minimum of every six months, but some are completed monthly. The reviews are accompanied by support plans, mutually agreed between the keyworker and the young resident.

"…they get a designated support worker/Keyworker from day one, every 12 days they will have a support plan with that Keyworker. And so, twice a month they'll get a support plan and then once a month they will have a review and the review is with a senior member of staff, client, the support worker and the outside agency are invited into it, to come along and have their input."

Onward Referral

During the ongoing assessment and planning process, if a need is indicated that requires specialist support/intervention the young person is referred as appropriate. A specialist support or intervention may be in the form of physical or mental health care, psychological support or criminal justice involvement.

"Yeah, we do liaise with other agencies and signpost and call them in if necessary..."

"We use the assessment to see if there are any risks or needs in that area and we will recommend and support people to access support from external agencies."

3.3.2 Education, Training and Employment

All of the hostel/foyer stakeholder's were keen promote the importance of education, training and employment in enriching and empowering the lives of the young people resident in their establishment. Some made involvement in positive activity or motivation to engage in education/training a criterion for residency (n=3), whereas others, although continuing to encourage this behaviour, did not make it a condition of their tenancy (n=2).

"…when they come in, within the house rules and the license scheme we have a positive time policy that they sign up to…"

"Bottom line here is, ready to start the work that's needed to get into training and education."

"Some hostels do have a requirement that they have to commit to being in some sort of engagement activity during the day. But we don't require that, but we do ask that, we don't make it a condition of tenancy but obviously we encourage and try to motivate throughout their time here to get them to engage in something during the day."

In-House Programmes

Similarly, there was variation between the establishments regarding the provision of education and training services in-house. Only two residencies provided an in-house programme of organised activities/training, these being two of the establishments that maintained positive activity as a criterion for residency.

"We have a full life-skills activities programme Monday-Friday that runs within the house, doing various things, and they have to be looking to seek some activities around whether its education, leisure or employment outside the hostel."

"We've also got…two voluntary work programmes, no three, three on at the moment."

External Education, Training and Employment Services

All hostels/foyer reported encouraging engagement with education, training and employment services that were externally provided. Three establishments specifically reported direct links with Connexions (an education, training and careers advice service), two mentioned several other agencies that they referred to or who regularly attended their hostel/foyer.

"…we have regular contact with Connexions workers…"

"Connexions coming in around education and employment, we've also got, the Jet service coming in around education and employment… No every week… we've got Oakmere community college that come in on a regular basis and that's about getting our young people into their college really, doing various courses and stuff like that."

"…colleges they'll come in regularly, they'll attend our coffee mornings… So we've got SLP (South Liverpool Personnel), Tomorrows People and Connexions are the three that we work with the most."

Barriers to Resident Engagement

Stakeholders agreed regarding barriers that young people face when entering into education, training and/or employment services. The two most commonly identified barriers were the amount of benefits the young people are in receipt of (n=3) and the lifestyle/life-skills of the young person (n=3). There were several other barriers reported, including motivation levels, the age of the young person, peer pressure and the agency perception.

The level of benefits received was reported as a problem by three of the stakeholders regarding entering into employment. Many young people residing in hostel/foyer accommodation are in receipt of housing benefit, along with at least job seekers allowance, and therefore the amount of rent they are required to pay is minimal. However, upon gaining employment they are required to pay either the full

rent or a proportional amount dependent upon their hours of work. This can make it extremely financially difficult to afford supported housing and many young people are economically 'better off' remaining unemployed, in receipt of benefits.

"…so I think a barrier for people going into work, could be they're receiving too much income and maybe they're able to live on that income cos they're not paying all these other things. And once they do go into work, they've got to be earning enough money for them to do that…Mostly our clients say I'm not going to go to work, why would I go to work, I'm going to lose money."

"It's not financially worthwhile for them to go to work while they're here. There are plenty of job opportunities that we can get them into, but when they look at it on a piece of paper and they do their incomings and outgoings, it isn't worth it. In many cases they're worse off if they work."

Lifestyle/Life-skills

The type of lifestyle and the amount of life-skills that the young people entering into supported accommodation have was suggested as another barrier into education, training and employment. Stakeholders reported that if someone has a particular lifestyle, then that in itself will negate their suitability for courses or employment. Also, the level of the young persons' educational attainment and previous job experience influence their ability to successfully gain entry into training, education or employment.

"…our own client's life, how they're living their life would be a barrier to attend. You know somebody who's high on substances or unmotivated and they're living on the streets… They're not going to be able to, at that moment in time, be able to sit in a classroom and listen to somebody. Maybe their educational attainment, that they've had, most of them have been excluded from school, and if they've been let down by their educational establishment. So where they are, to actually be able to go in, some of them can't read and write…"

"…being able to hold down a job, and maybe because they haven't been within the employment theatre, if you want put it like that, they don't have a history of references and things like that. Their life, maybe their criminality that they've been involved in beforehand could be a barrier to employers taking them on."

Levels of motivation were reported by two stakeholders as a barrier to engagement, although this is something that is challenged within the establishment.

"…because they're using like cannabis, about motivation and a nocturnal lifestyle as well."

"Motivation is often lacking. And also extremely low self esteem…"

One stakeholder mentioned the age of the young person being a barrier to engaging in education or training schemes, particularly that currently the funding is focussed on those young people aged 16 to 18; therefore those over that age can find it difficult to access the type of training or education they desire.

"…cos the drive at the moment by the government is to get young people into education, to get them into employment and there's stacks of money out there to fund that. If you're 21, there's not… "

The perception of the service provider was also mentioned as a barrier, in that if they haven't worked with young homeless people before, their perception may hinder that young person's engagement.

"…I think if there's an agency that hasn't really worked with our client group, they may have a perception about that individual before they come there, of what they're going to be like…which could then hinder them, going into those areas."

Peer pressure and the desire to belong were also cited as a barrier to engagement in positive activity, two stakeholders reported that the behaviour of other residents can sometimes have a negative effect.

"I think that peer pressure, when they come into a place like this, especially the bigger places and that they find that most of the other young people are not doing anything either it's like well why should I."

"The downside to coming into this supported housing is the group that you've got in; in any given time can have either a positive or a negative influence on the person who's coming in. You can have really, straight A sort of student, who comes in and is really motivated and they get hooked in with a load of people who just bum around doing not a great deal and then they just end up in another line of their ilk."

Positive Aspects of Support Provision

However, as the other residents can have a negative impact on each other, they can also have a positive impact. Two stakeholders reported that the behaviour of the residents can positively influence and increase the motivation of those around them.

"At the moment, we've got a really good bunch of residents in that are quite committed to training and education, so on the whole it is working and a lot of our residents are coming in to see me and they're saying " I've got onto a course", "I'm going for an interview", and that sort of thing. We're noticing because of our focus on training and education, because we've stepped up a gear on that, we're having less problems with anti-social behaviour, drugs and drink."

"…someone comes in and they see everyone else is out doing things and they think well ok, maybe I should, cos there's no one to hang around with. Cos they get

bored."

The variety of activities available and the links with other services was cited by many of the stakeholders as evidence of effective support provision.

"The range of options. It's basically a no excuses policy. We will find something for everyone."

3.3.3 Substance Use

The use of substances (including alcohol and tobacco) was discussed with reference to the rules and policies surrounding their use within the hostel, along with the internal and external service provision for education, awareness and support for substance use.

Alcohol Use

Each hostel/foyer reported different rules and policies regarding the use of alcohol on the premises. Some accommodation providers allowed alcohol consumption as long as the resident was over the legal age for use/purchase, whereas others had strict zero tolerance policies around all substance use.

"We allow people who are above 18 to drink in moderation in their own flat."

"…they can't bring alcohol onto the premises. Although, it's not illegal, we have 16 and 17 year old young people and people with drink related difficulties, so the last thing they want to see is people drinking it and the smell of it."

Despite the zero tolerance or moderate approach, most hostels/foyer reported that their young residents repeatedly drank alcohol, there continued to be instances of problematic alcohol related behaviour and that they were regularly required to enforce their warning policy due to alcohol use.

"…if someone's making a nuisance of themselves because they are drunk, and that becomes a perpetual thing, then obviously we need to address it from there because then they are breaking the rules around nuisance, noise, that sort of stuff."

"…If we notice, if we become aware that problems have been caused through alcohol, we can put an alcohol ban on a certain young person. It's an alcohol contract. And they have to agree to it, so they do have a choice as to whether they want to go onto it…"

All accommodation providers reported some contact with external agencies that would support young people around their alcohol use, those being Young Addaction and OKUK (a counselling service specifically for young people whose lives are difficult because of drugs or alcohol). Most establishments stated that they would

endeavour to refer and offer support to a young person if they developed an issue with alcohol, with the support often continuing throughout the warning process.

"…we can also put in there that they will have weekly support sessions with [name] from Addaction or they will go along and engage with another service of their choice if they want to go somewhere else."

"OKUK they provide, they've been in, yeah…And again Young Addaction, yeah."

Cannabis Use

All of the stakeholder's interviewed reported that along with alcohol, cannabis was the most used substance by young hostel/foyer residents. Due to its' illegal status, all of the accommodation providers maintained a no illegal drug use policy and if a resident is found smoking cannabis (and in some places if there is a strong suspicion) the warning procedure will be activated. Some hostels/foyer's will inform the police if a resident is found smoking cannabis and all will inform the police if a resident if found dealing cannabis on the premises.

"If they are smoking cannabis we then report it to the police as a criminal matter. And then we allow the police to do what they need to do and deal with it from there."

"…it's probably one of the biggest things we give warnings for, especially cannabis, cannabis is the major substance of use with our clients…we have enough evidence that we feel the likelihood that it proves that it was them, or the likelihood that it was you, then we'll give them a warning."

"We're also obliged by the law also as well. We can't be seen to be condoning drug use to be going on in the building. If we discover that there's been drug use we can go through, down a couple of routes. We can either, offer support first of all, record it in the drugs log book that we've taken action about it. And that could be we've made a referral, we've spoken to somebody about it in their support plan, they've been issued with a letter. If it becomes a recurring problem then we will contact the police, we will issue warnings."

As with alcohol, if a resident reports, or their behaviour suggests, they have a problem with cannabis use, the majority of the stakeholders stated they would support them in seeking assistance.

"…And on the times when we have smelt it [cannabis] *on the landing and we have suspicions as to who it is then at the support sessions the support worker will go through that and the support worker will act as an advocate and refer on to other places."*

"…We would maybe look to, if it becomes a problem, refer them onto Addaction,

and they'll go and see the worker here, and we have the hostel liaison worker who comes in and she'll do some work with them and stuff like that. So we try to put something in place that will hopefully, you know, their drug use will lower or stop…"

Two stakeholders specifically reported that the young people didn't think of their cannabis use as problematic, and, despite some negative impacts on their lives, it was often challenging to persuade them to seek support or advice.

"I think they do see it [cannabis] *as an issue, but they don't want any support for it……they quite, they enjoy it. It's like, how their lifestyle, you know it's cool, its, you know, all their friends are doing it; they'd be the odd one out if they didn't."*

"Yeah, they don't see it [cannabis] *as a problem. Quite often, it even happened to us last week, part of our interview assessment form is about drug use, do you use any drugs? No. And then two questions later on it turns out they use cannabis. And you say you do realise that's a drug….and they don't even see it as a drug…"*

Cigarette Use

The policies surrounding cigarette smoking, prevalence amongst residents and the support service provision were discussed during the interviews with the stakeholders. Some establishments permitted the smoking of cigarettes within the residents' own room, this was dependent upon the accommodation status, whether their rooms were seen as their own private accommodation or not. Regardless of this, cigarette smoking was prohibited in all communal/public areas, even within shared accommodation.

"They [the residents] *can smoke in their room, but because it's a public building, as of July 2007 they can't smoke anywhere else in the building, so that includes the kitchens, cos they're communal."*

"No, no [not allowed to smoke cigarettes in their rooms]."

Stakeholders stated that they believed most of the young residents smoked cigarettes, this was confirmed in our survey findings (section 3.1.7). Similar to all substances, if the resident requested support with addressing their cigarette use, the support staff in all hostels/foyer would refer them to a specialist service (such as Fag Ends).

Other Substance Use

As with cannabis use, any other illegal substance use on the hostel/foyer premises is prohibited, accordingly all stakeholder's reported that the warning procedures of the establishment will apply if a resident is found using or dealing illegal substances on the premises. Only one stakeholder suggested that there was use of any other substances by young people in hostel/foyer accommodation. It was suggested that the use of cocaine and amphetamines was occurring alongside alcohol use.

"Over the last couple of years, cocaine use. A few more dabbling in cocaine use, the majority of our residents that use are probably occasional users. And they're more, not dependent users, but problem users, so it means that they stay up till 4.00am in the morning, drinking, taking…sometimes I come in the morning and there's somebody wandering around the building who seems relatively sober, but they've been drinking all night, because they've took some tablets that've got amphetamines in, or they've taken some speed, or they've been using cocaine. So that is a problem, drinking now can go on for 48hrs and that is a problem yeah, and then it becomes much more problematic yeah."

External Service Provision

All stakeholders reported that they refer to external specialist service providers, as and when indicated, that is, if a concern is identified with substance use (including alcohol and cigarette use) at the assessment stage or throughout their support package, appropriate external agencies will be referred to (these included Addaction, FagEnds and OKUK most frequently).

"…we would try and support them with referral routes through Addaction and stuff like that to try and get them to realise the consequences of their drinking."

"Yeah, we've got leaflets from Fag Ends and we'll take them to Fag Ends. We have actually had Fag Ends come in and do sessions with them."

Two stakeholders specifically stated that a worker from Young Addaction held regular, weekly sessions in their hostel/foyer, which helped to promote engagement.

"...We've got Young Addaction coming in who will do counselling for substance misuse, and refer them onto specialist substance misuse and mental health services, anything to do with substance misuse, so they're coming in here. We've also got Addaction coming in for a full day, who are delivering alternative therapies for the clients, and that is acupuncture, EST (Electro-stimulation Therapy), reflexology, foot detox spa, massage, reiki, and that's a full day and the clients…"

"[Addaction worker] *will come into the* [residence] *once a week to do drop-in sessions, every second Wednesday she'll do a group session…so people will go along to that session, they'll get to know* [Young Addaction hostel worker], *then if we establish that they do have a problem in the future they're already aware of who* [worker] *is, the sort of work that* [worker] *does and it's easier for us to encourage them to attend the one-one sessions.* [worker] *will do an assessment with them, if* [worker] *thinks and they think that they could do with treatment then they'll be referred to a tier 3 worker at Addaction, choice is with them then."*

Barriers to engaging with external specialist agencies were suggested by three stakeholders. It was proposed that some young people were less likely to attend

these services due to misconceptions about them, as they are not attractive (decoratively) and due to lifestyle preferences. Two stakeholders mentioned that young people often have misconceptions about the specialist services, their staff and mistrust in the confidentiality agreements.

"Misconceptions probably. I'd say with about 50% of the cases they don't want to go and see a counsellor, they don't want to open up their heart about all of their life."

"I think the old barriers still exist, where I think clients who have got children, would feel very nervous going into a centre thing, oh god, that's where I'm going to lose my children…I think maybe some of the legal barriers of a young person using substances i.e. they're quite young and they think they're going to have to inform mum and dad and parents and other professionals and the police and stuff, which could be barrier for them and the school and, if they're at that stage…"

One stakeholder suggested that they are not particularly visually attractive to a young client base and that this may be a barrier to entrance.

"So I think some of the services could be developed better, that they look better, to attract young people."

Another stakeholder proposed that their lifestyle in itself and their peers may influence their decision to engage with specialist services. In fact it was suggested that many young people do not view their substance use as problematic.

"…they quite, they enjoy it. It's like, how their lifestyle, you know it's cool, its, you know, all their friends are doing it; they'd be the odd one out if they didn't."

3.3.4 Support

The level of support provision within the hostels/foyer was discussed by all stakeholders during their interviews. As previously mentioned, all hostels/foyer have individual support plans for their residents; referral to external agencies and support to move on are included in these. Improvements to the establishment and staff training and support were also stated as important factors as part of the overall support package.

Resident Support

All stakeholders stated that as part of their funding agreement, they are required to provide support to their residents, the level of support provision is dependent upon that agreed in their contract. Each support plan is individually agreed between the worker and the resident and will include any mutually agreed areas of interest.

"So on the support plan, that you…it's a negotiation about those needs that you've identified. You need to sit down with someone and say you know remember back when we did the interview, when you put on your application form that you're interested in doing this or you've got a problem about this, so we're going to look to see how we're going to address it now. What I'm going to do, what you're going to do, if there's a third party agency that we need to get involved with this?.. "

Within the support plan, if required and as previously mentioned the residents may be referred to external agencies. Along with the referral, one stakeholder mentioned that they endeavour to accompany their residents to their appointments in order to further support and sometimes advocate their needs.

"…that they can accompany the clients to these types of things, to actually go with them and advocate for them. Cos I always think a lot of them find it difficult just walking through the door into a class of 40 people, never done it before. So a member of staff being able to attend the interviews with them and the reviews with them and stuff."

Whereas another stakeholder mentioned their willingness to assist with attending appointments, with wake-up calls, in support, although it was stated that this will only be a short-term plan.

"The support worker may well put into their support plan that they will come in early, or they will pass on a message to give them a call to get them up. But we won't do it forever. We'll do it for a couple of weeks, if they can't get themselves up then we'll look at putting in their support plan putting themselves an alarm clock, get to bed early, eating the right food, not drinking."

All stakeholders stated that they actively support their residents to move forward in their lives, part of this being moving from this temporary hostel/foyer accommodation. Two stakeholder's reported specific in-house resettlement programmes that focus on moving the resident on both in their accommodation and in their life.

"…we have a resettlement programme, there's people going through our resettlement programme. And our resettlement's obviously about us finding them a property, and us moving them from here and we have a little resettlement grant that we give them that they can buy furniture and stuff like that… "

"…we have run an 8 week resettlement programme with residents called 'It's your move' and that prepares them for living on their own, in their own accommodation…And what we were doing was looking at their housing options, what choices they had. Getting them to realise the positives and the negatives of each type of accommodation; private landlord, moving back….moving back with your family is a positive move if it's done properly, private rented accommodation,

going to another hostel could be a positive move for somebody, going into accommodation with floating support, or an independent tenancy with another RSL (Registered Social Landlord). So we'll look at the plusses and the minuses of that…"

Improvements

Only two stakeholders specifically mentioned suggested improvements to their establishment's and their ways of working.

"More, more time for the individual support workers to actually be able to spend with the clients and not be stuck on the desk, that we talked about before. A new facility basically..."

"We could do with a training and education officer…"

Staff Support/Training

Each stakeholder reported that as part of the support package for staff and similar to the support provided to the residents, each staff member received regular reviews and supervision. Within the reviews, training needs are explored and development plans are designed to meet these needs. One stakeholder described the level of training available within their establishment.

"There is a robust training system within our own group but that's the most generic, so that's health and safety, fire marshall and first aid, the stuff that keeps people safe. Then from within there, in terms of supporting people training, there's also the Supporting People Programme which we engage in, which trains in needs assessment, support planning, risk assessment. We've had staff who've expressed an interest in NLP (Neuro-linguistic programming) training and CBT (Cognitive Behavioural Therapy) training…"

Stakeholders suggested opportunities for staff development, one specifically in anger management/conflict resolution and the other in substance use.

4. Conclusions and Recommendations

This section details the conclusions of this research and recommendations for provision of support within young persons' hostels/foyers, in addition to outlining further research.

4.1 Drug Use

Cannabis, cocaine and ecstasy were reported to be the most commonly used drugs amongst this cohort, a pattern which is similar to current drug use trends amongst young people in the general population, as reported from the British Crime Survey (BCS; Hoare, 2009). However, compared to the BCS, the young people from this cohort had increased frequencies of lifetime use ('ever use') for the majority of substances, specifically those included in the AACCE[54] grouping suggested by Hurst et al., (2009) and similar to the results found by Shaw et al., (2008). Twice as many young people in this cohort reported lifetime use of cannabis (79.6%) compared to the findings reported for young people (16-24 year olds) in the BCS (37.0%). Furthermore, the proportion of young people who had used cannabis in the last year was approximately three times that reported in the BCS; 58.2% and 18.7% respectively. Similarly, substantially more cannabis use in the last month was reported from this cohort (49.1%) compared to that found in the BCS (10.4%). Approximately three times as many young people from this sample reported lifetime use of cocaine and ecstasy compared to that reported in the BCS (2009), with similar differences observed for both last year and last month use of these substances (see Table 12 below for detail).

[54] Alcohol, amphetamines, cannabis, cocaine and ecstasy.

Table 12: Comparison of lifetime, last year and last month use of study cohort and BCS cohort (2009)

Drug	Time frame of use	This cohort (%)	BCS cohort aged 16-24 (%)[55]	Difference (%)
Cannabis	Ever Use	79.6	37.0	42.6
	Last Year	58.2	18.7	39.5
	Last Month	49.1	10.4	38.7
Cocaine	Ever Use	43.6	12.2	31.4
	Last Year	36.4	6.6	29.8
	Last Month	20.0	3.7	16.3
Ecstasy	Ever Use	30.6	9.9	20.7
	Last Year	18.1	4.4	13.7
	Last Month	3.6	1.5	2.1

Gender differences between this cohort of young people and that of the BCS (Hoare, 2009) are also notable. Approximately twice as many males from this cohort smoked cannabis in the last year compared to those in the BCS survey (67.8% compared to 23.3%); and approximately three times as many females from this sample smoked cannabis in the last year (47.8% compared to 14.0%). Approximately four times as many males from this cohort used cocaine in the last year compared to those in the BCS survey (38.8% compared to 8.8%); and approximately seven times as many females from this sample used cocaine in the last year (34.7% compared to 4.4%). The increased levels of substance use in young hostel/foyer accommodation residents is consistent with the findings expected and previously reported in research (Commander et al., 2002; Fountain et al., 2003; Neale & Kennedy, 2002).

The high level of last month cannabis use among the hostel/foyer accomodation residents is a notable finding; 27.5% of those who had ever tried cannabis reported daily use. Twice the number of males reported daily use compared with females (36.4% compared with 17.6%). Almost half of females who had tried cannabis reported that they did not currently use this drug (47.1%). The resident and stakeholder focus groups further provided evidence for issues relating to cannabis use; residents indicated that cannabis users may be self-medicating with the drug as *'it takes the stress'* and *'it takes the problems away for like a while'*. Stakeholders discussed that residents often don't regard cannabis use as an issue and *'they don't even see it as a drug'*. Cannabis use was considered by stakeholders to have a negative impact upon residents who often become 'unmotivated' and their lifestyle (late nights and often being 'high') could become a barrier to engagement in employment or education.

The findings indicate that the participants were open to experimentation with illicit drugs (particularly stimulant drugs), however regular use was not common, with the

[55] All proportions taken from the findings produced in *Drug Misuse Declared* – the results from the British Crime Survey (Hoare, 2009).

exception of cannabis. Participants showed an interest in other illicit drugs, but use was generally opportunistic and the drug was usually offered by someone else, as opposed to sought out by the participants. Residents' infrequent use of these drugs was related more to circumstance, such as limited finances, than disinterest; with the exception of heroin and crack cocaine which participants considered *'dirty'* drugs. Notably there were no reports of injecting drugs amongst the participants, which may be explained by participants' views of heroin and crack cocaine. However, 28.9% reported sharing equipment for snorting or sniffing powder substances, indicating a lack of awareness of the potential transmission of blood borne viruses, such as Hepatitis C. One stakeholder expressed concerns relating to a perceived rise in cocaine and other stimulant use amongst residents in recent years.

Two-thirds of participants reported that they had previously attended drug awareness sessions but that there was a general consensus that sessions were not particularly useful because they '*knew most of it anyway'*.

Recommendations

- Consider the potential for provision of indicated prevention initiatives (i.e. targeting those showing signs of substance use) with regard to cannabis use amongst hostel/foyer residents, with a particular focus on male residents.
- Given the profile of drug use amongst hostel/foyer residents appraise the opportunity to conduct selective prevention initiatives (i.e. targeting a particular sub-group of residents); specifically to prevent initiation and risky use of other illicit drugs including the sharing of notes and straws when sniffing or snorting substances and initiation into more risky administration practices, such as injecting. Initiatives may seek to add more information to the existing perceptions of heroin and crack cocaine and seek to emphasise the dangers associated with the use of other illicit drugs (such as cocaine, ketamine, ecstasy etc), in addition to highlighting transmission routes of blood borne virus.
- Any development of harm reduction and preventative initiatives with this group should consider that the participants may feel well informed about drug related issues. Analyse the effectiveness of techniques to promote engagement with this group, such as interactive workshops, where involvement of residents is encouraged, and the use of modern media should be considered.

4.2 Tobacco Use

The proportion of young people who reported current tobacco use was considerably higher in this cohort compared to that reported in the General Lifestyles Survey (GLS; Robinson & Bugler, 2010). In the 16-19 year old group from this sample, 78.9% reported current tobacco use, compared to 22.0% of the GLS sample; and in the 20-24 year old group 82.4% of this cohort reported current tobacco use compared to 30.0% of the GLS cohort. The increased use of tobacco found in this cohort is comparative to that demonstrated by Wincup et al., (2003), which reported that homeless young people smoked more tobacco when compared with housed young people. Notably, 13.6% of participants reported that they had first used tobacco since becoming a resident at a young persons' hostel/foyer accommodation.

The findings from stakeholder interviews re-emphasise that tobacco use is a cause for concern among hostel/foyer residents; within many residencies smoking was permitted in bedrooms or flats. Where a young person did express an interest in smoking reduction or cessation, most hostels/foyers had links with specialist support agencies, such as Fag Ends, or would accompany them to obtain prescriptions for nicotine replacement products.

Cannabis is typically smoked mixed with tobacco by young people. Given the rates of daily and frequent cannabis use amongst the young people nicotine addiction may be an issue, although they may not recognise it.

Recommendations

- Consider including tobacco use as part of the initial assessment upon entry into a hostel/foyer. Reviews of residents' smoking status may be frequently undertaken with a view to addressing such use at an early stage.
- Continue to address residents' tobacco use; consider encourage individuals to reduce their smoking by providing incentives and continue to make available cessation advice and quitting support readily available.
- Frequent cannabis users should be included within approaches for smoking cessation and harm reduction.

4.3 Alcohol Use

The proportion of young people who drank alcohol in the last week was less in this cohort when compared to findings in the general population (among 16-24s) as reported in the GLS (Robinson & Bugler, 2010. In this sample of young people resident in young person specific hostels/foyers, 48.6% drank alcohol in the last seven days, compared to 57.0% found in the general population. For young males, the proportion of those who had drunk alcohol in the last week was 25.0% in this cohort compared to 63.0% of the GLS sample. However, the amount of young females in this sample who drank alcohol in the last week was higher than that reported in the general population (75.1% and 52.0%, respectively).

These results suggest that the levels of alcohol consumption of young female residents in young person specific hostels/foyers are considerably greater than their male counterparts, and the general population.

The mean number of units of alcohol consumed in the previous week amongst this cohort was 47.5, compared with 13.1 units as reported among the general population (aged 16-24). The majority of those who reported alcohol consumption in the previous week were female and more females than males were drinking to harmful levels; the recommended weekly alcohol limit for females is 14 units (DoH, 2008), therefore, female residents were consuming approximately three times more than their recommended weekly alcohol limit. In addition, alcohol consumption amongst participants was concentrated on Fridays and Saturdays indicating high levels of binge drinking amongst current drinkers in this cohort (particularly females).

Recommendations

- Consider techniques to change residents' perceptions of drinking and engage hostel/foyer residents in mainstream alcohol prevention and reduction initiatives.
- Open consultation (both internally and externally) with a view to developing targeted reduction and alcohol awareness sessions, particularly for female residents. Include information on health effects, sexual health, alcohol and pregnancy, mental health and binge drinking.

4.4 Education and Employment

Over half of this cohort had at some point been excluded from school or college (57.4%); the percentage of males excluded was significantly higher than females at 70.0% and 39.0% respectively. Those who had been excluded from school or college were significantly more likely to have been in contact with at least one CJS organisation and a YOT. Almost half of participants (47.3%) were currently not in employment, education or training (NEET).

Stakeholders discussed that often when a young person first becomes resident in a hostel/foyer they may not be capable of attending college, training or a job, as other aspects of their life take priority. Often they work towards engaging with education, training or employment. Whereas other stakeholders reported that positive promotion of engagement in employment, education and/or training was their hostel/foyer accommodation policy, and some went further, by stipulating that engagement in one of these activities was a condition of residency in the hostel/foyer. There were mixed views on 'positive time policies' among the young people; some felt that it was good to be encouraged to attend college and to gain qualifications, while others attended college or training in order to get *'paid'* (i.e. receive their full benefit); others attended so they would not be *'kicked out'* of the hostel/foyer.

Some residents felt that the 'positive time policies' were not fairly enforced and that some were refrained from engagement with employers, education or training without consequence from the hostel/foyer accommodation staff. A number of participants indicated that they attended a course facilitated by the *'dole'* (job centre) where they undertook job searches and attended English and maths courses; attendance at these courses was considered a waste of time by participants who indicated that they were forced to attend otherwise their benefits would be stopped.

Given that such a high proportion of the participants had, at some point, been excluded from school and at the time of interview were NEET, concern was expressed that they may not have had accessed drug prevention sessions in school

(Edmunds et al., 2005). Remaining in education has been shown to improve awareness and provide protection from problematic drug use, and that those excluded from school are more likely to use drugs, be involved in antisocial and criminal activities, and have lower levels of communication with parents or guardians (McCrystal et al., 2007).

Of participants, just 10.0% were currently in paid employment. Concerns were expressed (by both young people and stakeholders) that the young people were not incentivised to secure employment as they would be financially 'worse off' due to the cessation of their benefit allowances and the requirement to pay rent at the hostel/foyer.

Recommendations

- Continue to extend support and encouragement to residents who are NEET to enrol in relevant college courses, training or find employment; with a particular focus on males who are more likely to be excluded from school and have contact with the CJS.
- Investigate the potential to subsidise rent, where possible and required, for those who gain employment, as a mechanism to encouraging continued employment. Consult with local area authorities to explore this possibility.
- Consider mechanisms to ensure fair enforcement of positive time policies, where they are in place and utilised.
- Examine the feasibility of training a staff member as an educational support officer (to assist residents with finding college or university places or engage in training which is appealing or useful to the young person). Such training may included the enhancing an understanding of grants, benefits and fees for educational courses.

4.5 Contact with the Criminal Justice System

A greater proportion of males than females reported contact with the CJS. Almost one-quarter of males had been in a youth offending institute (22.6%), while 32.3% had been given a youth rehabilitation order (YRO) and 41.9% had been in contact with a YOT. The difference between males and females in terms of contact with the YRO was found to be statistically significant.

Recommendations

- Examine the potential to conduct further research into the types of offending that young people become involved and consider employing appropriate preventative initiatives based on findings. Engaging residents in constructive interests may be a useful tool in achieving this aim.
- Ensure links are maintained between hostels/foyers and YOT in order to reactively provide support as required.

4.6 Family Contact

The majority of participants (92.7%) reported contact with family members (parent, sibling or grandparent) in the month prior to survey. Half of participants (50.9%) reported less family contact since becoming resident at the young persons' hostel/foyer.

Notably those without contact with a biological/adoptive parent had a higher GHQ-12 score than those who had contact with at least one biological or adoptive parent.

Recommendations

- Actively encourage and facilitate family contact (unless, in certain circumstances, contact is considered to have an unsettling or detrimental effect).
- Consider making visiting rules less rigorous with regard to immediate family members, especially among residents who do not have frequent contact with family members.

4.7 Mental Health

Two-fifths of participants (40.0%) demonstrated a GHQ-12 score which indicated potential psychiatric morbidity. The mean GHQ-12 score for females was double that of males. This finding was not found to statistically significant but approached significance and may not have achieved it due to the relatively small sample size. Consideration and reflection should be given to the substantial differences between the male and female scores. Additionally, younger residents had a significantly greater mean GHQ-12 score than older residents (under 20s compared with over 20s) indicating higher levels of potential psychiatric morbidity amongst younger hostel/foyer residents.

Those with a GHQ-12 score above the mean were proportionately more likely to report use of cannabis and cocaine; however, these findings were not statistically significant. There was a positive correlation between participants' absolute GHQ-12 score and the reported total number of used illicit drugs, which indicates that those with a higher GHQ-12 score were more likely to have used illicit drugs.
Notably, those with a below mean GHQ-12 score were significantly more likely to report contact with the CJS (and particularly the YOT). Those with a below mean score were on average one year older than those with an above mean score; 19.5 years and 18.5 years respectively.

Additionally, the GHQ-12 scores for participants who reported a diagnosed mental health condition were excluded from analyses. However, examination of their scores revealed that their average GHQ-12 score was 8.4 (n=5, range 5-11, SD=2.2).

Such a finding further demonstrates the requirement for strong links between the hostels/foyer and local mental health services.

Recommendations

- Ensure residents' mental health is discussed at the needs assessment conducted at beginning of residency. Monitoring mental health needs of residents at sensible intervals; with particular focus on younger and female residents (who may be more vulnerable).
- Ensure hostel/foyer staff are trained to recognise potential mental health issues.
- Ensure appropriate links with external agencies to provide further assessment, diagnosis and support for mental health conditions. Evaluate referral procedures for those with suspected mental health conditions. Ensure adequate support is provided for those with diagnosed mental health conditions in terms of access to health services and medication (via GPs and mental health teams).
- Consider the implication of the links between mental health status, age, substance use and contact with the CJS.

4.8 Sex and Sexual Health

Of participants who reported that they had ever had a sexual experience, going further sexually than they wanted, or planned to, was reported by 36.1% after drinking alcohol and 22.9% after taking drugs. Females were more likely to report having gone further sexually than they wanted or had planned to after drinking alcohol and males after taking drugs.

The Brook (a sexual health advice service) was the local service with which most young people (21.2%) reported past contact. Most hostels/foyer accommodation reported links with external sexual health advice services (for example, So to Speak and the Armistead Centre) who would visit the hostel/foyer accommodation to provide advice and distribute condoms. Additionally, the young people interviewed suggested that when hostel staff became aware that residents are involved in sexual relationships they often engage with them, offer advice and ensure they are equipped with condoms.

Recommendations

- Continue to promote safe sex practices and provide sexual health advice and condoms within the hostels/foyer accommodation.
- Continue to promote links with local sexual health agencies and provide education for all residents.

4.9 The Hostel/Foyer Accommodation Environment and Support

The participants expressed generally positive views about the hostels/foyer accommodation, with approximately two-thirds rating their hostel/foyer as very good or good. Participants generally felt at *'home'* in their hostel/foyer and considered the other residents as *'family'*. Suggestions made for improvements in the hostels/foyer mostly related to the building or facilities, changes in visiting hours and an increase in organised activities (particularly at weekends).

Regarding statements relating support from staff; approximately three-quarters of participants agreed that they felt comfortable talking to staff about problems and that the staff understood and made time to talk to them. Several participants discussed how staff took on a parental role, encouraging them to go to college, find employment and giving advice about sexual health and relationships. However, concerns were expressed among participants that warnings (particularly about rule breaking regarding alcohol or drug use) were sometimes delivered by staff without discussion; some participants felt it would be better if such issues were discussed face-to-face with residents.

A positive peer influence was identified with participants expressing that they could rely on their fellow residents for support. Participants discussed how hostel/foyer residency had removed social barriers that may persist had they continued to live in their original communities (for example young people from Norris Green and Croxteth living together and getting on). There was a level of respect expressed for those residents who were older or who had lived in the hostel/foyer for longer, with younger residents looking to them for advice and support. Stakeholders also discussed how positive peer influence had the potential to enhance other residents' motivation to engage in education, particularly when a resident observes that the majority of residents are out during the day.

Recommendations

- Consider conducting peer education training with residents in order to develop a number of peer advocates in each hostel/foyer. Such advocates may be able to deliver 'front line' advice and support, especially to residents who may not feel comfortable accessing mainstream services or confiding with authority figures.
- Assess the potential to provide a mentoring or training qualification for peer advocates.
- Assess the suitability of provision of motivational sessions for residents, including sessions conducted by previous hostel/foyer accommodation residents who have made successful progress since residing in youth persons' accommodation.
- Explore models of residents representation (where not already in place) to reduce potential friction between staff and residents and allow open discussion of potential issues and hostel/foyer policies.
- Consider using an anonymous suggestion scheme, relating to policies or practices, for residents to use with a view to enhancing communication and dialogue between residents and hostel/foyer staff.

4.10 Integrated Training

Participants positively rated their hostel/foyer overall, their interactions with staff and indicated that there was respect for more experienced (i.e. older and resident for longer) residents. Additionally, the least important aspect of the hostel/foyer was *'support to access alcohol or drug treatment'* whereas in-house support was rated as highly important (Figure 13). The lower rating of *'support to access alcohol or drug treatment'* may be due to the stigma attached to substance use treatment or the lack of appeal of services. Young people resident in hostels/foyers may have had contact with multiple and varied services in their lifetime and may prefer to have interventions and harm reduction delivered from key workers or peer support mentors (fellow residents) whom they know and are comfortable with. Edmonds et al. (2005) also highlighted the need for those who work directly with vulnerable young people to have a good awareness of illicit drug use and to be provided with appropriate training.

Research has shown that interventions which simultaneously address drug use and other issues such as housing, health or employment, have a greater impact with this group than those which focus solely on drug use, can have a more profound long-term effect (Ward, Henderson & Pearson, 2003). Building on the existing asset of communication and respect there is the opportunity to maximise engagement between staff and residents with regards to substance use, sexual health, financial planning, resettlement and other significant issues. Consideration of these factors

presents the opportunity for a novel approach: integrated training delivery for residents and staff of a young person's hostel/foyer in order to improve knowledge and understanding of significant topics amongst both groups and address potential harms and issues within the hostels/foyer as a joint agenda. It is expected that this type of intervention would benefit both staff and residents, particularly building resilience, promoting responsibility and contributing to post-residency re-integration.

Recommendations

- Consider conducting integrated training with both residents and staff of a young person's hostel/foyer in order to improve knowledge of both groups. Training could focus on mixed topics such as substance use and sexual health.
- Evaluate the applicability of delivering drug awareness training simultaneously.

4.11 Contact with External Agencies

Approximately two-thirds of participants reported attended substance use awareness sessions and one in 10 participants reported receiving treatment to reduce or stop their substance use. Such reported contact with external agencies may be interpreted relatively low when considering the expected support and service needs of this particular demographic. It was reported that substance use awareness sessions were mostly received from Fag Ends (a specialist smoking cessation service) or Young Addaction (a young person specific drug treatment service). However, participants also indicated that contact had been made with other local services, including The Brook and The Door/Connexions. Hostel staff indicated that they regularly invited, and referred residents to attend, external agencies. Residents' needs were generally assessed at the beginning of their residency and at regular intervals throughout their stay and, where appropriate, external agencies were recruited to be involved in the care and support of such residents. Additionally, hostel staff indicated that they invited external organisations in to run workshops, seminars and conduct alternative therapies and information sessions at suitable times. Participants reported that they were more likely to engage with the information sessions run by external services, when cash incentives were offered.

Since completion of fieldwork for this study, funding for the young persons' hostel/foyer worker at Young Addaction has been discontinued and therefore this post no longer exists. Stakeholders discussed how this post had promoted and

helped facilitate engagement of residents in substance use treatment and preventative initiatives. The discontinuation of this post was reported to have resulted in the loss of in-reach hostel/foyer accommodation services.

Recommendations

- Consider the extent to which awareness sessions or information seminars with external agencies can be specifically tailored for the young people in order to increase their appeal and improve engagement.
- Ensure the links established between the hostels/foyer accommodation and substance use support services are maintained. Consider developing the remit of hostel/foyer accommodation staff(s) roles to incorporate drug and alcohol expertise; facilitating referrals to treatment or support services where necessary.

4.12 Research Limitations

The finding of this report should be considered within the context of the research limitations. The data on drug use relied on self-reported data, which previous research has demonstrated may not always be an accurate reflection of illicit drug use amongst young people (Percy et al., 2005). However, focus groups were utilised in this study to validate survey findings, with the majority of participants verifying that the findings were a reliable representation of drugs and alcohol use in the hostels/foyer accommodation. One participant reported that there may have been concerns about confidentiality, in terms of communication between the research team and hostel/foyer staff regarding survey findings, stating that the reported drug use may have underestimated because *"they were just saying that so that you didn't go back and tell"*. Despite validation from the *Smoking, Drinking and Drug Use among Young People, 2008 Survey,* the alcohol related section in the survey was not always well understood or well completed by participants, despite the presence of a researcher during survey completion.

4.13 Further Research

The findings from this study indicate that hostels/foyers may play a protective role in preventing the progression of young people into frequent or problematic substance use. The types of substances used amongst this cohort were found to be similar to that of the general population (i.e. common use of tobacco, alcohol and cannabis), however the levels of use were considerably more than the general population, especially for tobacco use. Comparative research with young people living in adult hostel accommodation may provide useful insight into patterns and prevalence of

substance use for people who do not make the transition to more stable accommodation.

The GHQ-12 validated scale for potential psychiatric morbidity resulted in particularly interesting findings in the context of this research. Further and more detailed investigation into the mental health of young people resident in hostel/foyer accommodation, and the impact of substance use upon other areas of their lives, may provide a better degree of understanding in terms of the causation of correlations presented here; specifically between GHQ scores and ever used illicit drugs.

4.14 Conclusion

This research found that young people resident in hostels/foyer accommodation in Liverpool have similar trends of substance use as those in the general population. However, this cohort use increased amounts of drugs and alcohol and with greater frequency. The young people were also more likely to have been excluded from school, have been in contact with the CJS, be NEET and require support than those in the general population. The recommendations made include potential areas for further harm reduction and social re-integration for this group. Initiatives, such as integrated training with staff and residents, will increase opportunities for ongoing and long-lasting impact for the residents and accommodation providers beyond an individual's residency.

5. References

Biddle, L., Gunnell, D., Sharp, D. & Donovan, J.L. (2004). Factors influencing help seeking in mentally distressed young adults: a cross-sectional survey. *British Journal of General Practice, 54*, 248-253.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Crisis. (2003). The homeless factfile: A compact encyclopaedia from Crisis. *Housing, care and support, 6(4)*, 34-36.

Commander, M., Davis, A., McCabe, A & Stanyer, A. (2002). A comparison of homeless and domiciled young people. *Journal of Mental Health; 11(5),* 557-564.

Communities and Local Government (CLG). (2007). *Tackling Youth Homelessness: Policy Briefing 18.* London: Department for Communities and Local Government.

Communities and Local Government (CLG). (2008). *Digital Exclusion Profiling of Vulnerable Groups - Young People not in Education, Employment or Training (NEET): A Profile*. London: Department for Communities and Local Government. Available: http://www.communities.gov.uk/publications/communities/neetsprofile [accessed 01.06.2010]

Communities and Local Government (CLG). (2009). *Supplementary tables – Local Authority breakdown - Statutory Homelessness: July to September 2009 England*. London: Department for Communities and Local Government. Available: http://www.communities.gov.uk/publications/corporate/statistics/homelessnessq32009 [accessed 08.02.10].

Connexions. (2006). The *Client Caseload Information System – NEET figures for Local Authority areas 2006*. Available: http://www.dcsf.gov.uk/14-19/index.cfm?go=site.home&sid=42&pid=343&lid=337&ctype=Text&ptype=Single [accessed 22.02.10].

Connexions. (2008). *The Client Caseload Information System – NEET figures for Local Authority areas 2008.* Available: http://www.dcsf.gov.uk/14-19/index.cfm?go=site.home&sid=42&pid=343&lid=337&ctype=Text&ptype=Single [accessed 22.02.10].

Craig, T. K. J. & Hodson, S. (2000). Homeless youth in London: II. Accommodation, employment and health outcomes at 1 year. *Psychological Medicine; 30, 187-194.*

Department for Children, Schools and Families. (2004). *Every Child Matters; Change for Children.* London: Department for Children, Schools and Families.

Department for Children, Schools and Families. (2008a). *Reducing the number of young people not in education, employment or training (NEET) – The strategy*. London: Department for Children, Schools and Families.

Department for Children, Schools and Families. (2008b). *Staying Safe: Action Plan*. London: Department for Children, Schools and Families.

Department for Children, Schools and Families. (2009). *Statistical First Release: Participation in education, training and employment by 16-18 year olds in England.* London: Department for Children, Schools and Families.

Department for Education and Skills, Home Office & Department of Health. (2005). *Every Child Matters: Change for Children, Young People and Drugs*. London: Department for Education and Skills.

Department of Health. (2001). *Seeking Consent: Working with Children.* London: Department of Health.

Department of Health. (2008). *Units and You*. London: Department of Health. Available: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_085427.pdf [accessed 23.03.10].

Edmunds, K., Sumnall, H., McVeigh, J. and Bellis, M. A. (2005). *Drug prevention among vulnerable young people.* Liverpool: National Collaborating Centre for Drug Prevention, Liverpool John Moores University. Available: http://www.cph.org.uk/showPublication.aspx?pubid=175 [accessed 23.03.10].

European Monitoring Centre for Drugs and Drug Addiction. (EMCDDA). (2008). *Drugs and Vulnerable Groups of Young People*. Luxembourg: EMCDDA.

Fagg, J., Curtis, S., Stansfield, S.A., Cattell, V., Tupuola, A-M. & Arephin, M. (2008). Area social fragmentation, social support for individuals psychosocial health in young adults: Evidence from a national survey in England. *Social Science and Medicine*, 66, 242-254.

Fitzpatrick, S., Kemp, P. & Klinker, S. (2000). *Single homelessness: An overview of research in Britain.* Bristol: The Policy Press.

Fountain, J., Howes, S., Marsden, J., Taylor, C. & Strang, J. (2003). Drug and alcohol use and the link with homelessness: Results from a survey of homeless people in London. *Addiction Research & Theory, 11(4),* 245-256.

Goldberg, D. P. (1978). *Manual of the General Health Questionnaire.* Windsor: NFER.

Hawkins, J. D., Catalano, R. H. & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin, 112(1),* 64-105.

HM Government. (2004). *Every Child Matters: Change for Children.* London: Department for Education and Skills.

HM Government. (2008). *Drugs: protecting families and communities. The 2008 drug strategy.* London: HM Government.

Hoare, J. (2009). *Drug Misuse Declared: Findings from the 2008/09 British Crime Survey, England and Wales.* London: Home Office

Hurst, A., Parker, H., Marr, A. & McVeigh, J. (2009). *AACCE (non-opiate) substance use in the North West of England – The Changing profile of substance users engaged in treatment and its implications for future provision*. Liverpool: Liverpool John Moores University.

Klee, H. & Reid, P. (1998). Drug use among the young homeless: coping through self-medication. *Health, 2 (2)*, 115-134.

Krippendoff, K. (1980). *Content analysis: An introduction to its methodology.* Beverly Hills, CA: Sage.

Kristjansson, A.L., Sigfusdottir, I.D., Allegrante, J.P. & Helgason, A.R. (2009). Parental divorce and adolescent cigarette smoking and alcohol use: assessing the importance of family conflict. *Acta Paediatrica, 98*, 537-542.

Liverpool City Council. (2009a). *Children and Young People's Plan: 2009-2011*. Liverpool: Liverpool City Council. Available: http://www.liverpool.gov.uk/Education_and_learning/Copy_of_cypp/index.asp [accessed 18.01.10].

Liverpool City Council. (2009b). *Homelessness Strategy 2009-2011: Action Plan.* Liverpool: Liverpool City Council. Available: http://www.liverpool.gov.uk/Housing/Housing_advice/Homelessness/homelessnessstrategy/index.asp [accessed 18.01.10]

Liverpool Drug and Alcohol Action Team (DAAT). (2009). *Liverpool Citysafe (CDRP/DAAT) Adult drug treatment plan 2009/10.* Liverpool: Liverpool DAAT. Available: http://www.nta.nhs.uk/areas/treatment_planning/treatment_plans_2009_10/trpl1_09_10_yorkhumber_northeast_northwest.aspx [accessed 04.02.10]

Liverpool John Moores University. (2008). *Liverpool John Moores University Data Protection Policy.* Liverpool: Liverpool John Moores University.

McCrystal, P., Higgins, K. & Percy, A. (2007). Exclusion and marginalisation in adolescence: The experience of school exclusion on drug use and antisocial behaviour. *Journal of Youth Studies, 10(1),* 35-54.

McVie, S. & Holmes, L. (2005). *Family functioning and substance use at ages 12 to 17.* Number 9. The Edinburgh Study of Youth Transitions and Crime. Edinburgh: Centre for Law and Society, The University of Edinburgh.

Moran, P., Coffey, C., Mann, A., Carlin, J.B. & Patton, G.C. (2006). Personality and substance use disorders in young adults. *British Journal of Psychiatry, 188*, 374-379.

MORI. (2004). *MORI Youth Survey 2004.* London: Youth Justice Board for England and Wales. Available: http://www.yjb.gov.uk/publications/Resources/Downloads/YouthSurvey2004.pdf [accessed 23.03.10].

Neale, J. & Kennedy, C. (2002). Good practice towards homeless drug users: research evidence from Scotland. *Health and Social Care in the Community, 10(3),* 196-205.

Office of the Deputy Prime Minister. (2005). *Transitions Young Adults with Complex Needs: A Social Exclusion Unit Final Report.* London: Office of the Deputy Prime Minister.

Office for National Statistics (ONS). (2001). *All people in communal establishments: Census 2001, National Report for England and Wales - Part 2*. London: ONS.

Percy, A., McAlister, S., Higgins, K., McCrystal, P. & Thornton, M. (2005). Response consistency in young adolescents' drug use self-reports: a recanting rate analysis. *Addiction, 100(2)*, 189-196.

Pleace, N. & Fitzpatrick, S. (2004). *Centrepoint Youth Homelessness Index – An estimate of youth homelessness for England.* York: Centre for Housing Policy.

Pleace, N., Fitzpatrick, S., Johnsen S., Quilgars, D. & Sanderson, D. (2008). *Statutory Homelessness in England: The experience of families and 16-17 year olds.* London: Communities and Local Government.

Quilgars, D., Johnsen, S. & Pleace, N. (2008). *Youth homelessness in the UK. A decade of progress?* York: Joseph Rowntree Foundation.

Rachlis, B.S., Wood, E., Zhang, R., Montaner, J.S.G. & Kerr, T. (2009). High rates of homelessness among a cohort of street-involved youth. *Health & Place, 15*, 10-17.

Randall, G. & Brown, S. (1999). *Employment and training schemes for homeless young people.* Available: http://www.jrf.org.uk/sites/files/jrf/F6139.pdf [accessed 22.02.10].

Reid, P. & Klee, H. (1999). Young homeless people and service provision. *Health and Social Care in the Community, 7(1)*, 17-24.

Rice, E., Milburn, N.G., Rotheram-Borus, M.J., Mallett, S. & Rosenthal, D. (2005). The effects of peer-group network properties on drug use among homeless youth. *American Behavioral Scientist; 48*, 1102-1123.

Rice, E., Stein, J.A. & Milburn, N. (2008). Countervailing social network influences on problem behaviors among homeless youth. *Journal of Adolescence, 31*, 625-639.

Robinson, S. & Bugler, C. (2010). *Smoking and drinking among adults, 2008.* General Lifestyle Survey 2008. Newport: Office for National Statistics.

Shaw, C., Stredder, K., Woolfall, K. & Sumnall, H. (2008). *An exploration of the issues experienced by, and needs of, young people who are homeless or vulnerably housed in Liverpool.* Liverpool: Liverpool John Moores University.

Taylor, H., Stuttaford, M., Broad, B. & Vostanis, P. (2006). Why a 'roof' if not enough: The characteristics of young homeless people referred to a designated Mental Health Service. *Journal of Mental Health, 15(4)*, 491-501.

The Health and Social Care Information Centre. (2009). *Smoking, drinking and drug use among young people in England in 2008.* London: The Health and Social Care Information Centre.

The Salvation Army. (2009). *The Seeds of Exclusion 2009.* Available: http://www1.salvationarmy.org.uk/uki/www_uki.nsf/0/58A56A802FEAE3EC802575E5004A2FED/$file/The%20Seeds%20of%20Exclusion%202009.pdf [accessed 22.02.10].

Thompson, S.J., Barczky, A.N., Gomez, R., Dreyer, L. & Popham, A. (2010). Homeless, Street-involved Emerging Adults: Attitudes toward substance use. *Journal of Adolescent Research, 25(2)*, 231-257.

Votta, E. & Manion, I. (2004). Suicide, High-risk Behaviours, and Coping Style in Homeless Adolescent Males' Adjustment. *Journal of Adolescent Health, 34*, 237-243.

Ward, J., Henderson, Z. & Pearson, G. (2003). *One problem among many; drug use among care leavers in transition to independent living.* London: Home Office.

Wilson, D., Sharp, C. & Patterson, A. (2006). *Young People and Crime: Findings from the 2005 Offending, Crime and Justice Survey.* London: Home Office. Available: http://www.homeoffice.gov.uk/rds/pdfs06/hosb1706.pdf [accessed 23.03.10]

Wincup, E., Buckland, G. & Bayless, R. (2003). *Youth homelessness and substance use: report to the drugs and alcohol research unit.* Home Office Research Study 258. London: Home Office. Available: http://www.homeoffice.gov.uk/rds/pdfs2/hors258.pdf [accessed 23.03.10]

Woolfall, K., Wareing, M. & Stredder, K. (2009). Researcher Child Protection Protocol. Liverpool: Centre for Public Health, Liverpool John Moores University.