Homeless Young Women and Pregnancy

Pregnancy in hostels for single homeless people

Sarah Gorton
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Foreword

The focus of this report is young women who become pregnant while living in hostels designed for single homeless people. The findings of the study present a number of challenges to homelessness organisations, health promotion agencies and organisations offering support to young pregnant women and women with children.

Probably the most striking issue is how the homelessness sector organises itself in line with homelessness legislation, rather than in line with people's lives. The division created by the legislation of non-priority single homelessness and priority family homelessness means that almost every organisation and every publication or information resource is directed at either single homeless people or homeless families. The majority of hostels for young people will not accept a young woman at interview who said she was pregnant because a pregnant woman becomes priority homeless and so the responsibility of the local authority. People's lives are not so neatly divided and young women become pregnant while they are living in accommodation for single homeless people. Pregnancy is a very vulnerable time in a woman's life and they have big decisions to make. They need ongoing support, they need accommodation, and they need to be able to maintain relationships. Instead what happens frequently if they are in a hostel is that they are issued with a notice to quit, they leave the supported environment they have been living in and are out on their own in a bed and breakfast or in a flat, with few or no links to agencies that could potentially offer the support they need.

Young people living in hostels are often in a period of transition and turbulence in their lives. They may have had disrupted backgrounds; it is very likely that their family relationship has broken down, whether temporarily or permanently. They are without family role models, moving into adulthood, trying out relationships and often searching for some stability.

This brings up questions about the role of hostels in these young peoples lives. Do they have a role in addressing their sexual health, in improving their self-esteem, in helping them negotiate their way through their first relationships? What agencies exist that could support their decision making if they become pregnant and, if they keep the pregnancy, in helping them access the support they will need? Should the role of hostels be confined to the provision of safe and good quality accommodation? Or are there ways in which they can support the transition of a young woman into motherhood? What about the role of health promotion agencies? They are all currently addressing the issue of teenage pregnancy and submitting their plans to the Department of Health. Should they be addressing the specific needs of young homeless women, and what is specific about their needs?

This report addresses all these issues and provokes thought and debate about the solutions.

Libby Fry

Director, Barnardo’s Young Women’s Project
Summary of key findings

• A high incidence of unplanned pregnancy among young women living in homelessness agencies: in a survey of 31 London hostels approximately 24 per cent of young women residents had been pregnant in the previous year. There was also a low rate of abortion relative to other women in a similar age group in inner deprived London, where the rate of abortion for 16 to 19 year-olds is 41.3 per cent. An estimated 76 per cent of young homeless women were going ahead with the pregnancy.

• Young homeless women often leave home very young, have an unsettled family background, and have multiple moves. A background of abuse and neglect is common, as is a history of disrupted education and unhappiness at school. Low self-esteem and low expectations among the young women are perceived by the agencies as more relevant than a lack of sex education or poor access to advice and information.

• Homelessness agencies for single homeless people are struggling to find an appropriate role in relation to the issue and adopting different approaches. Many homelessness agencies do not accept pregnant women because they are seen as priority homeless. There are a lack of developed policies and a lack of staff training in sexual health promotion. Staff often feel unsupported by managers in addressing the issues. There is limited contact with external agencies offering advice and information and training in sexual health.

• Housing departments can be obstructive when hostels for single people are trying to move pregnant women on; demanding that they should go through the courts and get a Notice Seeking Possession. Women are caused considerable stress through uncertainty about housing and long waits in unsuitable environments. There is a general lack of housing options and a need for more supported and appropriate housing for young parents.

• Health Promotion Agencies are very variable in their level of contact with the homelessness sector. Some Health Promotion Departments are carrying out high quality work and are very proactive; others have no contact with the homeless sector.

• Homeless young women have difficulty in accessing mainstream health, social care and support services. Health visitors play an important role in providing a service in hostels. There is a need for support for young parents who have been homeless that feels accessible and comfortable.
Health Action for Homeless People (HAHP) is an agency, which works to promote access to the range of health and social care services for single homeless people. In 1996 we held a national conference on ‘Making Services Work for Homeless Women’1. The conference identified a number of issues, which have received little attention and needed further work. One was homeless women who had lost their children to the care system. We completed a piece of action research on this subject and launched a good practice guide in Spring 19992. Another issue identified was young homeless women and pregnancy, the subject of this piece of work, and the Cleopatra Trust and Lloyds TSB agreed to fund it.

Aims

The specific aim of the work was to explore what kind of support homelessness agencies can provide to young homeless women who are pregnant. In particular it aimed to:

1. make an estimate of the numbers of young women who are becoming pregnant or have children and are using services for single homeless people;

2. explore what provision, advice and support is available to them on contraception, termination, and parenting and how accessible and appropriate it is;

3. gather the views of the young women themselves and the agencies working with them about their experiences and models of care and good practice. This included finding out what support agencies need from the health sector, what young women want from services, what they have valued and what the gaps have been.

4. disseminate the findings through the production of good practice guidelines and a seminar for relevant providers and policy makers.

In carrying out the work it has become obvious that there are potentially a lot of other avenues which could be explored. We confined ourselves to looking at young women between the ages of 16 and 25 who became pregnant while using services for homeless people. We chose to look at this age group because it is the age range most commonly adopted by homelessness agencies providing services for young homeless people in London. This means we were not examining the equally important area of young women who become pregnant while living at home, who present to a Homeless Person’s Unit and are housed in a bed and breakfast. Nor have we looked at the large numbers of young women refugees and asylum seekers who are living in bed and breakfast accommodation and are pregnant or have young children. Also, in looking at the advice and support offered by homelessness agencies and sexual health promotion agencies to young women, we have not addressed the crucial area of services aimed at young men or explored the whole area of young homeless men as fathers.

HAHP is carrying out further research on behalf of the National Council for One Parent Families which will be looking at the housing experiences of young single mothers in housing need with the aim of influencing the development of appropriate models of housing and related support and provision.

Research methods

The research involved seven main strands:

Reviewing literature – Looking at any key policy documents and research in this area and any literature produced by local projects relevant to the issues.

Interviewing staff in 31 hostels for young single homeless people to get a picture of the numbers of young women who become pregnant while living in this type of accommodation and the issues it brings up for agencies. The agencies interviewed were selected from those categorised as for young people in the London Hostels Directory3. They included direct access, medium support and supportive housing schemes and leaving care schemes in inner and outer London Boroughs. The interviews were semi-structured and carried out on the telephone with the hostel manager, or a project worker if the manager was not available. They were followed up by face to face interviews with a small number of projects. All face-to-face interviews were recorded and transcribed.

Interviewing staff in day services for homeless people. Face-to-face interviews were carried out with staff from three agencies in central London offering day provision for homeless young people. One was unique in providing a playspace for the children of young women who have been or are homeless, one was a women only service and the third a day centre for 16–21 year old homeless young people.

Telephone interviews with staff in supported accommodation for single parents to find out the source of referrals to the projects, the agency’s relationship with external agencies, the support offered and women’s housing options on moving on.
Interviewing health promotion staff from health promotion agencies across London on the telephone to find out about any specialist work they are doing with homelessness agencies and whether they offer any generic training in sexual health promotion, which is open to homelessness agencies. In three agencies where more specific work was being done an in-depth interview was carried out face-to-face.

Identifying and making contact with parenting support agencies that may be able to offer support to young women who are pregnant or have a baby and are or have been homeless to find out about their referral criteria and any work they were currently doing with homeless women. One purpose of this was to explore ways of making links between parenting support agencies and the single homeless sector.

In-depth interviews with 11 homeless women who were or had been pregnant or had a child who also were or had been homeless. These interviews covered their background, their housing situation, their access to sexual health, pregnancy and parenting advice and support, their experience of homelessness agencies, their feelings about being a parent and any other issues they identified. Interviews lasted between half an hour and one hour and were recorded and transcribed. Women were paid £15 for their time.

The work was led by Sarah Gorton, policy development worker at HAHP and guided by a steering group drawn from homelessness agencies, the health sector and sexual health agencies. The group met three times over the life of the project to offer support and advice and plan the final outcomes of the project.

Policy context

Teenage pregnancy and parenthood has become a major area of policy in the last two years. There has been much publicity and concern expressed about the fact that Britain has rates of teenage pregnancy between 2 and 6 times higher than many of its European counterparts, only exceeded by the rate of teenage pregnancy in the United States.

The Social Exclusion Unit (SEU) was asked by the Prime Minister to develop an integrated strategy to cut rates of teenage parenthood and propose better solutions to combat the risk of social exclusion for vulnerable teenage parents and their children. In June 1999 they produced their strategy\(^4\) to halve the rate of conceptions among under 18s by 2010 and to get more teenage parents into education, training and employment. The strategy has been widely welcomed as understanding and tackling the issue in a way that is inclusive and far reaching. Every health authority now has had to produce, jointly with the local authority, an audit of teenage pregnancy in their area, identify the gaps in the services and how they are going to address them and submit this to the Department of Health by March 2001. In terms of accommodation the report states that teenage parents under the age of 18 should not be offered independent tenancies but by 2003 should be placed in supervised semi-independent housing with support. Different models of independent supported accommodation will be piloted in a number of areas with money top-sliced from the Housing Corporation’s annual grants programme.

In the wider policy context tackling teenage pregnancies is one of the issues addressed in Supporting Families\(^5\), the Government green paper on the family which looks at ways of strengthening family life. It suggests a range of ways to support families and promote access to advice on parenting issues, reduce the poverty experienced by people bringing up children, make it more possible to balance home life and employment, strengthen marriage and reduce conflict in the event of relationship breakdown. The green paper refers to the work done by the SEU as the basis for the Government strategy in the area of teenage pregnancy.

The £540 million Sure Start programme\(^6\) is part of the overall programme of support for parents but it aims to target support in the areas of greatest need. It will cover 250 areas of poverty and deprivation in the country. The programme aims to co-ordinate help for families with new babies and to ensure their children get the best possible start in life and that their parents have access to the type of help and support they need.

The government is also addressing this issue in relation to young people looked after by local authorities. One of the objectives of the Quality Protects programme\(^7\) is to have measures in place in all local authorities to ensure that the number of pregnancies to girls under 16 in public care does not exceed that of the general population. Penalties include the withdrawal of Children’s Services grants if these measures are not included in plans.

Literature review

Very little literature specifically related to the issue of young homeless women and pregnancy was identified. However the National Children’s Bureau (NCB) was funded by the Department of Health to undertake a three-year study\(^8\) on young people in care
becoming parents. The issues for this group are very closely related. There is a high rate of unintended pregnancy and a disproportionately high number of young women leaving care who are pregnant or already parents. The research looked at policies on sex and relationship education and the provision of contraception for young people in care and found them to be absent in most local authorities. Many of the young people had a history of interrupted education and had therefore missed out on sex education at school. However they found that a failure to apply their knowledge was more of an issue than a lack of knowledge. This finding is reported in another key study on teenage mothers:

“It has been demonstrated time and again that ignorance of contraception is not an important factor amongst most women who have unplanned pregnancies (Allen, 1985; Allen, 1991) even though perceptions that family planning services are inaccessible or lack guarantees of confidentiality may be a deterrent to teenagers” (Allen 1991). Allen & Bourke Dowling, 1998

The NCB study found a culture among the young people where sexual activity was the norm and there was a fear of not fitting in and being excluded; an important issue for young women who might already be feeling rejected and lack a sense of belonging. Pregnancy generally came as a shock to the young women. Adoption was never considered and generally having the baby felt like the easiest choice in the short term despite considerable pressure put upon them to opt for a termination. This is also reflected in the study by Allen.

“Continuing with the pregnancy was often not so much a decision as an acceptance of what had happened, reflecting a rather fatalistic attitude which characterised much of the behaviour of many of these young women subsequently. It could be argued that those who opt for termination of pregnancy have to make a definite decision, while for an important minority of the women interviewed in the present study, the decision to have a termination was not one which they felt they could make.” (Allen & Bourke Dowling, 1998)

Along with other work on teenage mothers they found:

“a clear anti-abortion feeling among these young women, rarely based on religious grounds, although it was by no means universal” (Allen & Bourke Dowling, 1998)

The relationship with social workers was generally poor and the fear of being labelled inadequate parents and having their children taken away meant they avoided any support or guidance on offer. The provision of suitable accommodation was found to be limited and uneven. Many of these themes are repeated in this work about young homeless women. The National Children's Bureau is now working on a range of materials and strategies to help looked after young women from having unwanted pregnancies and support those who do become parents.

Underlying all the research are socio-economic factors, which lead to disparity in the rates of teenage pregnancy. These were highlighted in the Independent Inquiry into Inequalities in Health which also made specific mention of homeless or runaway teenagers as within the high-risk groups for teenage pregnancy. Poverty appears to be as much a cause as a consequence of teenage pregnancy. In 1993–1995 the rate per thousand of young women under 16 becoming pregnant varied from 16.1 in Lambeth, Lewisham and Southwark to 3.8 in East Surrey. The abortion rate is also lower in areas of high social and economic deprivation. The list of family circumstances that make it more likely that a young woman will become pregnant at an early age listed in the SEU report is very similar to the list of risk factors associated with becoming homeless:

- poverty
- having been in care
- being the daughter of a teenage mother
- educational problems, low achievement and exclusion or truancy
- not being in education, training or work at 16
- experience of physical or sexual abuse
- experience of mental health problems
- being in trouble with the police.

This indicates that there is likely to be a strong correlation between young women who become homeless and those who become pregnant. A research study which explored mental health among young homeless people in a London day centre and hostel found
that in the intervening year between two interviews 40 per cent of the young women in the study had become pregnant.

The only literature found specifically on sexual health and pregnancy among young homeless women is a report from Luther St Medical Centre for Homeless People in Oxford. Results from their files show that 57 per cent of 42 women users under 25 have been pregnant at least once. Of those who did have children the vast majority did not have them living with them and in most cases social services were involved.

A paper on sexual health promotion from the Health Education Authority makes the point that until recently in the UK teenage pregnancy was not seen as problematic unless the young woman was unmarried. Age has now replaced marital status as the category determining acceptability. They conclude that there is an urgent need for a multi-agency, multi-strategy approach to this problem drawing together all aspects of housing, health, youth and voluntary work.

Most of the literature that exists on homeless young people and sexual health promotion is from the perspective of developing HIV and Aids education. This is useful and relevant but there is nothing looking specifically at the issues of contraception, pregnancy and parenting. An unpublished dissertation addresses the issue of sexual health promotion with workers in hostels for homeless people. This found that, in the area studied, the majority of hostel workers were involved in promoting safer sex with residents on some level, that no assumptions could be made about their understanding of safer sex, that most saw a role for themselves to be more involved in this area of work but there was a clear need for training to enhance their knowledge base, skills and ability.

Most literature on pregnancy among homeless women tends to concentrate on homeless families in bed and breakfast accommodation. A paper from Sue Walters, a health visitor in Nottingham, presents the findings of an action research study exploring the experience of homelessness on the lives of young mothers. The paper presents the idea that the experience of being in and out of homelessness is a pattern of loss. Survival becomes a priority and there is little space for mothers to relate to the needs of children or to stop and care for themselves emotionally and physically. Walters cites other work in which the evidence suggests that young mothers moving from homeless hostels and care situations are felt to be at the greatest risk and most in need of support services. Without support from other agencies the evidence suggests that young women who have been in care or repeatedly homeless may be unable to maintain independent living with their children and homelessness may be a trigger for child protection referrals.

The population of children spending long periods of their childhood living in bed and breakfasts and other poor quality accommodation is rising. All the evidence shows the detrimental impact this has on children’s physical and mental health and how the enforced mobility affects their access to health care to pre-school activities and to education. Bed and breakfast accommodation is likely to be where many of the young women in the hostels interviewed for this project have their first experience of motherhood.
2 Estimating the extent of the issue

Analysis of the results of the survey of 31 London hostels for single homeless people showed that approximately 24 per cent of young homeless women between 16 and 25 years of age were pregnant in the previous year. This is an estimate: sometimes hostels could give exact figures, sometimes only approximate. There were huge variations in the numbers reported; some agencies reported up to 60 per cent of their young women residents pregnant in a year, others as few as 5 per cent.

We also asked the agencies to give an estimate of the outcomes of pregnancies, how many women were carrying their babies to term and how many were having terminations. Again the estimates are necessarily approximate; hostel workers often felt that they did not know when young women had terminations. This means the above figures are more about pregnancies that young women carry to term.

However we gathered from the interviews that 76 per cent were going ahead with the pregnancy. The rest had arranged abortions or at the time of interview, had already miscarried. Agencies estimated that 24 per cent of young women were either having miscarriages or having terminations. The abortion rate for inner London deprived areas in 1995 in women aged 16 to 19 was 41.3 per cent and for 20 to 34 year-olds it was 45.8 per cent\(^{21}\). There are a number of factors which make this comparison unreliable. Workers did not always know when women had abortions and in some agencies abortions and miscarriages were grouped together so it is difficult to separate out different outcomes. It is also hard to know whether the number of miscarriages was affected by the stressful lifestyle of the respondents, but there were reported miscarriages where the woman’s homeless lifestyle seemed to have had a causal effect.

All information on hostels, including their categorisation, is taken from the *London Hostels Directory*. The above table gives an indication of the category of projects that were interviewed for the project and the number that were interviewed in relation to the number of that type of project in London. However the categories do not reveal very much detail. Within the category of ‘medium support young people’ there is one agency that manages 178 bed-spaces in 25 houses across a number of boroughs and another that manages 5 bed-spaces for women in a shared house. Most of the projects accept people within the age range of 16–25, but some accept 16 to 21-year-olds and one of the leaving care projects accepts 16 to 18-year-olds. The women’s housing scheme included in the study accepts women from 18 to 60 years of age and provided an estimate of the number of residents within the relevant age range.

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This section describes the complex pattern of accommodation and support services young women who are pregnant and homeless may have access to.

Local authority housing

The homelessness legislation states that women who are pregnant are in a category of priority need and that local authorities have a duty to house them. The code of guidance states that this duty starts from the beginning of their pregnancy. However some London local authorities in practice are stating that they do not accept pregnant women until they can show confirmation that they are 24 weeks pregnant. Some local authorities will not accept that a person living in a hostel for young single people is homeless and specify that the agency issue a notice seeking possession and take the young person to court. At this stage they may not be offering them independent accommodation but a room in a bed & breakfast, temporary council-run hostel accommodation or a foster placement. There is an extensive literature on the problems facing homeless families in temporary accommodation of this nature. (This issue is explored in greater depth in HAHP’s work on The Housing and Support Needs of Young Single Mothers, 2000).

Hostels for young single people

Hostels generally see their role as providing accommodation for non-priority homeless people who fall outside the scope of the homelessness legislation. However in terms of single people there are lots of grey areas in the homelessness legislation. People who are vulnerable due to mental health problems, youth and so on are priority categories and yet are provided for by hostels. Hostels are generally for single people without dependants. A young pregnant woman is single and without dependants but she does theoretically fall into the category of priority homeless.

The London Hostels Directory lists four different categories of hostels providing services explicitly for young people as outlined in the previous table. They vary in the type of accommodation they provide: shared rooms in large hostels, shared houses with no staff living in, single bedsits with staff on the premises, supported accommodation specifically catering for people with support needs, and possibly with a whole programme of activities. Most are mixed but some are women only and some are men only. The Hostels Directory has a category of ‘do not accept’ and hostels do not explicitly state that they do not accept pregnant women. However a telephone survey of 47 hostels in the London Hostels Directory providing services for young homeless people revealed that 72 per cent of those hostels did not accept women who state at referral that they are pregnant. Sometimes the responses were qualified by stating that if a woman became pregnant while staying there she would be allowed to stay and they would help her find move-on accommodation. But most often the short response was ‘No’.

Ten hostels stated that they would accept a woman who was pregnant but that it would depend what month she was in and that finding move-on housing for a pregnant woman was a difficult issue. One also stated that they would only take a pregnant woman if she already had somewhere to go when the baby was born.

As stated in the previous section there is a high incidence of young women becoming pregnant while living in hostel accommodation. Despite the majority of hostels adopting policies not to accept young women who are pregnant there are significant numbers of pregnant young women living in hostels.

Hostels for single parents

There are hostels providing specifically for single parents. These theoretically fill the gap when a young woman is waiting for her own accommodation from the local authority, and at the same time provide a level of support to women who are young, having their first baby, and might find it hard to cope alone.

It is difficult to find any comprehensive source of information on accommodation for young women who are pregnant or have a young baby. Many local authorities run their own temporary accommodation, which takes referrals from its own Homeless Person’s Unit but this is usually general purpose accommodation used for all homeless applicants. As the London Hostels Directory is the most likely information source for single homelessness agencies this was used to gather information on hostels for young women who are pregnant or who are young mothers. The London Hostels Directory lists 20 single parent projects. Some of these are specialist projects, for example for prisoner’s wives and their families or they are specifically for families where there are child protection concerns and where social services are funding the placement. Resource Information Service who produce the London Hostels Directory state that the information in this section is intended to be a guide to the type of provision and is not comprehensive. However, apart
from hostels in a number of London boroughs run by LIFE, the anti-abortion agency, the directory lists all the accommodation projects for young parents that are listed in the Really Helpful Directory which is the other source of information used by projects.

The majority of the projects for mothers and babies are run by housing associations. Some take referrals from a wide variety of sources and work with a number of local authorities to access permanent housing for the young women. Others have a close relationship with the local authority in which they are based or may be run by the local social services department and only take referrals from people who have been accepted as homeless within that borough. In all the projects the women claim housing benefit and rental income is the major funding source. Some of the projects take referrals from social services of young women who need a particular level of support or are care leavers or where there are child protection issues and an assessment of their capacity to parent is required. Social services then provide top-up funding and work in collaboration with the hostel in supporting the young woman.

Overall there appears to be a great shortage of bed spaces in projects for young mothers and there are local authority areas that do not offer any provision of this sort. Most of the agencies said they were nearly always full and had a waiting list, though some agencies said they could be full for a prolonged period and then have voids for several weeks. They are the types of projects where it is difficult to operate a waiting list as when young women are referred they are generally in urgent need of housing. The stage of pregnancy when hostels would accept young women varied from project to project; some took them in the first trimester, some not until the last trimester of pregnancy and some would continue to take referrals from women after they had given birth.

The average length of stay varied between 6 months and 18 months and was often dependent on the level of co-operation from the local authority and the availability of housing stock. Some of the projects had very good and close relationships with the housing department in their area; this was enhanced where the project was partly funded by the local authority. In the areas where the relationship functioned well, and there was available housing, projects could alert the housing department that a woman was ready to leave and she would be offered permanent accommodation within 2 to 8 weeks. In one borough they had a resettlement officer who worked alongside the project to resettle residents and in another a named liaison officer. These arrangements worked very satisfactorily.

In other boroughs communication was very poor, despite repeated attempts to set up liaison meetings by project staff. Sometimes the projects finally had to resort to evicting residents in order to force the housing department to take responsibility. The 1996 Housing Act was also perceived as having created difficulties and delays in moving women on.

### Day services for young homeless people

There are a number of day centres which are open to homeless people offering a range of services in London. The majority of day centres are male dominated and would not generally be comfortable for a pregnant young woman. However there are two central London day centres for young homeless people used by significant numbers of women and one project specifically catering for young women in housing need.

One of the central London day centres has a space especially for women and children open two mornings a week where the children can play, women can meet up with other mothers and with the family worker or get advice from a visiting health visitor. The playspace is very well used, both by women who are living in bed & breakfasts and women who have been settled in their own housing for some time. They continue to come back to the centre with their children because it is somewhere they feel comfortable and at home and can meet other women who have had similar experiences. A number of the women that use the centre have had their children taken into care so the worker supports them through that very difficult process, and attends case conferences with them. She has developed a working relationship with social services in a number of boroughs and tries to break down the barriers and invite them to come into the centre to see the type of work they are doing there. This centre is unique in providing for single homeless people but having a space for young parents. The centre is aware that the space can act as a magnet back into the world of homelessness and that it would be better for the young parents to be making links with support agencies in their area and going to parent and toddler groups. This would break their link with the social circle of homeless people. However for women who have been homeless for a long period or have had periods of street homelessness it is very difficult to integrate into local services and the centre provides a level of support which they may not access anywhere else.

The other day centre does not currently have any facilities for parents but it does do a substantial
amount of work around sexual health promotion, outreaching to young pregnant women who are on the streets and linking women into health and support services when they are pregnant.

The young women’s centre has recently changed its focus from women in housing need up to the age of 21 to women under 18, and is now specifically trying to reach women at risk of exploitation through prostitution. Sexual health is one of the issues addressed by all workers at the centre. Every week they run a health day and with Brook, the sexual health service for young people, they jointly employ a nurse specifically to work with the young women on sexual health issues. They have a counsellor, a beauty therapist, gym equipment and a programme of activities and groups running through the week. They are seeing an increasing number of young women who are pregnant.

Resettlement services

There are no specific resettlement services for young single mothers who have been homeless. Some of the hostels and some of the day provision for single homeless people have resettlement workers who provide an outreach service of varying lengths for people who have moved on into independent accommodation. For instance one of the day centres continues a key work relationship with a client if there is no other agency providing it.

“If they settle into a flat or a mother and baby unit we would try and maintain contact for four to six months, but we would carry on if there were problems. We try and make sure that the mothers and the children are linked into services. We try and look at the whole picture of how they are living and if they can’t cope we would try and bring in other support.”

However in general there seemed to be very little contact between homelessness agencies and agencies offering support to parents. There was also a feeling that social services were only there in a crisis and were not available to offer a preventative, supportive role when a homelessness agency had identified some concerns.

A number of agencies working with single parents continued to offer quite a significant level of support once the young women moved on. One project that was run by social services had a specific outreach service that supported young mothers who stayed with their families or with friends in the borough either by getting them involved in groups run in the residential project or by home visiting. The outreach workers also stayed in touch with women who left the project for at least 3 months to help with resettlement and ex-residents were welcome to use the project for ongoing support if problems arose.

A number of the projects had a very informal arrangement whereby young women were welcome to come back to the project and attend social events or bring practical problems but did not have any resources to offer a formal resettlement role. They said that women tended to use the project as a support for a short while but there was a high turn over of residents so they would let go after a while. One project offered one resettlement visit to each resident but then tried to put them in touch with agencies like Newpin or Homestart which could continue to offer them support. Some agencies mentioned transferring the support role to those or similar voluntary agencies in the community or putting people in touch with family centres in the area.

One project had recently taken residents on holiday and two of the recent ex-residents had joined them. The manager felt this was a way of maintaining continuity.

Another agency whose residents were generally placed for long periods in bed and breakfasts after leaving them tried to keep in touch but found that it was hard as the women were constantly being moved around.

Parenting agencies

There are three agencies which operate nationally and provide support to parents. They were contacted and asked about their provision of services for young mothers in housing need including referrals from homelessness agencies, whether homeless women formed part of their client group and what type of support was on offer. Local areas may have other agencies that hostels are in contact with or that health visitors and social workers know about. It is often the case that young women do not want to be referred to any support agencies or that they are apprehensive and need a lot of encouragement and help to make use of what is on offer. Many hostels had no Information about what might be on offer to women should they choose to use it.

Newpin is a national voluntary organisation which helps parents under stress break the cycle of destructive family behaviour. Newpin has a network of local centres where expectant mothers, parents and children are offered an opportunity to make positive changes in their lives. There are eleven Newpin centres in London.
The support offered by Newpin requires a time commitment from the mother or carer, in that members are expected to attend at least two sessions a week, and make a commitment to make changes. Once a member is settled the centres offer play facilities for the children and a programme of support and development for the mother based on the principles of support, equality, empathy and respect. Newpin now have a teenage mum’s project in Peckham and an ante/post-natal project running from Guys/St Thomas’ hospital. Women who become members of Newpin speak highly of the transformations it enables them to make in their lives and many of them move on to become volunteers for Newpin. Provided they can make the commitment required women can self refer or can be referred by hostels and get involved while they are living in temporary accommodation or a bed & breakfast.

Home-Start is a national voluntary organisation committed to promoting the welfare of families with at least one child under five. Volunteers offer regular support, friendship and practical help to families under stress in their own homes helping to prevent family crisis and breakdown. There are 23 Home-Start schemes in the London region.

Home-Start nationally has a policy to work with women with at least one child under 5 but all the local schemes have some autonomy and some of them will work with pregnant women and start the befriending process at that stage. Anyone can refer to Home-Start and generally the criteria is that a mother wants some support. Most schemes then do a visit to assess what Home-Start can offer home visiting, friendship, encouraging the parents’ strengths, helping them to get involved in activities in the community. They then try to match a referral to a volunteer befriender. The schemes vary in their contact with women who are or have been homeless. Some schemes, for example Islington, do a lot of work with women in bed and breakfasts and in the hostels for mothers. In addition to the volunteer befriending they are setting up playgroups, young parents groups and groups specifically for Bangladeshi women. Other groups had not had experience of working with women who were homeless but were open to taking referrals from any women in their area.

Sure Start is a national government programme which aims to improve the health and well being of families and children before and from birth, so children are ready to thrive when they go to school. By 2002, there will be at least 250 local Sure Start programmes in neighbourhoods where children’s needs are most pressing. Sure Start is currently being established in a number of London boroughs but each borough will have a Sure Start programme in only a limited part of that borough. Within that area every family with a child under 4 will be able to use the services offered by Sure Start which will be run by partnerships of statutory voluntary and community organisations with the involvement of parents. The impact this programme will have on women living in temporary accommodation will depend on whether the area covered by Sure Start includes hostels and bed and breakfasts and this will vary from area to area. Another programme called Sure Start plus will also be piloted from April 2000 in 20 areas, which are also covered by Health Action Zones and by Sure Start. This programme will offer personal support to all pregnant teenagers to help them make choices about their pregnancy and will offer support packages to help teenage parents with housing, health care, parenting skills education and child care. Sure Start Plus is only at the beginning of the implementation stage so it is unclear how helpful young women will find it as a resource.
This section is about the understanding that workers in homelessness agencies have of the issues affecting the young women in their hostels. Are agencies doing work on sexual health and pregnancy issues? Do they feel the young women have choices? Is there a basic lack of sex education? Are pregnancies planned or unplanned? What is their impression of young women’s feelings around the issues?

Firstly staff identified the hostel environment as giving the young people, who are mainly in mixed hostels, a high degree of freedom. They were away from home and from any parental control, sometimes there were no staff living in and the young people were having a lot of sex. Workers felt there was often a strong culture that put pressure on everyone to be engaging in sex, as there is in any environment where young people are away from home for the first time.

Nearly all the staff interviewed felt that the background of the young women and young men they worked with was a significant factor in the high rate of pregnancy and that there were a number of factors at play which were all interconnected.

A majority of the young women had poor educational achievement and low expectations; that they would do little with their lives other than have children:

“Definitely the ones that are going for it, they have no ambition about jobs or education; they definitely see themselves as having children no matter what, the boys too. It’s a purpose and a function, it gives you a sense of achievement; there isn’t that dream about a career.”

“I think for young women and probably young men too, is this notion of having a life, it goes with self-esteem, having some purpose and a sense of future. I think young women probably get drawn into having babies because they see no other future, and it gives them instant status, instant adulthood. They get an awful lot of attention when they are pregnant and then that probably runs the risk of serial pregnancy. Once you’ve had the baby the attention has gone, so what is there really left except to have another one, especially if that is the only sense you are getting of what is fulfilling.”

Their life experiences have given many of the young women a low level of self-esteem and a lack of feeling of control over their lives. This can mean that they are neither taking action to prevent pregnancy nor feeling they have choices once they are pregnant:

“It’s definitely about self-esteem and how they view themselves. It’s a holistic thing, one wouldn’t work without the other (sex education without work on self-esteem and assertiveness). They feel bad about themselves and the boys want sex and they know the boys will like them.”

“It seems to me so far that the issue of negotiating relationships and self-esteem is far more important than information. People have the information on contraception and sexual health, it’s the capacity to deal with that information in the context of a relationship and to negotiate it.”

“The young people are coming from unsettled lives, maybe having been exposed to abusive relationships. They have not had that building of self-esteem, they are not always able to advocate for their rights or negotiate about what happens to their body or what they do as a result.”

“I think it’s all about self-esteem; they have very low self-esteem; they don’t care about their health or well-being. Adolescence is a very turbulent time anyway and even worse if you have nowhere to live or are away from home and don’t have family roots. Their lives are so chaotic, they put themselves at risk every day of their lives on the street: health issues, drug issues and pregnancy is part of that.”

Many of the young women have missed out on education, been excluded from school or truanted for long periods. So in some cases even the personal health and sex education that should have been available through school has been missed. However the feeling of most of the workers was that sex education had to go alongside building up self-esteem and negotiating skills in relationships and that even with a lot of input the issues at stake ran very deep and could not be changed.

“I can think of three women I have worked with where I think they would have kept their baby whatever. They had their own agenda about it. We might be saying ‘Oh, they are 16 years old, it’s an unplanned pregnancy’ and have fears for them and they will fall in with that and say they used a condom and it didn’t work and it was unplanned but I think sometimes it wasn’t so unplanned. The ones where we feel we have had a lot of input, sexual health information, role plays, trying to think of innovative ways of putting information across and they are the ones getting pregnant. So we end up thinking ‘Are we doing it wrong or what’s happening?’”

A worker from a project for young people with multiple needs also emphasised a hidden agenda:
“It’s never an accident – they will rarely articulate the real reasons and will usually say ‘It was an accident, I’m against abortion, therefore I’m going to have the baby’. The feeling among the staff team here is that it is about having something of your own, something that people can’t take away from you, something that is going to love you – not for you to love them but for them to love you unconditionally. It’s a measure of success; it’s a measure of adulthood and independence.”

Many of the young women have never had a family life and the idea of a baby enables them to imagine changing that narrative in their lives and creating a family and undoing the damage:

“I think it’s more about creating their own family and trying to get it right in their own way.”

A worker from an agency that worked with a high proportion of women who have slept rough thought that the majority of pregnancies were mistakes but those that were planned were planned with the idea of creating ‘a family’:

“Most of them don’t care about their health or well-being, they are too chaotic…I would say a very small percentage feel that they want to settle in a relationship that is theirs and it doesn’t work out that way. They think they are in love with this boyfriend and this will cement it: ‘If I have a baby we’ll be a family which is something I never had.’”

Their peers around them support this fantasy. One worker described the level of excitement in the hostel for a young woman and her boyfriend, both aged 17, who are about to have a baby:

“It shocks me how excited they are and how normal they think it is and how everyone else thinks it’s great.”

A number of workers in agencies mentioned that it gradually became apparent how many of their residents had fathered children but had no contact with them:

“The dad’s attitude is ‘I’ll stand by, I’m going to do it right, I’m not going to treat my baby like I was treated.’ But again it’s fantasy land. How compliant they are with the pregnancy is questionable but they have such a short-term focus. They know at the end of the day they won’t have to be responsible and they don’t emotionally engage with it at all. The relationship runs its span and quite often they are hooked up with someone else before the baby is born, the dad is never around when it is born.”

“They haven’t learnt. They are repeating the same thing all the time. At the end of the day it’s the woman who has to deal with it. We need to be making them aware of the pressures that women have to go through and that they have responsibilities as young men. They are really nonchalant about having children.”

There was also recognition of how little chance young men had to explore and understand relationships:

“They are young, they have probably not had good role models or people they can talk to easily and they are suddenly in a house with other young people, they have a real issue about relationships and they need somewhere to express things and talk about it.”

There was a feeling that, where there had been a break with their family, this was sometimes perceived by young women as a way back in:

“And their families, that is a huge thing, absolutely huge, phoning up and saying ‘Mum, Dad, I’m pregnant’. They are more likely to be reaccepted by their families because they are pregnant than for themselves.”

The rate of abortion in most cases was reported to be relatively low. This was felt again to be an issue related to self-esteem and lack of self worth and women not feeling that they had a choice:

“I’ve worked with women who decide to terminate and I’ve helped them through that, made sure they had the right counselling and stuff and I feel they are the ones who feel as though they have a choice. It’s those who are the most vulnerable who feel they don’t have a choice that decide to keep and struggle.”

“I’ve found when they are pregnant and I say ‘Let’s discuss your options’ they say ‘Well, what options? I’m going to have it’ almost shocked as if I would consider it and there is no option. I’m surprised, often they don’t even consider terminating.”

“It’s a very small minority, tiny, (who decides to have a termination). They don’t feel they have the choice. If they have been in and out of care and from broken homes, they feel this is theirs, it makes them feel special, and if they did any different and if anybody found out, it would be a judgmental thing again.”

It is also related to taking control of their lives. To decide to have a termination a woman has to be organised and assertive. She has to find out in time
that she is pregnant, make a decision to terminate, make contact with services and arrange an abortion. If that action is not taken the pregnancy goes to term. It was the impression of a number of respondents from homelessness agencies that it was not a question of choice but rather taking the option that did not require any decisions.

The ready acceptance of the level of sexual activity in many of the hostels for young single people is in contrast to the stricter regime imposed in many of the hostels for single parents. Very few of the projects allowed overnight visitors. So if women were still in relationships with the father of their child or in another relationship there was a difficulty for them in sustaining the relationship or having normal contact with their boyfriends. The projects are designed for single parents which denies the reality that often single parenthood is a shifting status and that when a woman claims as a single parent it does not necessarily mean she has cut off all contact with the father of the child or that she may not choose to enter other relationships. The way in which much of the supported accommodation is provided acts to drive fathers further out of the picture. Projects that did not allow overnight visitors felt that it would put young women at risk and one project stated that if the rule was broken, even in their second stage independent accommodation, it would be grounds for repossession. Two projects where the women were all in bed-sit accommodation did allow overnight visitors for up to three nights a week and found that this worked well. The women were very responsible and did not abuse the rules of the project.

Policy

Many agencies have policies on not accepting women who are pregnant and on the length of time a woman can stay at the project if she becomes pregnant. Yet policies on training for workers, contact with sexual health agencies in the community, and making information resources available were notable for their absence. It was often quite arbitrary and dependent on the initiative of individual workers if more than a minimal amount of work was done in this area. This was identified as a gap by a number of workers and an issue they felt needed addressing by management. For example two workers were doing a substantial amount of work on sexual health but felt quite unsupported:

“I think the best way is a clear policy. It would make our jobs a lot easier if there were clear policies and if there was recognition from management that this was a valuable job and an important part of our role. It would free up time to develop things. At the moment we are just trying to get things together but there is no designated time or statement that this is part of your role and just as important as collecting rent. If there was that sort of policy it would legitimise what were you doing.”

“I think that it’s really important for managers or service providers to realise that you are dealing with young people with special needs. You can’t just think that we are dealing with housing. There are so many issues that you are dealing with and we should have training to advise and have the time and the resources to find out where to refer onto.”

Two women workers in another agency felt that their male manager was embarrassed at the mention of sexual health promotion and they had to be covert in attempting to make improvements to the service for their tenants. There was also an indication from more than one project that managers who were not based in the organisations where the young people were could be very out of touch with the issues that the workers were dealing with around sexual health and the pressures and strains that this put them under.

Role of homelessness agencies

We asked homelessness agencies what work they did in giving specific advice and assistance on contraception, abortion, pregnancy and parenting and how they felt about their capacity and resources to offer an appropriate role in relation to these issues. The responses ranged from:

“We are incredibly lacking…we are desperate for help and advice. It has only just struck us what a problem it is.”

to:

“It’s not much of an issue at this particular hostel.”

Homelessness agencies fell into two distinct categories in their attitudes towards their role in relation to sexual health promotion. They saw themselves either in ‘locus parentis’ or as primarily promoting independence.

In ‘locus parentis’ agencies saw themselves in many ways as a substitute family for the young people in their care. They described them as vulnerable and likely to have missed out on much of the support and
advice that other young people might hope to get from parents. As a consequence they saw the agency as having a duty and a role to fulfil ensuring that the reside its were aware of sexual health issues, that condoms and information leaflets and advice were very easy to get hold of and that they always felt they had somewhere to turn with their questions or for support.

Promoting independence agencies took the attitude that their young residents were independent young people and that their role was one of housing management and facilitating independence. They saw their function in relation to sexual health promotion as minimal and mainly consisting of having information on agencies in the area and encouraging young people to make use of their GP or sexual health clinic locally:

“The ethos of the project is enabling independence. If contraception is freely provided the young people are not finding out for themselves or learning anything. We feel it is better to encourage them to do it for themselves.”

Condoms in hostels

The availability of condoms in hostels reflected the attitude of the agency to their role. Those that saw themselves with a more nurturing function to a group of vulnerable and quite damaged young people generally put forward the argument that, if they could get hold of them, condoms should be made as easily available as possible: in the bathrooms, in packs given out to residents, or there for the asking in the office:

“We have a stock of condoms in a sweet jar in here…. We would encourage them to go out but quite honestly however many ways they get the condoms as long as they get them. There may be a duplication but it’s not major if it prevents someone getting pregnant when they don’t want to be… If a young woman needs a condom the time it takes her to get dressed and to get out to a clinic, well…”

“We supply free condoms. We have discussed and discussed the best way to do it. We were putting them out in bulk and they were nicked and sold. Now we try to have a few out in a basket in the bathroom and in the resource room. We are not trying to create dependence. Obviously the ideal would be if we were helping them to access sexual health clinics but they are from the client group who find that difficult and provided they get them I don’t care where they get them from.”

And as one health promotion specialist put it:

“You are taking responsibility if you walk into the loo and take a condom from there.”

A number of projects reported having put in a substantial amount of effort to get access to a supply of free condoms for their residents and many had not succeeded. One of the projects with a strong agenda of teaching independence skills took the attitude that young people needed to learn to make use of agencies in the community and go out and get advice and get condoms and take responsibility for their own needs:

“We don’t have condoms available in projects. We would give them information about where to go but we would expect them to go. We would encourage people to make their own arrangements and that is very much a principle we would work on and that comes from being a housing organisation and seeing ourselves with a role to enable people to make community links and to make use of what exists in the community and not to have special arrangements just because you live in one of our projects.”

The supply of condoms was not on the agenda of other projects; they did not see it as an issue within their sphere of responsibility.

Staff training

Staff training was identified as a gap by a significant number of the agencies interviewed. Even in the hostels where sexual health was one of the key areas they worked on with the young people, staff had received no training and were not confident themselves of their information or that they were approaching the issue in the best way.

“I think there is a big issue around training for staff. There needs to be compulsory training for staff working in these kinds of settings so they are aware of the types of contraception available. The young people who are here may have been on the streets, they will certainly have led very unsettled lives, so to expect them to take tablets 7 days a week at the right time of day is unrealistic. So it’s about having the knowledge to be able to advise them as well.”

“We are supposed to be Jack of all trades but they are not providing us with the skills to be master of any. I think it’s important to be aware that we have limited knowledge and that you need to refer that person on. But if you build up
a relationship with somebody and you are the first person they have trusted, maybe in their whole life they are very reluctant to be passed on.”

Where workers in agencies had attended training courses they were very positive about the impact on their work. Two had attended a Family Planning Association course and said that, although they had known most of the factual information, the course really helped to give them the confidence that they knew what they were talking about and to think about innovative ways of putting it across; for instance facilitating role plays.

Key working

Most agencies in both categories operated a key work system and this was the main mechanism for offering advice around sexual health issues. But the level of support offered varied a great deal. Some agencies stated that sexual health and relationships was a prominent issue in key work:

“There is an 8-week assessment period. Part of the key work role is looking at their health issues and within that we will ask them what they know about contraception and safe sex. It’s such a closed culture here and in-house relationships are common and that’s quite often where the pregnancies come from too. We don’t force it down their throat, but we ask what they know and we check it out throughout that period.”

At the other end of the continuum were agencies that stated that health work of any kind was not seen as their role, they were there to manage the housing. In the middle there were many agencies where workers said it was part of the support plan to discuss those issues and they would always ensure that they knew what agencies were around locally to refer young people to and have information leaflets available to give them.

Workers in some agencies felt that their residents would consider it an unwarranted intrusion into their privacy to bring up issues such as contraception but that if they were asked they would try and answer their queries:

“They get a list to tick of things that they want to talk about and they can add things. Safe sex is one of them, but to be honest it wasn’t something we pushed. I suppose when someone turns up here there are so many things and the first thing is abuse… and as a staff team we are quite lacking in sex education. But when I did the statistics last year (44 per cent of 16 to 17-year-olds were pregnant during that year) is really hit us that we had to do something.”

As already mentioned very few staff members had training. The attitude seemed to be that they were adults, knew about sex and should be able to pass on that information. There were individuals that took this role very seriously and had taken the initiative to find out as much as they could, order information resources, ensure literature was up to date, make contact with agencies in their area and become a specialist resource for their residents and for other workers. They were also doing specific key work sessions on sexual health if it was requested:

“I have taken it on board myself to give out literature and make contact with Brook and the STD clinics. I have not got any formal role but I have decided myself to prioritise it. I can’t sit comfortably with the feeling we just plonk young people into a hostel and that’s the end of our role. I think we need to do work on employment, training, relationships, health. They might be sixteen and without a family. A lot of people think we are only responsible for housing advice, I think we need to address a lot of other issues.”

But there were also agencies where no one had taken on this role and it was very dependent on an individual’s knowledge and their confidence and ability to pass on that knowledge during key work sessions:

“If we do it, it’s very ad hoc, we don’t really know what we are doing.”

It was also clear that many workers had identified sexual health and advice around contraception and relationships as an issue they would like to do more work on but time and resources were limited and there were very real practical constraints:

“Rehousing and hostel management take up so much of our time. If we did have extra time it would be good to do more on life skills and parenting with the younger women, but we don’t.”

Some agencies offer very low support though it does not necessarily mean their residents are not in need of a lot more than they can offer. One agency with bedspaces for five women, three of whom had been pregnant in the past year, has one part-time worker.

“I’d like to do more, but I only work 28 hours a week. There are real issues around sex without protection, multiple partners, a lack of vision, lack of self-esteem and low expectations. It really is a frustrating area. You see women you get close to,
they get pregnant and then you think that’s their life now.”

Role conflict

A number of agencies mentioned the difficulty of juggling the role of housing manager and confidante on issues around sexual health, relationships and contraception. Sometimes this difficulty was connected with resources:

“I am a surrogate parent, the housing manager and I am male, so I am not the most appropriate person. All this stuff comes out about negotiating relationships but they can’t really be confident about telling me about the pressure they are coming under from male residents, as they would be contravening the rules.”

And sometimes it was simply about the roles not sitting comfortably with each other:

“You are at one point collecting rent and giving out warning letters and then saying ‘I am a trusted person who you can come and talk to about sex’. Sometimes it doesn’t work and it does mean that you have to think about when you are going to raise subjects and sometimes there’s a risk and you feel like you have to raise something when they are feeling like they hate you and it’s just very difficult.”

There was also conflict within organisations about how much time and energy should be spent on sexual health promotion and support and advice. In one agency the workers felt very involved with the tenants and tried to offer a supportive role when their tenants became pregnant or wanted to talk about relationships and health. However they also felt, as far as management was concerned, that the only priority was getting the rent in and maintaining the properties. As one housing manager said:

“I have a concern that the housing support officers have a conflict of interest. There’s rent owed and you are advising someone on their pregnancy and a decision on whether to have a termination… that’s just not appropriate.”

Contact with external agencies

The majority of agencies for single people saw it as their business to know about local resources for sexual health and pregnancy advice. But while they thought this was important their knowledge was often very scanty:

“I know of one, but they are very pro life and I’m not that confident in them. I think they just move people towards adoption.”

Sometimes the role was limited to encouraging residents to register with local GPs but in some areas that was said to be problematic and could take two or three months. Brook clinics were mentioned the most frequently as the service that agencies were aware of and advised young people to go to, even if it was some way from their area. Agencies did not have very much in the way of feedback about the quality of advice and support offered to young people when they went to external agencies but most had the impression that Brook was good and accessible for their client group. A number of agencies also had Brook or a local agency like the local health promotion team, in to do sessions with their young people. Reports of the success of these types of sessions varied. Some people felt they were really useful, popular and informative.

“The local health promotion team is fantastic. They do all the hostels and the children’s homes. They do sessions in the evenings in our houses and they are very well attended. They use a lot of role play.”

Others felt that the young people found it quite hard to talk about issues around sex and relationships in a group and that it was better to work on it in individual sessions:

“Brook used to come in, but because it was in a group, people weren’t going to talk about intimate details of their sex lives. It was always a struggle to get people to go to it.”

One agency worked hard with a young woman who could not decide whether to keep the pregnancy or have a termination. The pregnancy was quite advanced when she disclosed it. The agency was not aware that their local health authority had a strict time limit of funding abortions for anyone over 18. The young woman was 18 and by the time she decided to have a termination she had exceeded that time limit so she kept the pregnancy. The agency stressed the importance of finding out about local health authority policy.

Agencies commonly expressed a lack of knowledge about where to go to request sessions in hostels from external agencies and a desire for more support and advice for their residents:

“We are not proactive, it is a very limited role. It would be great if we could link into a community health network and get posters and leaflets
regularly and offer staff training so they know who to refer to.”

“We are hoping to get external facilitators in to do sessions for residents at house meetings, do you know of any?”

However in an area where there was a really active health promotion department who regularly offered sexual health promotion training sessions to all hostel workers and workshops to residents, the take up was much lower than one might expect. The health promotion team did not know whether this was a question of improving publicity or whether there was a reluctance on the part of managers to take up the training on offer.

Most of the agencies for single parents offered something beyond basic housing management and some offered a whole range of groups or sessions, usually in the project but also facilitating access outside, for example with counselling agencies.

Most reported that it was very difficult to motivate the young women to go to anything in the community:

“It’s very difficult to motivate people to go out. They are put off by the distance or the fact that groups are perceived to be for older women.”

“It’s a bit of an effort to get people to go to anything – they would rather just stay here. We thought ‘Is it too cosy?’ but have decided that it’s not the issue. They wouldn’t go out if they were on their own. A lot of people need some help in going out, a support worker to accompany them. But will they do it when they are resettled?”

The sessions that were offered in projects ranged across life skills, cookery, childhood illnesses, health issues, baby massage, head massage and manicure, play, parenting skills, and training and employment advice. The agencies that offered a whole range of options had generally made good contact with external agencies and had health visitors, voluntary sector agencies and organisations like the Body Shop or Blackliners coming in to do sessions:

“We work closely with all agencies. Health visitors come in twice a month. The school nurse does family planning and sexual health. We have tutors as two young women are doing GCSEs and the careers service come in twice a month. In terms of our outreach service there is a new befriending agency that takes on families and works with them, a mature person working with younger women and we use them too.”

“We approached the health visitors to do a series of talks on parenting. They were so keen it was unbelievable and we really got to know them. They did a series of ten and those who attended really got a lot out of it. We had individual health visitors come in before but nothing on that level.”

Quite different opinions were expressed about offering something called ‘parenting skills’:

“So many of them have had such poor parenting themselves, especially the younger ones. I think the new emphasis on parenting skills is a good thing.”

“Parenting skills – forget it just don’t go down that line. They find it insulting and experience it as stigmatising and I feel it is not acceptable or appropriate. The vast majority don’t need parenting skills. What they are very keen on is health visitor sessions.”

It may be that the term ‘parenting skills’ is what is at issue here and that what the health visitors were offering in their sessions was parenting skills by another name.

All the projects have health visitors coming in to see the women, mainly on an individual basis. There could be six different health visitors coming to a project that the staff would get to know and would liaise with if there were any worries about an individual. The projects were positive about the input of health visitors. The relationship with the young women was generally easier because they were not seen as a service that had the same stigma attached as social services and there was less fear that they were judging parenting ability or that they had the power to remove a baby. It was less common for the projects for single people to have regular health visitor contact. Where they did they were also positive about it:

“We have a health visitor who comes in once a fortnight, she brings condoms and puts them in the toilets so they don’t have to ask for them. They quite often speak to the health visitor about sexual health issues because it is confidential. She’s attached to our local GP and she’s an older woman, they like her and they trust her, so that’s useful.”

A number of the projects took a small number of referrals from social services departments where the department would pay a top up fee to the hostel. Sometimes extra support would be provided to a young woman by social services in liaison with the hostel, sometimes this relationship would be specifically with the local leaving care team. Generally this arrangement functioned satisfactorily, although sometimes the agencies stated that they felt that the
standard of support that they received from social services was low.

**Housing options**

“Something needs to be done. Women shouldn’t be feeling terrified that they are pregnant because they don’t want to lose a hostel place. There should be accommodation there within the month that they discover they are pregnant. It should be a straightforward referral process. All the stages that they have to go through, their bodies are changing, their hormones are rising, the system is setting them up to fail. Sooner or later the frustration of being a parent is taken out on the child. There are too many issues for them to face at one time, finance, health, housing. It’s way too much.”

Rehousing for young women that become pregnant while living in hostel accommodation was one issue that many hostel workers described as needing a lot of time and resources and creating a lot of stress for both the young women and the agency.

A number of the agencies for single people had nominations with the local authority or local housing associations so hostel residents would in time have an opportunity to move on into permanent housing. But these nominations were also for single people without dependants so it was problematic to use them for a woman who was pregnant. A number of workers mentioned the fact that their tenants knew they would get permanent housing and the fact that this became more, rather than less problematic when they were pregnant, exploded the myth that young women were getting pregnant in order to get housing.

There was a wide diversity of experience of the rehousing process reported by hostels and single parents projects. This depended on the local authority with which they worked, their practice and policies with regard to accepting young women who are pregnant and in temporary accommodation and their relationship with the hostel in question. Hostels working with some local authorities were very positive about the process and said that women were generally offered a flat before the baby arrived, or if moving on from a single parents project, within a few weeks of saying they were ready. Those projects stated that, as yet, they had not had any residents who had been moved into a bed & breakfast:

“We’ve been quite successful with that so far. I know that in other boroughs there have been issues with how long a young woman can stay and issues around whether she has made herself voluntarily homeless. But here we have an agreement that where a young woman can no longer benefit from the project or the project is not appropriate for her needs she moves on and in most cases she has got housing quite easily in mother and baby units, in independent housing, or back with her family as a temporary move.”

Other agencies felt really frustrated at the difficulty in finding a place in a single parents project. The perception was that there were only places for women where there were serious child protection concerns, and then although there were places, it was really difficult to get funding.

A substantial number of agencies stated that around the middle of the pregnancy the young woman would be issued with a notice to quit, referred to the homeless person’s unit and that before the baby was due she would move out and be placed in a mother and baby unit, a bed and breakfast or offered a flat by the local authority. Often this was the end of the agency’s involvement and they had no knowledge of how the young woman fared after leaving the hostel.

Agencies that had a pastoral approach to their tenants expressed significant concern about the impact of the whole process on a young woman at a time when she is vulnerable and potentially isolated. Most agencies had to go through the process of issuing a notice to quit and there was recognition that this could be difficult for the woman concerned:

“At an early stage in the pregnancy we support them to make an application for priority housing. We try and ensure they realise that we are 100 per cent supportive and that we are not being negative about them having a baby.

“We had to be very sensitive about how we portrayed it to young women. ‘This is not a real eviction, we won’t really put you on the street but we have to go through the process in order to get you a flat.’ So we would serve notice while doing heavily supportive work with the tenant.”

Even where young women did get offered a flat the timescale generally made things very difficult:

“Sometimes it’s at such a late stage that the baby is practically born or has been born. If you look at the state of the accommodation they still have to go through the process of getting the grant and getting it decorated. For someone who has just had a newborn baby that is a nightmare. You are on your own. Motherhood doesn’t come easy, you are learning it as it comes. It’s frightening.
They’ve got this accommodation which they have to look after, get the furniture in and learn independence. They have got the child to look after and learn to be a mother too and they have to look after themselves. It’s incredibly hard. It needs to be staged. You need to get the flat well before the baby is due.”

The process was made much more difficult by some local authorities who were not only insisting that the tenant should be issued with a notice to quit but that the agency should issue a notice seeking possession and take them to court before they would accept them as homeless and therefore their responsibility. At least four London boroughs were mentioned as pursuing this policy which was proving very problematic, time consuming and frustrating for hostels:

“We refuse to evict them, we won’t put a young woman through that, the cost in stress… and money. We are determined to follow it through politically. It is a moral issue. It’s taxpayers money, our time, their time. It is crazy, what can they gain? They know what sort of housing provider we are.”

“We have had to devote huge resources to getting them rehoused. We used to work with the HPU well, but now we are having to get possession orders costing several hundred pounds. We have tried to negotiate but they are intransigent, saying that when young people are here they have a roof over their head and that others are on the streets. That’s their way of looking at the issue.”

Where local authorities were insisting on this course of action it was the source of a lot of anger. Sometimes the authority was funding the hostel but then insisting that they spend their scarce resources on getting a possession order to evict a pregnant woman in order to force the local authority to take responsibility. Aside from the costs in time and money it meant a very difficult relationship was created with the tenant. The hostel workers were trying to be caring and supportive but were in effect making someone homeless. A number of them stated that they found this impossible and consequently found other ways around the situation such as giving a young woman money to secure private rented accommodation or letting her stay in the hostel.

The difficulty in successfully housing the young women meant that workers in more than one third of the agencies reported women still living there once their baby had arrived and for several months afterwards. This was often seen as illegitimate, inappropriate, inconvenient for other tenants and contravening the policy of the agency, but it continued to happen because of the difficulty of persuading local authorities to take responsibility and not wanting to put young women into even more stressful circumstances. Where the accommodation provided was in self-contained bedsits it was not too problematic to have a woman there with her baby for some months. But where there were shared facilities, which is the case in most hostels, it obviously did have an impact on other tenants and there were concerns about health and safety issues, hygiene and insurance. The woman with her baby did not generally want to be living in shared accommodation and may have changed her standards about issues such as the cleanliness of common facilities. Those sharing with her could be quite intolerant of having a baby on the premises and the implications of this change. Sometimes women were technically still tenants while waiting to be rehoused but were staying somewhere else if they had family or a boyfriend in the area. This caused other problems; one woman missed her offer of rehousing because she wasn’t there when the offer came through. It obviously also has implications for their ability to settle down with their baby in a new area and link into health services, parent and baby groups or any other support agencies.

A project that works specifically with young people with multiple needs had a very high rate of pregnancy within the house; approximately 40 per cent of their women residents had been pregnant over the last three years. The women they were working with had all had periods sleeping rough and came from backgrounds where they had experienced a lot of damage. When they became pregnant the project made contact with social services in order to try to move them on to somewhere supportive and appropriate for their needs. The project was very unhappy about the response of social services and said they felt that they consistently let their clients down:

“They get referred to the local children and families team who do an assessment. They are always assessed as needing a high support mother and baby unit... We highlight all the potential problems as well as the potential areas for progress and our emphasis is always given the right support and given a chance in the right environment they could be a great mum. They always agree it and then argue about funding for months and months.”

On a number of occasions by the time the baby arrived nothing had been agreed and despite high support needs, the young women ended up in inappropriate
accommodation. Many of the same project’s clients left the project early in their pregnancy and returned to their families or foster families – back into environments where they had been abused or neglected.

A move into a single parent’s project was often not a young woman’s first choice, but where it was her choice it was often not available. All the single parent projects interviewed were asked if they felt that the young women referred to them were positively seeking supported accommodation or whether independent accommodation would have been their first choice. The general impression was that very few young women would take up places in single parents projects if permanent accommodation of their own was on offer. But once they were there they were appreciative of the support and the feedback they gave to the projects was positive:

“They don’t want to go into a B&B, they want better quality accommodation. But they are not positively seeking support; in fact we do it by stealth. The younger and more vulnerable and more in need they are the less they want it. If they are older and more together and aware they see the support as a plus, although they too would rather have gone into an independent flat.”

“The majority are not seeking a supported environment, once they come in and live here they seem to like it. When we evaluate it they say they got a lot out of the support.”

“They think of it as a shortcut to permanent housing. Most of them are young, it’s their first child and few have a support network so it’s a bit of both.”

If a young woman moves into a mother and baby unit this can mean another long wait for accommodation.

“All the projects are full, now we are waiting for the current babies to move on. We only have a 12-bed unit, so if one baby leaves it takes our space. It’s a nightmare.”

Gaps in services

All the agencies were asked if there were other services that they would like to offer if there were resources available. Quite a number of the issues raised have already been mentioned: clear policies, training for workers, better access to external facilitators to come in and do workshops on self-esteem and assertiveness for residents, on sexual health, on life skills and parenting, and free condoms. Agencies also wanted improved contact with community health networks, improved ease of access to health workers, registration with GPs, and regular supplies of ‘young people friendly’ literature and posters. A moving-in pack with information on sexual health and contraception was mentioned by more than one agency as something they would like to develop. One project had carried out a mini survey among their residents and had found that their knowledge level of sexual health and contraception was entirely adequate but that they were still having unwanted pregnancies. They felt that a lack of self-esteem and assertiveness was at the heart of the issue:

“Assertiveness training and counselling to build up self-esteem is what we need. But it’s very costly and we have nothing in the budget. But that is the big one that I would like to take on this year.”
Two projects specifically mentioned the need to do work with young men; to help them to understand and take on the responsibilities that fatherhood implied. Some mentioned the need for a specific worker to take on responsibility for all these issues within the agency. Several projects mentioned more accommodation and more variety of accommodation including suitable and good quality move-on housing as the big gap for their residents. They wanted to be able to offer self-contained accommodation, accommodation for women sharing, accommodation for couples and accommodation where they could continue to offer support. They wanted to be able to move women on when they were ready and not to continue to accommodate them when they were heavily pregnant or had given birth.

Resettlement services for young women that did move on, either into their own flat or further temporary accommodation, was a major gap for many projects. There was an identified need for stable accommodation and a specific resettlement service that was about providing parenting support and encouraging links with parent and baby groups:

“It is a shocking gap, given everything we know about the huge importance of the first six months in a baby’s life. We seem to be operating in a very short-sighted way. There seems to be a terrible dearth of services which recognise the amount of work that needs to be done in supporting a woman in building a firm relationship with the baby in the first months and making that a priority.”

“The whole system is not giving them any support to be parents. That should be the priority. If you look at the homeless issue a lot of them came from broken families. If you don’t want them to continue that cycle it has to start from somewhere. Allow them to focus on bonding with their child without having to worry about going from A to B and moving on from the B&B, stays of three months, no stability whatsoever.”

A minority of the agencies working with single homeless people had heard of agencies such as Newpin or Homestart which can provide some befriending and parenting support, but few links had been forged.

Projects for mothers and babies had concerns that they were accommodating toddlers and the accommodation was unsuitable. Managers of several projects welcomed the new emphasis on parenting skills and felt that they wanted to be able to offer courses or workshops in parenting skills or just to have more staff time available to spend with the women and their children, offering support and shopping and cooking with them. Some of them wanted to be able to offer more ongoing outreach and resettlement work. Others felt that the needs of the women residents were less than originally anticipated and that they mainly needed help with practical things when they were moving on. They were looking at fund raising so they could provide women with a pack of essential items when they moved on into a flat because community care grants proved to be so inadequate.

A project that housed a majority of refugees and asylum seekers, many of whom had come from war zones and suffered trauma, said that the major gap in services for their clients was access to psychiatric counselling, especially because of the language barrier and the lack of services offered in the languages of their client group.
5 Health promotion specialists

The recent report on contraception and abortion services in London found that although all London NHS trusts make some form of special provision for young people – dedicated clinics, subcontracting to Brook or outreach work – health authorities do not appear to have put as much priority on provision for young people as might be expected. Only five had specific policies for young people’s service provision and only five had service specifications.

Homeless young people are obviously a small subgroup of the young population. As was stated earlier the support available to homelessness agencies in doing sexual health promotion work with their residents or user group varies from area to area. Some hostels have been proactive in making contact with the health promotion agency locally and in some cases the health promotion agency has taken the initiative and offered training and support to homelessness agencies.

In order to gain a general picture of health promotion work with homelessness organisations nine health promotion agencies covering most of the inner London Boroughs were contacted. A semi-structured interview was carried out over the telephone or face to face with the person responsible for sexual health promotion with young people in the area. The interview was designed to elicit information about whether they had a specific programme of sexual health promotion on offer to homelessness agencies in their area, to explore how it was promoted what it included, which agencies they worked with and whether the work was with staff or directly with homeless people. If there was no specific programme they were asked if there was a generic training programme open to staff from homelessness agencies, and how that was advertised. They were also asked about the provision of condoms to hostels and any issues specific to working with the homeless population.

Work with homelessness agencies

There was a striking variation in the level of commitment and interest in this area of work and in the actual amount of work that was taking place. In areas where there was a high level of visible homelessness and a large number of hostels there was generally awareness of the issues. A few health promotion agencies were doing no work at all with homelessness agencies and expressed no interest in the issues when the subject was raised. However the majority were very interested and wanted to hear about the evidence of need in that population and were open to being able to respond to expressed need. Some, although varying in the amount of time and resources they had been able to put into young homeless people, had clearly identified them as a group whom they should be targeting and were thoughtful about the particular issues that would arise in working with them.

East London & City Health Authority (ELCHA) covering Newham, Tower Hamlets, Hackney and the City had the most established and comprehensive record on working with homeless agencies. The health authority has a history of taking the needs of their homeless population seriously, which had obviously permeated through departments. One of the health promotion workers had done a piece of academic work examining the role of hostel workers in promoting safer sex. The results of this survey some years ago had then informed their work programme and they had developed a comprehensive training programme for hostel workers on different aspects of sexual health. They now run a general training programme and all hostels are on the mailing list and encouraged to attend. They send out a newsletter to hostels two or three times a year promoting particular campaigns and offering to provide free sexual health workshops for hostel residents. Some hostels that had taken this up were very positive about the quality of what was on offer and how much their residents valued it. However, despite the proactive approach of the health promotion agency, take-up of the training for hostel workers and residents was lower than expected and quite manageable in their workload. They questioned whether their publicity was reaching the right people or being seen by all the staff as they had anticipated greater demand.

Croydon Health Promotion Department, although not so directly active, had a thought-out strategy, which included a rolling programme of training on sexual health. A large number of participants came from voluntary sector agencies working with homeless people. They also worked closely with and provided resources for a voluntary sector youth counselling service that offered workshops to groups of young homeless people and drop-in advice. They were planning a walk-in health centre, which will have a specific focus on young people, and in particular young homeless people tackling the issue of ease of access to services.

Other areas also ran central training programmes, which were open to a wide variety of agencies. But when asked about homelessness agencies they did not have them on their contact list nor necessarily know of their existence. Some agencies felt they could respond to a need for training if a request was put to them by a homelessness agency. Others said
that homeless people were not a priority group and if it was not in their work programme they may need to negotiate payment before they could provide any training. One health promotion agency operated a system of making small grants available to agencies in their area to buy in the training they needed. Apparently there had been considerable take up of this programme by agencies working with homeless people. A limited number of health authorities also buy into the services of Brook’s Education and Outreach Team. Brook is able to provide a limited amount of training to hostel workers or face-to-face work with residents.

In two health authority areas, Camden & Islington and Lambeth, Southwark & Lewisham, there were a range of agencies and individuals working in the area of sexual health promotion who had some remit around homelessness. But the impression was that work had become so specialised that there was not necessarily access to a basic training programme for hostel workers or to workshops for their residents. Lambeth has an outreach clinical nurse specialist for contraception and sexual health who has been working with hard to reach groups in the borough since 1991. However, since there is a specialist primary care team for homeless people that covers Lambeth, she was doing very little work with homelessness agencies. The Three Boroughs Primary Care Team had no specific programme on offer in terms of sexual health promotion in hostels but could respond to requests if asked. They had recently carried out a health training needs assessment of the staff and residents of hostels for young people across the three boroughs. Training around sexual health, contraception and sexual transmitted infections and pregnancy was requested by every hostel in the survey. As a result the team were offering a dedicated phone line for advice half a day a week to those hostels and raising their profile in terms of offering training on health promotion.

Camden has a specialist team called Central London Action on Street Health (CLASH). The health promotion agency, when approached about work with homeless agencies, referred on to CLASH. However CLASH mainly does specialist work with sex workers and does not offer any training programme to hostels. So despite a lot of valuable work being carried out there was nowhere for hostel workers to link into to have their training needs met. The health promotion department used to run a central training programme and are considering whether starting that up again is the most effective way of meeting the needs of some of the hard to reach groups. Interest was expressed in the needs of young homeless people and the findings of this work in terms of informing their strategy.

Encouraging health promotion departments to offer training to hostel workers is only one half of the equation. Hostels obviously have to be interested in taking it up and able and prepared to put in the time. Where health promotion departments were being proactive in offering training they did experience some difficulties:

“I think, as with all staff groups, there might be individuals who are keen and interested and want to come on the training but as a whole the agency is reluctant to deal with the issues. Sometimes it’s taboo and religious and moral concerns, sometimes there is a concern that the client group will have those taboos. I think there is also the issue of the personal and professional. They see it as those people’s home, there is then a reluctance to put out too much information which is making it an institution. Then when workers are meeting clients in their rooms and it’s quite an intimate space and there are concerns about raising issues of sexual health.”

It is obviously important to be aware of potential barriers to hostel workers taking on a health promotion role. However the importance of their understanding sexual health issues, particularly as they often have positive relationships with young homeless people, cannot be overemphasised:

“Hostel workers must have up-to-date knowledge, know the implications of what they are hearing and when and where to refer young people onto. If for instance someone has unprotected sex with someone who is Hep B positive, getting a vaccination into him or her within 24 hours could save them from years of ill health. They are the ones where a relationship of trust and openness builds up and if they understand the implications of what they are hearing a lot of good could come from increased levels of knowledge.”

Where training with hostel workers had been evaluated the results were very positive:

“When we did a two-day course with hostel workers about talking about sex we got them to develop action plans and we followed it up about five months later and went to talk about how it had gone… All of them bar one out of a group of 15 said they were using material from the course and were doing more work around sexual health.”
Sexual health promotion with the young homeless population

Many of the issues identified by health promotion workers as pertinent when thinking about training on sexual health with this client group were not very different to working with other young people. In terms of face-to-face work with young homeless people a number of approaches were identified as effective. Some health promotion agencies talked about a skills-based approach, teaching assertiveness and skills in communication and negotiating relationships. Some talked about using a community health development approach and having moved away from an information-based focus. One specialist working with hard to reach groups had developed her own specific style which she described as hard hitting, straight talking and making use of photographs from medical text books to show the reality of the impact of sexually transmitted infections. She agreed with the stance that had been taken by a number of hostel workers that they generally found it more effective to talk to the young people about sexually transmitted infections than to talk about unwanted pregnancies:

“I don’t just talk to them about unwanted pregnancies but about protecting themselves from diseases. That seems to get across to them more. The thing about safe sex I feel they are receptive to but the desire to be parents hasn’t dented. If you’re talking about safe sex they can take it on board, they will get ill if they don’t use contraception but if I say ‘If you become a mother or father you won’t enjoy life’ no matter what I say I don’t have any influence.”

“It’s more effective to talk about the reality of sexually transmitted infections. They just think of HIV and they don’t know anything about the others, and how serious they can be or what a long-term impact they can have on their lives. Pregnancy, at least you have options, but some STIs you don’t have options and they will affect you for your whole life.”

There was a recognition that the issues that had meant the young people becoming homeless in the first place had a continuing impact:

“Everything is exacerbated. They live their lives in such a chaotic way and that has implications. If they become pregnant and then become homeless it implies that they don’t have the level of family support that others might have. They are likely to be on the worst end of the continuum in terms of what their experience of being parented was like and in terms of support in their background.”

They were likely to have come from a difficult family background and therefore may have low self-esteem and difficulty forming and sustaining relationships. Self-esteem and communication within relationships needed to be worked on and were perceived as important or more important than getting across factual information about contraception or sexually transmitted infections. It was also identified that many young people who become homeless had missed out on education through truancy or exclusion and hence may have missed whatever sex education had been on offer at school.

Their literacy skills were also often poor for the same reason so different approaches to written literature were needed to put information across. There was recognition that homelessness can bring elements of chaos into young people’s lives and consequently their health may become a lower priority. They are less likely to be registered with a GP and less likely to manage contraception like the pill, which needs to be taken on a regular basis. Where health promotion agencies did provide specific workshops for young homeless people they were generally perceived as working well even if there was an initial show of disinterest or reluctance:

“Although people might initially say they don’t like being part of a group or they are not interested or whatever and they might come in but say ‘I can only stay half an hour’ but once they’re in three hours later I can’t get them out of the door. You can make it quite fun.”

Young people who slept rough were identified as having specific issues:

“A lot of the hostel population reflects the population in youth clubs and schools. Where I think there is a real difference is working in cold weather shelters or with rough sleepers. They are particularly hard to work with and hard to get to come to groups and very needy. Sometimes their knowledge levels are fairly high but I think they find it particularly hard to put it into practice, partly because of the very vulnerable position they are in.”

Most of the work that was identified was preconception. There was no specific work being done around pregnancy and parenting although it was an issue that some of the health promotion agencies were considering and there was a recognition that choosing
a termination might be less of an option for young women in this group:

“The teenagers are likely to go ahead with the pregnancy. ‘It’s someone to love me, a baby.’”

“I think that quite a lot of the young women, even though they don’t plan to get pregnant, see being pregnant and having children as very significant and about becoming adult and having status where they might not have status elsewhere.”

“This again may be the chaos factor: choosing a termination implies motivation, action, a whole series of hoops to go through and it implies support during and after. It might appear to the young person that going on with the pregnancy is an easier option. Why not?”

There is a growing interest in the health promotion field in the use of ‘virtual babies’ as a tool for learning about the realities of parenthood. These are lifelike dolls which cry when they need feeding, changing or comforting and do not stop until given the right kind of attention. They are taken home by young women and record over that period how they have been treated. A health promotion worker in Camden and Islington who uses them with groups of young women described them as a very powerful tool and very emotional. She advises thinking about it carefully before using them with young people who are homeless and who have had damaging experiences in their own lives. If they don’t have a proper home to go to it would be hard for them to care for the baby anyway. They need to be able to commit themselves to the whole project, coming back with negative feedback about how the baby was cared for can be very difficult and upsetting unless the whole process is worked through properly. One health promotion worker perceived it as difficult to motivate young people to attend any kind of workshops on parenting or to get them to see it as relevant to them until they are in a situation where they are facing it. It is an issue that needs to be addressed, because as previous research has shown and as one specialist health promotion worker with homeless people put it:

“Their only expectation is to have children. Then what is frightening is the regularity with which those children are taken into care.”

Condom distribution

The availability of free condoms for hostels was another area where there was inconsistency in policy and practice between different health authority areas. Only two areas, Croydon and Brent and Harrow, had a condom distribution scheme that was open to all agencies. Brent and Harrow fund an agency called Sexual Health on Call which offered free training and condoms to any voluntary agency which provides a service to people from the area. The condition for the supply of condoms, leaflets and posters was that staff attend a one-day training on how to talk to clients or residents about sexual health. The agency was not doing specific work with homelessness agencies currently but was open to requests from any agency. They did follow-up visits where agencies used the scheme and collected data and offered any follow-on help.

Croydon had a condom distribution scheme open to any voluntary agency; agencies were required to attend a two-hour training session. They had a budget, which was big enough to meet demand, so they have not had to impose restrictions. They mainly distributed through GPs but their monitoring showed that condoms distributed in this way mainly went to white European women between 25 and 35, not the groups they were aiming to reach. They changed their focus to more vulnerable groups and at least half their distribution was through the voluntary sector.

Enfield and Haringey Health Authority also stated that any agency that asked for condoms could have them, but it did not have any particular distribution scheme. Kensington, Chelsea and Westminster had a condom distribution scheme through which they also targeted their sexual health promotion training but this was mainly aimed at GPs and primary health care staff. They said that in terms of condom provision they would prefer people to be sign-posted to their GPs.

Other health authorities contacted had strict restrictions on condom availability. The budget for condoms was generally located within the HIV budget and distribution was sometimes limited to groups that were perceived as high risk for HIV. There was no mechanism through which to supply hostels. This was seen as short-sighted and detrimental to encouraging responsible contraceptive use by a number of the health promotion specialists interviewed.

“In the early 90s there was a lot of ring-fenced HIV money and it was made available for the groups. I worked with so anyone could access condoms on an anonymous basis as often as they wanted. That budget has been consistently cut back and the whole thing is going into reverse. It takes years to change opinions, actions and behaviour and then they do away with the funding. A homeless young person is not going
to go out and buy condoms… they will go and take a risk.”

“For a short time we tried to set up some projects giving condoms to hostels and monitoring their use to put together an argument for funding but provision of condoms is a really problematic area. Even GPs don’t have condoms to give out.

Basically we try and encourage hostels to work it into their budgets to be able to purchase condoms because I think it’s essential, free access to condoms.”

How to make condoms available within a hostel was also recognised as an issue and is a central subject death within training for hostel workers by ELCHA.
6 The young women’s story

Eleven young women with the experience of homelessness and who either had a child, were pregnant or had a termination were interviewed. All were contacted through hostels or day centres in London.

Background

All the young women had either left home precipitously and in an unprepared way or were taken into care from a young age. As shown in Table 5 nearly all left home very young. They had complex family histories and some degree of relationship breakdown within their family.

About half the young women had been in the care of the local authority for some part of their early lives. One young woman had been taken into care as soon as she was born but had never had a settled placement and had been in numerous foster and children’s homes. Another who left home at thirteen following sexual abuse, had lived in children’s homes and hostels ever since.

“After what the situation was like at home I’ve never really been into going into a home environment. To me that was too intense, I’ve always preferred to go into hostels or homes where there are 20 girls around. I’ve lived everywhere; I’ve had at least nine moves since I was 13.”

Two of the young women had moved to the UK from their country of origin at the age of 11 or 12 and come to live with relatives. One went to the police to escape violent incidents. The other stayed with her aunt until she was 19 but had been sent to a boarding school by social services having been excluded from school for violence.

The common experience was that the act of leaving home or being thrown out of home was followed by numerous moves, sometimes periods of sleeping rough or squatting, staying with friends, relatives or boyfriends and living in hostels. Without exception the young women had experienced periods of enormous instability and difficulty. It was only rarely that this was balanced with a period in their life when they were settled and had enjoyed a positive relationship with a parent or other carer.

Current relationship with family

One young woman had a good relationship with her mother who suffered from periodic mental health problems. The council evicted her for not paying rent while her daughter was away and when her daughter returned the flat was boarded up and her mother had become homeless. She did not know where to find her and became homeless herself:

“We’ve always had a good relationship. It was just at that time when all the problems were around we weren’t really friends you could say. We didn’t really talk as much as we used to, we were bitchy with each other. We’ve always argued very easily, but now we’re getting back to having a good relationship. The friendship is now much closer than before all that started.”

Another young woman’s relationship with her mother had been repaired since she had her first child. After
a period of three years in hostels and her mother not speaking to her throughout her pregnancy her son’s birth had changed things around. She was rehoused close to her mother and by the time her second baby was born her mother was offering a lot of support. She moved back in with her for three months after her daughter was born.

For the majority there may have been renewed contact with a parent and some kind of truce called but no family support on offer:

“My mum’s left the country. She’s met this husband and shipped out. I don’t hate her for it, she had to find her happiness, and she brought me up the best she could. I have contact with my mum’s brothers and sisters, extended family, but I don’t have a lot of contact. Even when I was in the homes they never took time out to see me, I’ve always been on my own since I left home at 13.”

“I came to this country when I was 11. I’ve not seen my mum since I was 15 so I’ve just learnt to depend on myself.”

“I wasn’t a settler, I didn’t settle into any of my foster parents. I’ve got one that I phone from time to time but as she said ‘You made your bed, you got to lay in it girl.’”

“They know I’m pregnant and they know who the father is but they want me to get an abortion. They don’t care about me, they just care about what the rest of the family will say and the shame of it.”

The majority of the young women interviewed were not receiving any support from, or having much contact with their families. However workers in homelessness agencies raised concerns about the not uncommon scenario where young women returned to their family with their baby. The baby was then in an environment where the perpetrator of abuse, violence or neglect, on the young mother when she was a child, was still living.

Education and information on sex and relationships

None of the young women felt that their school had given them a useful grounding in understanding sex, contraception, sexual health or relationships. This may have been due to their poor attendance but also appeared to reflect a poor quality of sex education:

“Teachers don’t really like to get into it. It would have been better if a nurse had come from outside or something. Like it was our PE teacher and she was a bit embarrassed and we were embarrassed and that was it.”

“Not since primary school. I mean we did sex education in science but it was all about flowers and stuff.”

One woman who had spent most of her young life in care felt she had been given good information by social workers and in children’s homes. However most interviewees had picked up everything they knew from magazines and friends and a number of them did express the wish that they had had better information and from different sources:

“I wish it could have been from my mum. She never talked about things like that and up till now she still hasn’t.”

One young woman said that if she had been better informed she would not have had a baby at 16. She felt she didn’t really have any access to sex education. Her foster parents had never talked about sex. Her first contact with useful advice was when she attended the homeless day centre, where she found the information on offer very helpful. But by that time she was pregnant:

School

Experience at school generally mirrored difficult home lives. Of the eleven women interviewed two reported a reasonable experience of school. All the other young women were either excluded on numerous occasions, bullied, or just stopped attending:

“I was excluded all the time, I was bad in their eyes. There was a reason behind that but no one ever took the time to find out.”

“I was bullied, I had something wrong with my legs, which I still have, a disability but they didn’t know that at the time. I was bullied and was pushed down stairs which made it worse. I’ve had four operations on my knee.”

“I never had schooling really, thick as two planks as they say.”

“My experience of school was hell. You know, someone just come from a different country and has a different accent and I was bullied, a girl’s catholic school. I had a lot of fights for two years and then I was excluded and I got sent to a boarding school in Sussex where they taught me how to control my temper.”
"If I had had it earlier I wouldn’t have had him. It would have saved me from making the mistake. I wasn’t planning to have him until I was older."

Another young woman said that she, along with in her opinion everyone else, knew about using condoms but sometimes made a mistake because they were drunk or felt pressurised by their boyfriends not to use them. She had found a nurse at a homeless day centre very helpful.

“She put it a good way. She said ‘The boys just want the sex, so they’re going to put the condoms on. So just make sure they do. They will because they want the sex.’ She was really good but she was the first person.”

The type of advice and support around contraception and sexual health at day centres for young homeless people was appreciated as accessible and appropriate, but many of the young women would have found it more valuable earlier on in their lives.

Pregnancy and abortion

All the young women said that their pregnancies were unplanned. However six said that despite not planning the pregnancy they were really pleased when they found out that they were pregnant and that they would not have contemplated abortion. Three of the women, who were either still pregnant or had a young baby expressed the unhappiness they felt on finding out they were pregnant but they did not choose to have abortions for a variety of reasons.

“It wasn’t planned but when I found out I couldn’t have an abortion because it’s part of you really. So I went through with it. I couldn’t do it. You bring a baby into this world to bring it up not to kill it."

One woman had contemplated abortion but had not been able to decide. It appeared she had drifted into having the baby because of the difficulties in making a decision:

“I weren’t too happy because obviously I was thinking ‘How am I going to cope?’ but I just got used to it after a while.”

Another woman had a termination three months previously and felt that she could not have another:

“I’ve heard that if you keep on having terminations it does damage to your body and I’m worried that if I have a termination this time I might not have no more kids. So I might as well, and at the end of the day me and my boyfriend knew what we were doing so we have to take on responsibility for it. That’s how I see it.”

She felt certain of the decision she had made not to have another termination but she did not feel she had anyone to go and talk about her feelings with. She was embarrassed to be pregnant again shortly after a termination and felt she could not talk to her keyworker or her mum or her boyfriend about the current pregnancy:

“I had a social worker who was the only person I could ever really talk to but now I’m eighteen my case is closed. Cos my case is closed I can’t really keep going to the social workers and ask to see her.”

Another young woman had only found out she was pregnant because of going for an HIV test and so was very shocked. But having previously miscarried and fearing that she might not have a child she decided immediately she was going to keep it.

One young woman had had a termination very recently and was feeling emotionally raw. She said she had been brought up to consider abortion as wrong and her first reaction was to think she would keep the baby. However for the first time she had a secure place in a hostel and she was frightened they would throw her out. She also felt that she was not ready to be a mother.

“I started thinking ‘What have you got to offer a baby? You’re in a hostel. If anything they’ll put you in a B&B or a mother and baby unit.’ I’m only young myself; I’m a baby. A baby having a baby, that’s how I see myself. I couldn’t bring one up and I want to sort myself out financially. I don’t want a baby on Social Security. At first I kept seeing all these babies, but then I thought babies aren’t all about being pretty. I helped bring up my cousin and at first he was all cute and gorgeous but he was always crying and I don’t think I could handle that.”

She had been offered counselling by Brook when she went there for a test but had been in a state of shock and refused it saying she was okay. Once the reality had sunk in she had sought counselling through her GP but the counsellor she saw had increased the burden of guilt she was carrying. However the nurse in the practice had been helpful, as had the nurses at the hospital where she had the termination.

A young woman who had been a user of crack and heroin and a sex worker in Kings Cross had previously been pregnant and miscarried. She was pregnant again and was making a big effort to change her
habits. Prior to finding out about the pregnancy she had helped withdrawing from heroin from the Hungerford project:

“I used to take a lot of crack and I used to do path. Now that I’m pregnant I give up the path and I give up smoking. I done crack about the middle of November and I done a few pills but I didn’t know I was pregnant then. I’ve been clean from brown for about a year.”

She was living in a hostel where she was surrounded by drug users:

“The place I’m in now everyone is doing drugs. You walk in and they’re doing a crack pipe in the room. I told her to do it out the window because I didn’t want to inhale it. I told my boyfriend and he said ‘Oh, you’re not going on that stuff’, but if I wanted to I could; it’s like getting sweets. But I’ve already had a baby that’s died of drugs and it just doesn’t interest me. It’s so stupid, it’s mental. I’ve seen what it does to people and what it done to me.”

Some of the young women with children and those who were pregnant invested a lot of hopes and expectations for change in their babies:

“When I found out I was pregnant I was ecstatic.”

“I was really happy. I was happy because I thought it was like a miracle. I thought ‘Oh, I’ve got someone to love for myself, someone to look after and care for.’ No-one’s ever cared for me so I’m going to make sure I love and care for my little boy as best I can.”

“I’ve always said to myself, because of my past and the insecurities I’ve got because of certain things what’s happened and because of the way I feel about myself, I’ve always said to myself I want something to live for. But I don’t want to have a child to do that. That’s just more responsibility, but then thinking about it maybe by having this child it will help me improve myself. I will have something to live for, I will have something to get up for in the morning. I played truant for so long, I could stay up all night and stay in bed all day, just get up to eat and go to the toilet. There was nothing to get up for.”

“I think if I had it open to me to go back and get schooling again I would go… I could get a job, bring up my little boy really nice.”

Support and advice

All the women were asked whether they had turned anywhere for advice and support when they found out that they were pregnant. Four of them said they had not been anywhere specifically, one had sought counselling through her GP, one had been to a family planning clinic. The other four had used the advice and support on offer at day centres for young homeless people and were appreciative of it. A worker from a day centre had accompanied one of the women to all her scans and generally given her support through the pregnancy:

“Before I was pregnant I used to come to London Connection and then when I was pregnant I would come in here a lot. I got a lot of support from people here, telling me where to go for check ups because I was living in a hostel at the time. They helped me find a more permanent place and then I moved into a B&B and London Connection helped me with that.”

If they were in a hostel at the time they became pregnant they were asked whether they had talked to the workers in the hostel about the pregnancy. A number of the women expressed the apprehension they had felt about telling the hostel because they were dependent on the hostel for accommodation. They were aware that the hostels they were staying in were for single homeless people and thought that as soon as they said they were pregnant they might lose their hostel place. In the event the majority of them felt supported by the hostel workers and were allowed to stay until they were found other accommodation.

“Someone in the hostel told me ‘You can’t stay here when you’re pregnant’ and I thought ‘Oh No! I’m going to be kicked out.’ I don’t want to go through all that again, I’ve finally got a long-term hostel.”

This woman asked the staff and found out that they would allow a young woman to stay until the baby was born and that they would help her with housing. But she still did not disclose that she was pregnant until they finally asked her outright. Another woman who had been thrown out of a number of hostels for fighting and breaking the rules found one where she felt comfortable and supported:

“The staff were friendly. I made a lot of friends. I met his godmother there. They all went through the pregnancy with me and he (her son) now knows most of them. I got very very good support there.”
A third woman initially decided to keep her pregnancy a secret but then thought she might be in more trouble for not revealing it.

“When I moved in I was pregnant and I told them and they weren’t really supposed to let me stay there. Most of the hostels in this area don’t take pregnant people. So I thought when I told them that they might tell me to leave but they were really good about it and really friendly and said if I ever needed help or to talk about anything, they would always be there.”

Generally women had experienced some level of support from hostel workers when they had let them know they were pregnant:

“They have said when I get my confirmation they will give me a notice to quit. They’ll keep me as long as they can. They’re not really allowed a pregnant woman on the premises but they are not going to throw me out onto the street so they will drag it on, and then they’ll send me to the HPU and hopefully they will put me in a B&B or maybe a mother and baby hostel.”

However despite the support offered hostels were often stressful and difficult environments to be in while pregnant. One woman had wanted to get away from the area where she had been a sex worker and a drug user but was placed back in a hostel in Kings Cross near all her old contacts. Another woman was on the fourth floor of a hostel without a lift until the eighth month of her pregnancy and she was in and out of hospital due to bleeding.

“It was very stressful being in the hostel. It was for ex-offenders and drug users. There were lovely people I met there but some were very rude and there were fights. I’m not judging anyone but sometimes it was very heavy. I just started to avoid people after I was abused by some guys who said very bad things to me. I never went into the lounge again.”

A woman was still living in a hostel for single people without children with her two-month-old baby. She said she knew her case-worker should really be evicting her and they were doing her a favour letting her stay while she was waiting for an offer of housing. Another woman had moved out of the hostel four years previously into her own flat but the workers at the hostel were still her main source of support:

“I love them to bits here. They don’t have to. Like my social worker the day I turned 18 she literally washed her hands of me, I haven’t heard from her since. Here they don’t give me the impression that they are just here for the money; their hearts are in it. They genuinely want to know how I am.”

Others had less positive experiences of hostels and had moved on or been thrown out of places where they did not feel supported or comfortable.

The majority of women were satisfied with the ante-natal care they had received but all but one woman said that they did not attend ante-natal classes. Although they were not specific about what made them feel uncomfortable there was an undercurrent running through the interviews. The young women suggested they found it difficult to use mainstream services with other women who had not experienced homelessness, whether this was ante-natal classes or parent and toddler drop-ins or other parent support groups. The woman who had attended ante-natal classes had felt very isolated.

“No-one round here gets pregnant at this age and they are all in couples. I think there should be ante-natal classes for single parents. All the breathing and everything and it’s all done as if you have a partner. By yourself you can’t do anything.”

Only two of the eleven women had spent any time in a mother and baby unit. One woman went immediately her child was born. She had stayed there for six months and was appreciative of the support it had offered.

“It was a big help. I learnt that even though I’ve got a little baby there’s still help available for me and it showed me how I could cope and made me understand the dangers of leaving children alone.”

One woman was on the waiting list for a mother and baby unit throughout her pregnancy but by the time the baby was born no place had been offered.

“She was due in August and by the time she was two weeks overdue I had nothing and I was so stressed out. The hospital wouldn’t let me stay so when she was a day old I had to get a cab to the Homeless Person’s Unit and they sent me to a B&B. It was so stressful. When I remember it, I cry. It was a tiny little room: one bed with a little sink in the corner. The kitchen was horrible, used by everyone. I couldn’t walk because I was in so much pain. She wanted to be on my breast all the time but to breastfeed you need to eat regularly. It was like a nightmare.”

After some weeks she got a place in a mother and baby unit where she was living with her daughter.
which she found helpful. But she would have liked support around childcare and opportunities back into training and employment which were lacking. Other women said that they would like to, or would have liked to have had, the opportunity to go into a mother and baby unit:

“I think I need some support and a bit of advice, I do need some support in being a parent. I wouldn’t mind going into a mother and baby unit for a couple of months and then move into a flat. I’m scared to move into a flat with just me and the baby. I don’t think there are any mother and baby units in Hackney.”

“I would have liked to have gone into a mother and baby unit. It would have given me time to settle down and get myself sorted. I’m quite independent but I would have liked that time just to settle down.”

Without exception the women said that they would have liked more support around them and places to go with their children. However there was also fear expressed about the judgements that would be made about their parenting ability if they were to go to a mother and baby unit:

“Some people say that if you go to a mother and baby unit you leave your kid for one minute and they are reporting you and they are reporting what time you come in and then social services come and take your kid off you. They try and twist things. They will find out I used to be on drugs. I’m not going to let no-one take my kid off me.”

Others were more frightened of having to cope with no support:

“I need some help, I can’t kid myself. This is something I’ve never done, especially for the first child, second child I might be OK. Yes, I do need help definitely.”

“There wasn’t really anywhere to go when I was pregnant and when he was little. I would have liked more mother and baby places where the mums and the children can all get together.”

One woman had been placed by Westminster Council in Hackney after a period in a bed and breakfast. She had a three-week-old baby and was isolated:

“I don’t know anyone there; I’ve only been living there three weeks. I know where the doctor is but I don’t know anything about support groups. I would like to find a place like London Connection in Hackney. I don’t know if there is one and I don’t know where the council is or who the council people are.”

All the women were asked if it was important to them that people they met had an understanding of what it was like to be homeless. The majority of them said that it made them feel more comfortable and confident if other people had that experience. A number of the women had been contacted through Playspace at London Connection and although they were living in boroughs across London they continued to use Playspace as their main source of support:

“It would be easier to go somewhere local because it’s quite hard to get down here but I like to travel and I’m more confident coming down here because I know people.”

“It helps because then you don’t feel that you’re the only one who’s gone through that. Okay, you might not talk to the person about what they went through but at least they know where you are coming from. They understand what you went through and they went through it as well so they know how you are feeling.”

“I love it. The staff are brilliant, it’s safe and confidential. I’d recommend it to anyone I know to come here and have a chat. You can’t fault this place. My little boy loves it, they all do. You’ve got the support in here. It’s just a shame it’s not a bit bigger.”

These comments confirm the view of the Playspace worker and of staff in some of the mother and baby units that it is hard to link women into services in their local areas because they feel different. They do not have the confidence to mix with people that they have not met or who they think have a very different experience to theirs. Those who mentioned friendships seemed to have formed them with other women who had been homeless but friendships in terms of emotional support featured very little in how they talked about their lives. One woman talked about a relationship with a neighbour who she referred to as her step-mum and who gave her a lot of support:

“It’s been great at the flat. I’ve got a step-mum, well she’s a friend but I call her mum. She’s been helping me because my family doesn’t help. She’s a neighbour and she’s been so good to me, she treats him like a grandchild. She has grandchildren but he’s the latest addition.”

But most of the women did not refer to other supportive relationships and were quite proud of their independence and survival ability:
“He wanted me to depend on him and I’m just not that type of person. I can look after myself. I came to this country when I was 11, I haven’t seem my mum since I was 15 so I’ve just learnt to depend on myself.”

“I’ve always been forward. I’ve been in and out of semi-independent units since I was 14, shared housing and I was just bunged in them. Foster carers don’t want you no more: ‘Here’s your key.’ Sometimes it’s great, sometimes I run away from it, but I can always survive. I’m a survivor.”

“I don’t think I can really talk to my friends as such. I don’t like to ask my friends for much because then to me they are going to be too in my business and because I’m the type of person that’s always done things for myself.”

The impression was that, for many of the young women, their life experiences meant they found it hard to make lasting emotional attachments.

Being a mother

Eight of the eleven women interviewed were mothers. They were all asked how they were feeling about being parents. Two of them, who had not been enthusiastic about the pregnancy, were clearly finding it very hard and appeared quite low and depressed. One woman who had been very enthusiastic about the pregnancy was also very enthusiastic about the joys of being a parent, but some of her comments appeared out of touch with the needs of her 18-month-old child:

“I don’t leave him by himself and go out. I wouldn’t leave him on his own in the house or out in the street. I’m very protective towards him… I mean you do have to discipline children but not to the extent that you kill them or injure them or neglect them. I give him a slap on his hand to let him know he has been naughty but to beat him the way I have seen children being beaten, that isn’t right.”

Four seemed to be coping well and were positive about it but realistic about the difficulties and stresses of being a parent:

“If you don’t give it what it needs it won’t be able to survive. So I find it a lot of responsibility. It’s really stressful at times. I didn’t think it would be this much. You have to do everything, you can’t think of yourself before them.”

“Being a parent, being a single mum is very hard. It’s lovely waking up to her smile, but it’s hard. Normal daily things like shopping and cooking. Some of the others have got boyfriends, that’s really different because they have someone to help.”

At the time of interview three of the babies were very young so their mothers were experiencing the shock of transition to parenthood and getting used to having a little baby for the first time. Three of the women had toddlers, which obviously bring different challenges.

Women were asked whether having a child had prevented them working or training or socialising in the way they had hoped. Most of the women had already, or hoped to, return to college to undertake some sort of training when their child was old enough to go into the college nursery.

“I think having this child will encourage me a lot, not just for me but for my child, go and get an education, go to work. I do the odd bit of agency work but nothing stable.”

One woman had been doing NVQs before she got pregnant. Her baby was six months old and she felt very frustrated that there was no available childcare which would enable her to go back to finish her studies. It was striking that any aspirations they had for the future generally seemed to be inspired by having a child rather than thwarted. Yet they did not always have access to the support they needed to follow through their plans.

Relationships with the father

Two of the women interviewed were in a relationship with the father of their child and a further two women who were pregnant hoped to be in a continuing relationship with their boyfriends. One woman did not know who the father was and another had never told the man in question that she was pregnant. Where the women were in a relationship the accommodation they were living in had a continuing impact on their relationship. One woman had been in a bed and breakfast since she was four months pregnant until after the child was born; the room was too small for her boyfriend to stay. They had sometimes
stayed at his mother’s house but otherwise they had been forced to live separately for the duration of the pregnancy and immediately after their baby was born. The other young woman had moved into her boyfriend’s flat which he had got just before she found out she was pregnant, but was worried about her security. The tenancy was not in her name and she felt that she was making herself very vulnerable.

A young woman who was living in a hostel and was pregnant had to travel right across London to see her boyfriend:

“He can’t come to the hostel so I have to travel all the way to see him, and then when I’m with him I’m tired and then I have to go all the way back. At least if I had a B&B he could come there. I’m worried about the staff checking on me if I went to a mother and baby unit, writing things down about me. But if I did I would want it to be somewhere he could come. He goes ‘Look you’re having my child, why can’t I come and see you?’ I can’t go and see him every day it’s just too much.”

One woman was in a relationship with a man who was not the father of her child:

“This is serious, we’re getting engaged at Christmas. I suppose he is my life and I am his. He works and everything. My son is crazy about him and he is very attached to my son. It’s comforting that I’ve got someone who loves my little boy as well as me. It’s very comforting, it’s brought us closer together.”

The father of her child also played a major role in her son’s life and looked after him for almost half the week.

None of the other women were in relationships with the fathers of their children and some had little or no contact:

“He comes round when he feels like it. I wish he didn’t come really. He just comes in and he upsets him, disappears for another three weeks and then will turn up. So it’s not really worth him coming at all.”

But a majority wished that the father would play some sort of role in the child’s life:

“We tried to make it work and he does want a role looking after her but we can’t be in the same room together. So I’ve told him ‘If you want to see the baby or bring something for her I’m not stopping you but you are having nothing to do with me.’”

“He’s saying the day I tell him he can’t see his child is the day he walks, and I would never do that. My dad wasn’t around and I know what it’s like not to have a father.”

Despite the expressed wish of some of the women to be in a relationship with the father or have him play a role in the child’s life, the experience of workers in homelessness agencies was that it was rare for there to be any continuing contact and that many of the young men had fathered a number of children with whom they had no contact:

“They are nineteen, twenty years of age and they might have children with three different women who they don’t see or support.”

A worker in one agency felt the responsibility for this lay as much with the young women:

“A lot of the women I speak to argue that they and the baby will be fine. They don’t care if the man isn’t around, the fantasy is about them and the baby. That’s hard for the boys as well. It has to work both ways. The women have to encourage the men even if the relationship doesn’t work out. They need to understand the importance of having a male figure within the relationship of bringing up a child.”

**Government policy**

All the women were asked what they thought about two aspects of government policy. The proposal that 16 to 18-year-old mothers should not hold independent tenancies, but should go into supported accommodation with their babies and the proposal aimed at young men to inform them of the responsibilities of parenthood and to pursue fathers more actively for financial contributions. They were uniformly in agreement that young men needed to take the responsibility of parenting more seriously and that anything that could be done to promote that was a valuable development. One young woman felt very strongly about it:

“They don’t meet their responsibilities, they don’t look after their children and leave the women there just to get on with it. That’s what leads some women to beat a child or kill a child, or commit suicide or just leave the child and go because they don’t have the support they need. If parents had the support they need – it doesn’t matter whether they are male or female – there wouldn’t be so much of this badness in the world in this day and age.”
There was a more mixed reaction to the proposal concerning supported hostels. Most of the young women acknowledged that some teenagers would need support when they first had a baby but most felt that it was not universal and that it was less dependent on the young woman’s age than other factors like her own upbringing and how she was feeling about having the baby. Some of the women felt it should be up to individuals to make that choice. Others felt that some young women needed the choice making for them because they thought they could cope but they were actually in need of support.
Teenage pregnancy and youth homelessness are matters which require urgent policy attention. Many of the same risk factors in a young woman’s background are associated with both homelessness and with pregnancy at a young age. This report shows how important it is to view the issues as connected and to establish better joint working between homelessness agencies, sexual health promotion, social services, housing and agencies offering support to parents.

Hostels may in theory be set up to provide for young single homeless people, yet in practice they are dealing with around 25 per cent of their young women residents becoming pregnant in the course of a year. Where agencies are making provision for the most vulnerable, either the youngest or those with multiple problems the figure can be considerably higher. In the context of their lives as a whole, these women are likely to be estranged from their family, to have been in care, to have slept rough, to have experienced poor parenting themselves and to be on their own with the baby. There is a cogent case for examining the issue and planning for the care and support they need.

The current situation for a young homeless woman who becomes pregnant is complex and unsatisfactory. If she declares she is pregnant while looking for a hostel place she is unlikely to find anywhere. If she becomes pregnant while in a hostel she is aware that they do not accept pregnant women and fearful that she may be evicted. Depending on which area the hostel is in she will then face varying levels of difficulty moving on. She may move into her own flat or it may be a bed and breakfast or other form of temporary accommodation. Women who find a place in a single parents project are generally better placed, although it is another temporary move. They have support on offer but this is counterbalanced by a lack of independence and sometimes unwelcome limitations imposed by the project.

Voluntary sector homelessness agencies are struggling to respond to the needs generated by these issues without the experience or resources to do so. Project workers are thoughtful about, and troubled by the low self-esteem of their residents and the high rate of pregnancy. They are aware that many of their young male residents are fathers and that they lack positive role models or any acknowledgement of their support needs. They are aware of the need for advice around sexual health and relationships and for support and care when a young woman becomes pregnant. They are responding to these needs but often feel unsupported by managers and ill equipped to make an adequate response. Hostel policies in this area are under-developed. There is a lack of training both in sexual health and pregnancy, abortion and miscarriage and parenting and in how to talk to young people about these issues. Staffing levels are low and housing management tasks have to take priority. Knowledge about agencies in the local area that can provide services is often inadequate.

When women do move on resettlement services are very ad hoc and continuing contact often relies on the young women keeping in contact with the hostel. There is little contact between hostels and parenting support agencies such as Home-Start and Newpin.

Many hostels do see some work on sexual health promotion as part of their role but few are well linked into the services of the health promotion department or to local health providers. Only one health authority was identified as having a comprehensive programme of workshops and training aimed at the homelessness sector. Others were aware of the issues and some contact had been established but young homeless people had not been identified as a priority target group.

Hostels for single homeless people clearly cannot be expected to provide for all the needs of a young pregnant woman. However neither can they ignore the significance of the issue and the impact it has on their workload. Hostels are well placed to start the process of interventions that are supportive and helpful, and to forge links with other key agencies.

From the time a young homeless woman finds out she is pregnant she is in need of continuity of care. She needs appropriate housing offered to her before she is well into the pregnancy. She needs to have time to settle, sort out her accommodation, make links in the community and be given a chance to make the important bond with her baby when it arrives.

A young woman on her own, having given birth in hospital, not knowing where she is going to live, with no financial stability, or support from her family or a partner is being set up to fail as she embarks on motherhood.

Walter’s paper states:

“It is apparent that there are multiple policy contexts, as the difficulties experienced by the mothers cross health and social barriers, and it is unclear which agency should take the lead in helping families to resettle.”

The research has shown that no agency is taking on that role currently. The solution that arises from Walter’s work is a model of practice based on close inter-agency working with a team of people drawn
from social work, health and housing and with a model of user empowerment at the centre of it where women make sense of their past in order to move on. Whatever model is adopted the onus is on a number of different agencies to take on board policies that work better for young mothers and to work together in a more effective way. Young women who become pregnant while they are homeless need to be given a chance to bring up their children in some stability and enabled to make use of support services rather than evade them for fear of having their children taken away.

**Recommendations**

**Hostels**

- Hostels providing for young single homeless people are advised to review their policy on accepting women who are pregnant at the time of referral. Reasons for their decision should be clarified and made clear to all staff and in policy documents.

- Hostels should adopt policies on the provision of information, advice, support, and training for residents on sexual health, relationships, self-esteem and becoming parents. It would be helpful if managers clarified for staff what their role is in relation to these issues and offered ongoing support to project workers who are dealing with the stressful life circumstances of their tenants on a day-to-day basis.

- All hostels for young single homeless people should consider appointing an existing or new member of staff with responsibility within the hostel for co-ordinating work around sexual health promotion. This might include arranging training or workshops for residents and staff where appropriate, ensuring a supply of accessible literature on sexual health and publicity for local services. They could be the regular contact person with health services, health promotion and voluntary sector agencies in the community, keeping up to date with their policies, opening times and so on.

- Hostels have a role in working with male residents to enable them to acknowledge themselves as fathers of children and to look at what that means or could mean in their lives. Hostels providing support to single parents should review their policies in relation to fathers and other male partners. The exclusion of men and ban on overnight visitors compounds women’s isolation and lack of support and drives fathers further out of the picture.

- Hostels should aim to make available a supply of condoms to residents either by negotiating with the health trust for a supply or building the purchase of condoms into their overall budget.

- Hostels should make links with GPs, health visitors and agencies such as Newpin and Home-Start which can provide befriending or a more intense programme of support to new parents.

**Health promotion**

- Health promotion departments should ensure they have an awareness of the providers of services to young homeless people within their area and that they have an understanding of the specific needs of this group.

- Health promotion departments should make contact with homelessness agencies and offer support in terms of training for residents and project workers in sexual health promotion. This might involve:
  - a direct training programme or series of workshops for project workers and residents.
  - invitations to a generic programme which will meet their needs.
  - the offer of small grants to buy in training for agencies that make a case for specific provision.

**Local authority housing departments**

- Local housing authorities should follow the code of guidance to the Housing Act and accept that a young woman who is pregnant and homeless, including in hostel accommodation for single homeless people, is in priority need from the time that she contacts them.

- Housing departments should make every effort to offer a young woman suitable permanent accommodation early in her pregnancy so that she will not be forced into making a number of moves. At the time of re-housing she should be made aware of and linked in with local support services.

- Housing Departments should co-operate with hostels for single homeless people and recognise that they are not suitable accommodation for young pregnant women. Hostels should not be put in the position of evicting tenants in order to have them accepted as homeless.

- Housing departments should be making plans for the provision of semi-supported accommodation
that they will have to provide from 2003 for young single mothers. They should be looking at best practice and how best to provide support with independence.

Social services and health providers

- Social services departments should recognise that young women in homeless hostels are a very vulnerable section of the population. When they are contacted they should make a proper and prompt assessment of their needs. Undue stress is caused by long waits and uncertainty and women move on and become lost to support.

- Providers of ante- and post-natal care and parent and baby support groups should recognise the difficulty that young women who feel excluded have in using mainstream services. Services should be made available in hostel accommodation or in places where they feel at home and providers should consider setting up specialist drop-in services for young women and women who have been homeless.

- Providers of ante- and post-natal care should undertake training about homelessness so that they have an increased understanding of the specific experience and needs of homeless mothers.

Government

- As part of their ‘Supporting Families’ strategy the government should make a commitment to ending the use of bed and breakfast accommodation for pregnant women and women with young children.

- The government should recognise the huge role played by the homelessness sector in providing for the most vulnerable and excluded sections of the population, including those who have not necessarily slept rough, and resource them accordingly.

- The continuity of care provided by Sure Start plus should be on offer to pregnant young women who are vulnerable for reasons other than age, for instance homelessness, lack of family support, having been in care or having slept rough.
References

6. Sure Start is a national programme to improve the health and well being of families and children before and from birth. By 2002 there will be 250 local Sure Start programmes in deprived areas of high need.
7. Local authority Quality Protects plans will contain steps to prevent teenage parenthood amongst looked after children and to provide better support to those who do become parents.
10. Sir Donald Acheson (1998) *An Independent Inquiry into Health Inequalities*, HMSO.
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