

#HealthNow peer research report

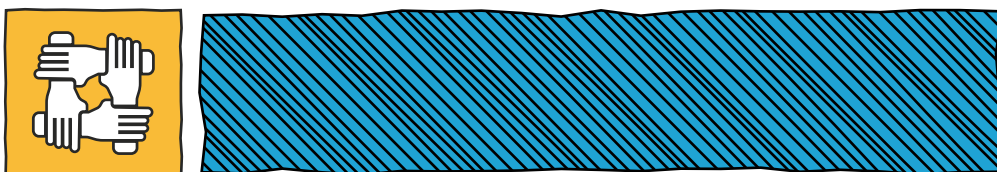
‘Knowing where to turn’:

**access to mental health support whilst experiencing
homelessness**

Summary

Accessing mental health support while experiencing homelessness is challenging and complex. This qualitative, peer research is based on interviews with 73 people experiencing homelessness and 7 stakeholders. The findings highlight the key difficulties people who are homeless face when experiencing poor mental health. Key themes indicate that:

- People experiencing homelessness face additional stigma concerning mental ill health. This leads to shame and embarrassment for many people who are unable to open up about the difficulties they were facing and reach out for help.
- Stigma can be perpetuated by interactions with healthcare professionals. Many people told us they felt judged when they did reach out for help. This was especially the case for people experiencing co-occurring mental health and substance use issues, who were more likely to face significant barriers to accessing the support that they needed.
- Many people cannot prioritise their mental ill health when they have more pressing immediate needs, such as securing accommodation. Lack of suitable accommodation exacerbates mental health issues, while simultaneously making it harder for people to prioritise accessing mental health support.
- People have a lack of trust in mental health services and mental health professionals. People told us about not being listened to, especially in relation to treatment options and diagnosis. People have greater trust in voluntary and community sector organisations and peers.
- Many people experiencing homelessness do not know where to go when they need mental health support. While some people told us they reached out to their GP, this often led to dissatisfaction. A significant proportion of people need support from a case or support worker to navigate the complexities of the system.
- Several people told us their only experiences of interacting with services were through primary care or emergency care. For some, despite ongoing mental ill health, a mental health crisis was the first time they were able to receive support. Support is often only available when a person's mental health had significantly deteriorated.
- When people were able to access mental health services, they told us that transitions between different services and localities often meant they had to re-tell their story, re-refer themselves or begin the process of accessing help entirely.
- Key suggestions participants identified that would improve the mental health and wellbeing for people experiencing homelessness included: access to safe, suitable and settled accommodation, earlier intervention and faster response from services, flexibility in service delivery and alternative types of support and, crucially, the involvement of peers.



Summary of change needed

This research has identified the need for focused action to ensure that people experiencing homelessness have access to the mental health support they need. We must:

1. Ensure everyone can access a safe, suitable and secure home

Safe, suitable and secure accommodation is an essential foundation for good mental health.

- The UK government must prioritise increasing social and affordable housing availability and meeting its commitment to ending rough sleeping for good by 2024. They should provide adequate housing benefit to ensure people can afford a tenancy.
- Local authorities should adopt evidence-based, housing-led solutions to prevent homelessness, such as Housing First fidelity models where people receive suitable accommodation and intensive unconditional support.
- Statutory homelessness services should lower the burden of proof to be considered 'vulnerable' and therefore in 'priority need' for statutory rehousing.
- Local authorities and housing providers should provide holistic, person-centred support and personalised housing plans to enable people to maintain tenancies, to prevent homelessness happening in the first place and to stop repeat episodes of homelessness.

2. Address the stigma of mental health issues and homelessness

- Healthcare services should adopt trauma informed and psychologically informed practices at an organisational level to ensure they provide a safe, non-judgemental space for all patients.
- Peers have identified the need for more robust staff training, co-designed and co-delivered by people with lived experience of homelessness, to help raise awareness and challenge judgements, especially in relation to mental health, homelessness and substance use.
- Healthcare services should make available training on tackling stigma to both clinical and non-clinical staff.
- Healthcare and homelessness services should consider using Groundswell's '[Clarissa](#)' video and accompanying resources in training for staff, to improve awareness of the challenges people experiencing homelessness face when accessing healthcare.
- Mainstream healthcare services should learn from and adopt best practice from inclusion healthcare services in order to deliver holistic and person-centred support.
- NHS and local authority commissioners should incentivise providers to work in a person-centred way. There is also a strong case for commissioning non-clinical services that can provide a safe space and listening ear when people experience mental ill health and are unable to access clinical services promptly.
- Peers have identified that providing designated mental health practitioners within GP settings would ensure people feel listened to when initially reaching out for help with their mental health.

3. Prioritise peer involvement in the design and delivery of mental health services

People with direct experience of homelessness and mental health issues must be involved in the design and delivery of mental health services.

- The Department of Health and Social Care must fully involve people with experience of homelessness in creating and delivering the Mental Health and Wellbeing Plan for England.
- Integrated Care Boards (ICBs) should ensure that people experiencing homelessness are meaningfully involved in the development of health inequality plans. Local areas should involve people experiencing homelessness in the co-design of their community mental health transformation programme.
- Mental health services should embed the NICE Guideline ‘Integrated health and social care for people experiencing homelessness’, with ongoing monitoring, to ensure peers continue to be involved in the design and delivery of services.¹
- Commissioners of mental health services should involve peers at a strategic level in the commissioning process.

4. Remove barriers for people using drugs and alcohol

There is a clear need for mental health services to support both people who are using substances as a coping mechanism for their mental health and those who are simultaneously accessing drug and alcohol services.

- Commissioners of mental health services should explore 24/7 crisis provision, in line with NICE guidance on ‘Service user experience in adult mental health’ and ensure services can support people regularly using, or under the influence of, substances.²
- Services should develop a multi-disciplinary approach when people need both drug and alcohol support and mental health support to ensure people do not fall through the gaps in between services.

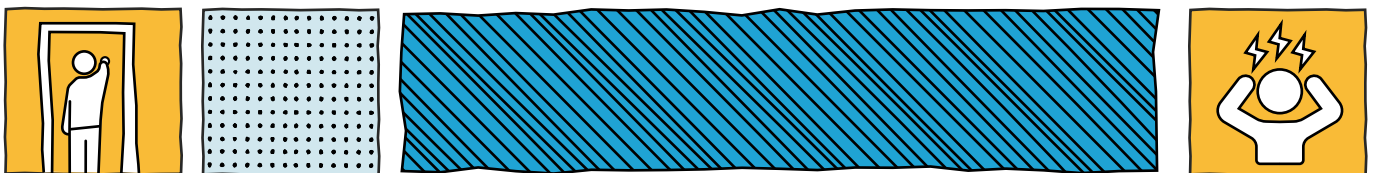


¹ National Institute for Health and Care Excellence (2022). *Integrated health and social care for people experiencing homelessness*. <https://www.nice.org.uk/guidance/ng214>

² National Institute for Health and Care Excellence (2011). *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services*. Clinical guideline [CG136]. <https://www.nice.org.uk/guidance/cg136>

5. Ensure people experiencing homelessness can access support with their mental health

- Mental healthcare in the UK needs urgent investment. The Department of Health and Social Care's forthcoming Mental Health Plan for England, and the planned update to the NHS Long Term Plan, must address critical shortages in support.
- ICBs should promote joint working relationships so both mental health services and homelessness services are aware of the local service provision and referral pathways.
- Commissioners should work with GPs to increase knowledge around homelessness and mental health and of the appropriate referral mechanisms.
- Local areas should consider funding care navigator roles to ensure people are referred to the most appropriate support, including services such as social prescribing and voluntary and community sector support. This would ensure people have a clearer understanding of the types of support available and may also provide crucial support for those awaiting NHS mental health support, to prevent mental health issues worsening.
- Commissioners and service providers should explore strategies to enable effective transitions between services, to avoid the need for re-referrals and maintain continuity of care when a person moves area or leaves the criminal justice system.
- Professionals working in mental health and homelessness services should share Groundswell's new collaborative [information leaflet](#), created in partnership with Mind, which provides tailored mental health information for people experiencing homelessness.³ This leaflet was informed by findings from this research and co-produced with peers.
- Increased funding for digital inclusion is required to ensure people can access services which are increasingly delivered remotely through providing digital devices and support to use them.
- Greater use of peer support could help address practical barriers to access for those who need support to navigate the system, attend appointments or require financial support to travel to healthcare settings.



³ Groundswell and Mind (2022) *You have the right to feel OK*. <https://groundswell.org.uk/wp-content/uploads/2022/10/Groundswell-MentalHealth.pdf>

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Acknowledgements

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We would firstly like to acknowledge the important and valuable contributions of the Peer Research volunteers who have led the research process and conducted the fieldwork for this project.

We would also like to thank the many partners and organisations who supported us to reach people experiencing homelessness and those who were engaged with their services.

Most importantly, we would like to thank everyone who participated and took the time to share their views and experiences with us as part of this research. We aim to ensure that your insights and experiences lead to positive change.



Date published - November 2022

⁴ <https://groundswell.org.uk/healthnow/>

Background

1.1 About Groundswell

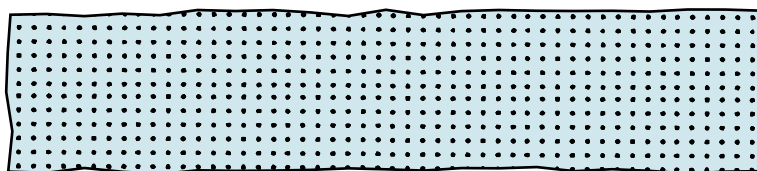
Groundswell works with people with experience of homelessness, offering opportunities to contribute to society and create solutions to homelessness. Participation is at our core because supporting people to participate creates more effective services and policy and, crucially, enables people to move out of homelessness.

Groundswell exists to tackle:

- **Homelessness** - everyone has the right to a safe home and to contribute to society
- **Health inequalities** - everyone has the right to good health and a right to access healthcare
- **A lack of participation** - people with experience of homelessness should inform the solution
- **A society that doesn't work for everyone** - the system has been designed in a way that restricts opportunity, it needs to change to work for everyone.

We achieve this through:

- **Good health** - We believe good health creates a foundation to move out of homelessness. Groundswell's people focused health work and innovative services enable people who are homeless to access the health care they need – because everyone has a right to good health.
- **Progression** - We are committed to developing and supporting a workforce of people with experience of homelessness to participate in designing and delivering solutions to homelessness while progressing in their own lives.
- **Creating Change** - Groundswell brings together insight from people with experience of homelessness, we use this insight to tackle issues through changing practice and challenging policy. We believe that the experience of homelessness brings insight that can help tackle the issues of homelessness and create change.



1.2 About #HealthNow

[#HealthNow](#) is a UK wide campaign, working towards an inclusive health system where everyone has access to the healthcare they need, ultimately moving people out of homelessness. #HealthNow is led by [Groundswell](#) and delivered in partnership with national charities [Crisis](#) and [Shelter](#).

#HealthNow is delivered locally in Newcastle, Birmingham and Greater Manchester; establishing Homeless Health Peer Advocacy (HHPA) services to provide ongoing practical support to people experiencing homelessness to address their health needs, conducting peer-led research into health inequalities and establishing local #HealthNow alliances. Alliances are formed of people experiencing homeless or who work in housing and homelessness, health and social care, and voluntary and community organisations. Alliances tackle local barriers to accessing healthcare for people experiencing homelessness by informing and acting on insights from peer-led research and from HHPA delivery in those areas. Local #HealthNow alliance members use this insight to co-produce solutions to overcome homeless health inequalities in their area. The local activities, insight and changes inform a national #HealthNow alliance, leading to nationwide actions to improve homeless health. Peer research to better understand patient experience of healthcare is central to the #HealthNow campaign. Informed by research gaps highlighted by our patient experience literature review⁵, each local #HealthNow alliance worked with peer researchers to co-design and deliver research into homeless health inequalities. Across Birmingham⁶, Greater Manchester⁷ and Newcastle⁸, peer researchers interviewed 160 people experiencing homelessness. #HealthNow peers also supported the delivery of a project capturing the impact of the COVID-19 pandemic⁹ and rapid research into the uptake of COVID-19 vaccines and testing for people experiencing homelessness.¹⁰

In 2021, a further piece of research was delivered in West Yorkshire, funded by West Yorkshire Health and Care Partnership.¹¹ This continued to track the effects of the pandemic on homeless health inequalities and added fresh evidence to highlight which health service experiences were national issues for people who are homeless. In 2022, we launched an update to our #HealthNow literature review exploring insights from across all our #HealthNow research and any new patient experience literature since our original review.¹²

⁵ Groundswell (2020) *#HealthNow Literature Review 2020: Trends in patient experience when experiencing homelessness*. <https://groundswell.org.uk/wp-content/uploads/2020/12/HealthNow-literature-review-2020.pdf>

⁶ Groundswell (2021) *#HealthNow peer research report: Understanding homeless health inequality in Birmingham*. <https://groundswell.org.uk/wp-content/uploads/2021/03/Crisis-and-Groundswell-HealthNow-Birmingham-research-March-2021.pdf>

⁷ Groundswell (2021) *#HealthNow peer research report: Understanding homeless health inequality in Greater Manchester*. https://groundswell.org.uk/wp-content/uploads/2021/08/Shelter_HealthNow_Manchester-report-2021_Final.pdf

⁸ Groundswell (2021) *#HealthNow peer research report: Understanding homeless health inequality in Newcastle*. https://groundswell.org.uk/wp-content/uploads/2021/05/Crisis_Health-Now-Newcastle-Report_FINAL.pdf

⁹ Groundswell (2020) *Monitoring the impact of COVID-19 on people experiencing homelessness*. https://groundswell.org.uk/wp-content/uploads/2020/12/Monitoring_Impact_COVID_Groundswell-FINAL-REPORT.pdf

¹⁰ Groundswell (2021) *COVID-19 testing and vaccines: what's working for people facing homelessness?* <https://groundswell.org.uk/wp-content/uploads/2021/11/COVID19-testing-and-vaccines-whats-working-summary-FINAL-updated-1.pdf>

¹¹ Groundswell (2022) *#HealthNow West Yorkshire: Understanding homeless health inequality in Calderdale, Kirklees and Wakefield*. <https://groundswell.org.uk/wp-content/uploads/2022/03/HealthNow-West-Yorkshire-Report.pdf>

¹² Groundswell (2022) *#HealthNow literature review update: How has patient experience changed for people who are homeless?* <https://groundswell.org.uk/wp-content/uploads/2022/09/Patient-experience-literature-review.pdf>

This report focuses on a key issue identified throughout our research so far and provides in-depth peer research into the experiences of people experiencing homelessness when accessing mental health support across the #HealthNow locations and London.

If you would like to find out more about #HealthNow, carry out peer research or set up a HHPA service in your area please [get in touch with Groundswell](#).

1.3 The relationship between mental health and homelessness

Mental ill health is a widely reported challenge for people experiencing homelessness. In the most recently published annual national statistics on statutory homelessness (people accepted as eligible for homeless assistance by local authorities), mental health was the most common support need. 29% of single people accepted into temporary accommodation were had a recorded history of mental health issues.¹³ Recent figures from London's Combined Homelessness and Information Network (CHAIN) showed that over half of people sleeping rough were assessed as requiring mental health support.¹⁴ This information was drawn from assessments by outreach teams, but people who are sleeping rough are even more likely to self-report mental ill health. In the UK government's Rough Sleeping Questionnaire, 83% of respondents reported facing mental health challenges.¹⁵ Recent analysis of data from 31 Homeless Health Needs Audits¹⁶ illustrated a stark increase in the number of people reporting a mental health diagnosis from 42% in audits from 2012-2014 to 82% in audits from 2018-2021

Mental ill health and homelessness are closely and complexly connected. Recent research by Homeless Link found that "of those reporting a mental health condition, 72% (101) reported that this condition predated their experience of homelessness. This suggests that mental ill health may often be a trigger for homelessness, which can then be further exacerbated by the experience of homelessness."¹⁷ The findings from our Rough Sleeping Questionnaire differed slightly, but showed the same pattern, with 43% of respondents saying that they already had a mental health condition when they first slept rough, while 17% said that they had developed a condition while sleeping rough.

Escaping from homelessness can make a significant difference to mental health. Research has shown that improvements to housing situations can make a meaningful difference to long-term mental health for people who are homeless, but a good level of accompanying support is usually also necessary.¹⁸ For those with more severe mental health symptoms, suitable housing is the solution to their homelessness, but they'll need on-going support to sustain a tenancy and avoid repeat homelessness.

¹³ Department for Levelling Up, Housing and Communities (2021). *Statutory Homelessness Annual Report 2020-21, England*. <https://www.gov.uk/government/statistics/statutory-homelessness-in-england-financial-year-2020-21>

¹⁴ Greater London Authority (2022). *Chain annual report: Greater London April 2021 - March 2022*. <https://data.london.gov.uk/dataset/chain-reports>

¹⁵ Ministry of Housing, Communities and Local Government (2020). *Understanding the Multiple Vulnerabilities, Support Needs and Experiences of People who Sleep Rough in England*. <https://www.gov.uk/government/publications/rough-sleeping-questionnaire-initial-findings>

¹⁶ Homeless Link (2022) *The Unhealthy State of Homelessness 2022*. https://homelesslink-1b54.kxcdn.com/media/documents/Unhealthy_State_of_Homelessness_2022.pdf


¹⁷ Homeless Link (2022) *The Unhealthy State of Homelessness 2022*. https://homelesslink-1b54.kxcdn.com/media/documents/Unhealthy_State_of_Homelessness_2022.pdf

¹⁸ Centre for Homelessness Impact (2022). *What works: evidence notes, 06: mental health*. https://assets-global.website-files.com/59f07e67422cdf0001904c14/61deb16c421740401955c829_CHI.WWC.EvidenceNotes.MentalHealth.pdf

In our previous #HealthNow research, in which we interviewed people who were staying in a range of unstable accommodation types, 64% of participants told us that they had faced challenges with their mental health over the previous year.¹⁹ Two thirds of those participants said that they had not seen mental health services enough to meet their needs. Among the most frequently mentioned issues were:

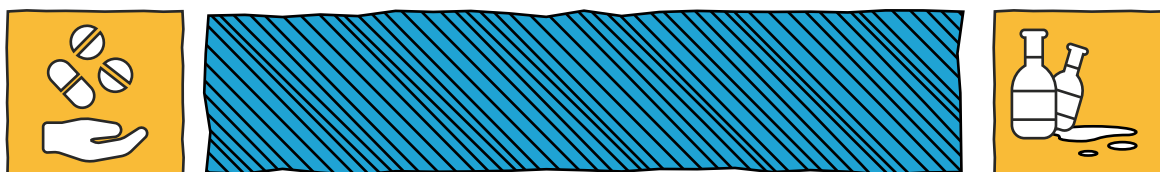
- Complex, unclear and inflexible processes for accessing services and long waiting lists to receive support. Mental health had often got worse before support was given.
- Difficulties re-entering services after being discharged or changing circumstances.
- Difficulties accessing mental health services for people with drug and alcohol dependencies. This was especially the case when people attempted to access mental health services via their GP.

These barriers to accessing and engaging with services are becoming more widely recognised and have been reflected in government strategies and recommendations. The most recently published NICE guidelines on ‘Integrated health and social care for people experiencing homelessness’ acknowledge that:

 *Barriers to access and engagement with preventive, primary care and social care services can mean that problems remain untreated until they become very severe and complex. These barriers include stigma and discrimination; lack of trusted contacts; fragmented, siloed and rigid services; strict eligibility criteria; and lack of information sharing and appropriate communication.²⁰*

The #HealthNow Peer Network consulted on these guidelines and welcomed the significant emphasis on the benefits of peer involvement in the design and delivery of services, alongside the important role of peer support in tackling the barriers people experiencing homelessness face when accessing healthcare services.

In her Independent Review of Drugs, Dame Carol Black draws attention to how commonly mental ill health leads to addiction but that this is not suitably accounted for in service provision.²¹ The report urges commissioners of drug and alcohol and NHS mental health services to ensure that people who need to access both do not “fall between the cracks”. Recent findings from Homeless Health Needs Audits²² continue to highlight the prevalence of co-occurring mental health issues and substance use issues (25%) with a further 45% of respondents reporting they self-medicate with drugs or alcohol to help them cope with their mental health.



¹⁹ Groundswell (2022) #HealthNow literature review update: How has patient experience changed for people who are homeless? <https://groundswell.org.uk/wp-content/uploads/2022/09/Patient-experience-literature-review.pdf>

²⁰ National Institute for Health and Care Excellence (2022). *Integrated health and social care for people experiencing homelessness*. <https://www.nice.org.uk/guidance/ng214>

²¹ Black, C. (2021). *Review of drugs part two: prevention, treatment, and recovery*. <https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery>

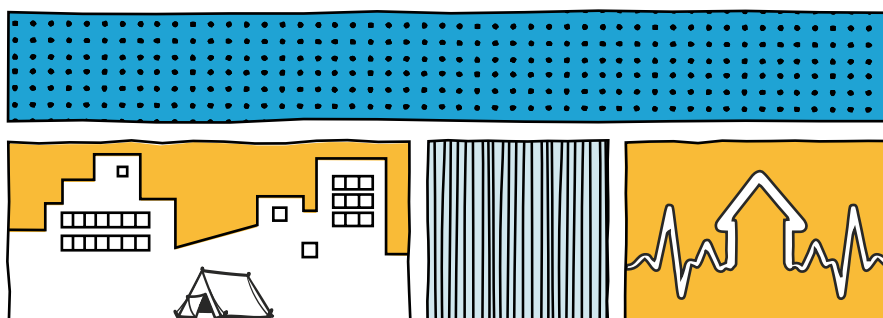
²² Homeless Link (2022) *The Unhealthy State of Homelessness 2022*. https://homelesslink-1b54.kxcdn.com/media/documents/Unhealthy_State_of_Homelessness_2022.pdf

The government's new rough sleeping strategy also acknowledges the need to improve mental health provision in light of the challenges faced by people experiencing homelessness in accessing it.²³ It highlights the difficulties in accessing services faced by those with drug and alcohol dependencies, and notes that services are not always as joined-up as they should be, "meaning that people often access services in crisis or not at all." It commits to "making sure the needs of those experiencing rough sleeping are taken into account in any future [NHS] Mental Health and Wellbeing Plan".

The rough sleeping strategy refers to mental health as one of "a range of individual factors" that contribute to someone sleeping rough, but this fails to acknowledge the socioeconomic or structural circumstances that lead to homelessness and contribute to mental ill health. For centuries (dating back to Tudor Poor Laws) people's personal circumstances have been blamed for their homelessness, rather than a failure of social provision. Suggesting that individual factors cause homelessness, risks exacerbating the long-standing stigma that people experiencing homelessness face.

There is extensive evidence that feeling stigmatised leads to poor access to health treatment for people experiencing homelessness, with people commonly reporting that they perceive discrimination from health professionals.²⁴ This was explored in our local #HealthNow health inequality research reports and was found to be especially prominent in the West Yorkshire findings. Participants who had experienced a drug or alcohol issues reported feeling stigmatised and discriminated against by health professionals when they tried to access mental health support, due to their drug or alcohol use. This led to a general mistrust of health services, in turn leading to poorer physical and mental health outcomes.

While research into stigma and discrimination for people who are homeless has focused mostly on the experiences of individuals who feel stigmatised, some research has also explored the effects of cultural and institutional values on stigmatised groups. Several studies have found evidence that living in an area where attitudes are particularly negative towards minority groups makes people within those groups less likely to engage with healthcare, more likely to suffer mental ill health and more likely to die younger.²⁵ This has serious implications for people who experience homelessness, poverty, drug dependency or mental ill health, which can all make people susceptible to prejudice. Research has shown that belonging to more than one of these groups can increase the overall likelihood of experiencing stigma, something highly likely to apply to people who are homeless.²⁶



²³ Department for Levelling Up, Housing and Communities (2022). *Ending rough sleeping for good*. https://www.gov.uk/government/publications/ending-rough-sleeping-for-good?utm_medium=email&utm_campaign=govuk-notifications-topic&utm_source=8f33dd1b-1879-45fd-94a2-e4e9bcf85ebb&utm_content=daily

²⁴ Reilly, J. (2022). *A systematic review of the effect of stigma on health of people experiencing homelessness*. <https://doi.org/10.1111/hsc.13884>

²⁵ Hatzenbuehler, M. (2016). *Structural stigma and health inequalities: research evidence and implications for psychological science*. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5172391/>

²⁶ Skosireva et al. (2014). *Different faces of discrimination: perceived discrimination among homeless adults with mental illness in healthcare settings*. <https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-14-376>

2. Aim

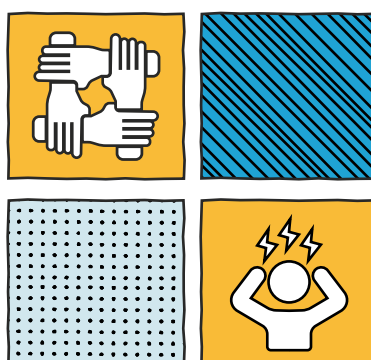
A key element of the #HealthNow campaign is peer-led research to better understand health inequalities for people experiencing homelessness. Our definition of homelessness includes rooflessness, houselessness and inadequate and insecure housing, in line with the European Typology of Homelessness and Housing Exclusion.²⁷ In 2020, our first research projects explored health inequalities at a local level across [Birmingham](#), [Newcastle](#) and [Greater Manchester](#). Across these areas peer researchers interviewed 160 people experiencing homelessness about their patient experience of using healthcare services. [Research](#) was simultaneously carried out about the impact of the COVID-19 pandemic on people experiencing homelessness. In 2021, a further piece of research was delivered in [West Yorkshire](#), funded by West Yorkshire Health and Care Partnership.

Through an interactive workshop, Groundswell brought together peers and stakeholders from across the country to review findings from the existing research and local inequality reports to identify which key themes should be investigated at a national level. We followed up this workshop with a focused session with peers to explore not just the key themes which emerged but also to consider if these themes were already effectively addressed through existing research and consider the potential for impact for policy and practice.

Patient experience of mental health support was highlighted as poor across all report findings, with a particular emphasis on the barriers to accessing appropriate services. Workshop discussions also emphasised the importance of developing a better understanding of what people experiencing homelessness would like to see when engaging with mental health services and support. Therefore, two key aims were devised for this new research study:

- To understand the barriers to accessing mental health services for people who are experiencing homelessness to identify actions that can address health inequality
- To find out more about what works and what people want to see from mental health services going forward

This research provides empirical evidence to address these aims and informs peer-led recommendations for policy and practice to improve access to mental health support for people experiencing homelessness.



²⁷ FEANTSA (2005) *ETHOS - European Typology of Homelessness and Housing Exclusion*.
<https://www.feantsa.org/download/ethos2484215748748239888.pdf>

3. What we did

We used a peer research methodology, which means people with lived experience of homelessness were central to the process of designing and delivering the research. There are significant benefits to using this approach including, but not limited to; addressing power imbalances between researchers and participants, ensuring research is accessible and flexible, and being informed by those with a real understanding of the issues people may discuss. We believe this means data is richer and solutions are more likely to be appropriate and implemented successfully.

First, the team took part in training to refresh research skills, explore ethical implications and refine the research approach. We then worked together to prioritise key research questions and co-design research tools. We developed two semi-structured interview guides, one for interviews with people experiencing homelessness and one tailored to mental health professionals and commissioners. Finally, we piloted interview guides through peer-to-peer researcher interviews and refined them ahead of the fieldwork starting.

We carried out research across Birmingham, Newcastle, Greater Manchester and London. We conducted face-to-face interviews with people experiencing homelessness at various settings such as hostels, daycentres, and healthcare drop-ins. We used an in-depth, semi-structured approach because of the sensitive nature of research topic and the need to gather rich qualitative data. It also allowed us to give people the opportunity to speak freely about their journey through various systems and support services.

We carried out Interviews with mental health professionals and commissioners via Zoom. Our interview questions aimed to understand the various services and commissioning processes involved in providing mental health services for people experiencing homelessness. We also explored any barriers professionals face in their role that affect their ability to meet the needs of people who are homeless. All interviews lasted between 15 to 60 minutes and were recorded and then transcribed.

We came together for a further participatory workshop to ensure peer researchers were central to the analysis of the data. In small groups peers reviewed anonymised transcripts and collaboratively devised key themes. Additional thematic analysis was completed using NVivo software. We worked together through a series of #HealthNow Peer Network meetings to co-produce and prioritise recommendations for policy and practice.



Image from participatory findings workshop

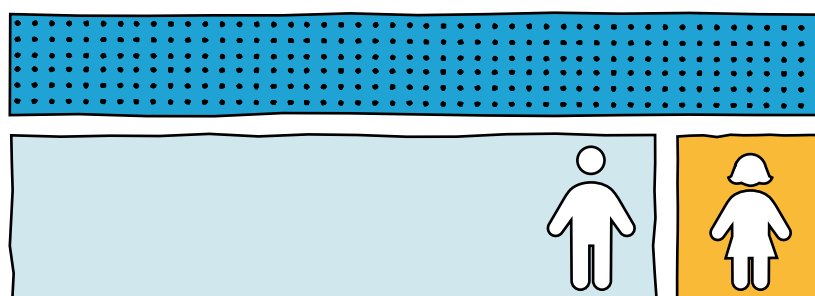
4. Who we heard from

This research was informed by interviews with 73 people experiencing homelessness and 7 mental health professionals (front-line staff, service managers and commissioners). We heard from people across various locations in Greater Manchester (48%), Newcastle (26%), Birmingham (14%) and London (12%). Interviewees experiencing homelessness were living in a variety of accommodation situations, including sleeping rough and staying in temporary or emergency accommodation, rehabilitation facilities or with friends or family, and people who had recently moved into local authority housing. Although we did not ask for specific information around people's mental health conditions, people described experiencing a range of mental health conditions including depression, anxiety, schizophrenia, bipolar disorder and psychosis. Some people described experiencing more than one mental health condition.

Despite a concerted effort to reach people experiencing homelessness from a range of backgrounds, there are still limitations to whose voices this research represents. A significant proportion of those we heard from were aged between 30-59. The majority (84%) identified as White, with only 9% of participants identifying as Black and 3% identifying as Asian. A significant proportion (88%) identified their sexuality as heterosexual. Because of the relatively small numbers of some groups, we are not able to draw conclusions about specific experiences faced by particular groups of people.

Only 18% of participants identified as female. We know from previous research that women have distinct experiences of mental health while homeless. In Groundswell's '[Women, homelessness and health](#)' research, we found that women very often became homeless because of reasons linked to gender inequality, such as domestic violence and sexual abuse; these experiences had ongoing effects on mental health and wellbeing.²⁸ 59% of those participants felt that physical or mental health issues had contributed to their homelessness. The same percentage of female #HealthNow participants in West Yorkshire said they believed their homelessness could have been prevented if their health needs had been better met. Almost all said they felt this way because of unsuccessful attempts to access adequate mental health support. Only 31% of men in West Yorkshire shared this attitude, often telling us that they were to blame for their own homelessness and mental health, or that they had been too proud to ask for help. This is a prevalent societal view, however, a well-functioning housing system (with tenancy sustainment support where needed) should mean people avoid homelessness.

It is a significant limitation of this research that so few participants were women. While we have included women's stories as much as possible, we acknowledge that this report represents a primarily white male point of view. That point of view is undeniably valuable, but we cannot claim that it represents a comprehensive picture of experiences of mental health support for people who are homeless.



²⁸ Groundswell (2020). *Women, homelessness and health: a peer research project*. <https://groundswell.org.uk/wp-content/uploads/2020/02/Womens-Health-Research-Report.pdf>


5. What we heard


5.1 The role of stigma and trust in accessing mental health support


5.1.1 Stigma and perception of mental health

A significant theme that emerged from the data was the experience of stigma and how participants perceived mental ill health. Many people we heard from reported being judged and stigmatised about their mental health and this leading to feelings of shame and embarrassment. It was often noted that people already experienced significant stigma concerning their homelessness situation and that mental health issues compounded this.


Many people also described a reluctance to reach out for support with their mental health due to their pride or fear of further judgement.


 *It affects your pride in a way that... because you lose that pride when you are homeless. But it is still there. It doesn't completely go... And then it's like when someone tries to help you, in your mind, it's saying... they are saying to you that you are weak. And that is kind of what you are telling you... they are telling you are weak; you can't do it on your own. And that's why you end up in a shit mess because of that.*

 *It's a stigma, isn't it? As soon as you say oh, I have got mental health issues, people just like look away.*


 *When you are homeless, you don't give a flying shit what people think about it. But deep down somewhere it probably does affect you.*

Similarly, people described being embarrassed about disclosing their mental health issues to friends or family members. Several people did not feel that they had a safe space to discuss their mental health concerns.


 *Well, it's embarrassing really. Because I am on medication for the rest of my life. In my eyes it is.*


 *I mean... like the homelessness bit and the mental health bit. You feel so ashamed going to your family saying that you need help. And you don't go and ask for that help. So, you are stuck. And you think, where do you go next?*


This was also reflected in participants' preferences in where they would like to receive support for their mental health, with a few participants indicating that they would rather not receive it in their accommodation setting due to the fears of other residents knowing.

 *I would probably feel better speaking to someone face to face. But not like in here, because I wouldn't want other people knowing...*


Often participants described feelings of pride leading to a desire to cope independently and “just get on with it” rather than disclose mental health issues to those around them or reach out to mental health services.


 *Had it [mental ill health] for nearly five years. But I want to try and cope on my own... I don't want too much help. It's making me feel less independent then really. If you get where I am coming from.*

 *I would rather just get up and go and sort it out myself.*

 *If anything, you have got to be grateful for the problems because they make you who you are, you will curl up in a ball, cry like a woman or just get on with it. Maybe I am just a bit old school. Get on with it, keep yourself busy and don't think about it. Sitting around, nothing to do, you can overthink things way too much.*

Often when people did reach out to services for support with their mental health, interactions with professionals perpetuated feelings of stigma and judgment, leading people to either have negative experiences or disengage with support completely.


 *[healthcare professionals] Judge you...All day I get judged.*

 *It's just I feel like they need to be more understanding and a bit more... understand how things are linked. In life... and be less judgmental and understand that everything sometimes connects.*

Perceptions of mental health were not always negatively viewed by participants, some people described feeling comfortable discussing issues openly, and others expressed poor mental health being the ‘norm’ or an expected consequence of experiencing homelessness or previous trauma. Narratives indicated that some people felt resigned to experiencing poor mental health and felt that mental health and homelessness came “hand in hand”.

5.1.2 Co-occurring mental health and substance use

Issues around stigma were intensified even further when people experienced both mental health and substance use issues. They described facing increased levels of judgement by professionals which often acted as a significant barrier to getting the help they needed.

 *The mental health crisis [team] can often be quite judgemental to you if you have got... issues with alcohol and things like that. I feel like they are quite condescending sometimes... Like you have been drinking. Yeah, fair enough I can understand where they are coming from. But at the same time, they have got to understand, sometimes it's the way someone is coping with how they are feeling that day. If they're feeling low, I know the worst thing is alcohol, it's a depressant. But sometimes it's your way of coping with how you are feeling.*



“ In our experience most people who fit into the category of both mental health and homelessness... they get labelled as having complex needs. Yet... Their needs aren't complex. If you listen to the story... well this happened and this happened and this happened... It makes perfect sense. I would react like that. Well, I did, I have reacted like that. But you kind of go... That's not complex. The complexities lie in the system and its inability to deal with more than one thing concurrently. (Stakeholder)

Participants with co-occurring issues frequently faced two overarching barriers to accessing mental health services. First, there was a misconception that people were attempting to engage with services to receive medication which meant some people were unable to access the support they needed and were reluctant to engage in future.

“ I have never been on the crisis team. I rang the crisis team, and they are exactly the same. They just think I am screaming for drugs.

Second, narratives also highlighted the long-standing issue of people who are currently using substances being unable to access drug and alcohol services and mental health services at the same time. This was the case both for people who were engaged in drug and alcohol services and those who used substances as a coping mechanism for their mental health issues. This was despite many participants emphasising that the two issues were significantly interlinked.

“ Well, it's a bit more complicated, isn't it? They don't want to talk to me when I am drunk.

“ I have explained to the doctors that I have had drug issues in my past and mental health problems. And none of the two seem to be connected. They are seen like two different things; two different organisations do different things. It's the chicken or the egg... You are struggling, you take drugs. Then you come off the drugs, you are struggling even more, you think hang on a minute... I am running round in fucking circles here. No one wants to help you. You are a just a number and a name.


The lack of joined up working between drug and alcohol services and mental health services increased the complexity of accessing support and led some people to fall through the gaps between services, meaning they were left with no support.

“ I find that homelessness ends up sitting with housing or it sits with substance misuse. And actually, it's everybody's responsibility. (Stakeholder)


Interviews with professionals working in the sector explained the challenges of effectively supporting people who have a 'dual diagnosis' for both commissioners and providers.

“ There is a reluctance I would say, in the professional, probably... medical [unclear] I would think. To try and... support people with a dual diagnosis. We try and commission it – I think we get probably pushed back from professional groups sometimes. They say they can't possibly see someone with an active substance misuse issue. And treat them effectively. (Stakeholder)



 *It can be more challenging because it complicates an understanding of the person's need. Do they have presenting mental health needs triggered by their addiction and the drug and alcohol use? Or are they using because they have got a need? So it can complicate things...But there is a recognition across the trust as a whole, outside of our services, that people will present with co-occurring needs and they shouldn't be excluded from either or treatment model. Because of that. (Stakeholder)*


Despite describing their efforts to ensure people with co-occurring needs were not excluded from mental health treatment, stakeholders identified inconsistencies between policy and practice.

 *Although on paper my NHS trust at the most senior levels execs say oh no, mental health services will work with someone who has substance misuse problems. But I think then when it comes to the individual clinicians on the ground, they might be wanting to think about what psychological readiness means. Whether it going to be – if they are using substances to cope with their difficulties, can they bear to get in touch with the things that may come up in the therapy, for example? Older school theoretical thinking that might get in the way. But I am hoping that things are beginning to shift. (Stakeholder)*


Both people experiencing homelessness and those working in the sector acknowledged that voluntary and community sector services were often more likely than NHS services to support someone with co-occurring needs. Stakeholders we spoke to from voluntary sector services noted that the majority of the people they worked with had concurrent mental health and substance use needs – “if we didn't, we would have nobody coming in the door.” Most of these services had fewer eligibility criteria and shorter waiting periods for people to access support.

5.1.3 Prioritising mental health needs


We asked participants who had not accessed mental health support why they had not. People identified not feeling “ready” to engage with services, which links back to feelings of pride and stigma discussed earlier.


 *Yeah, just at the time it wasn't something I was interested in. It was just something that – it was nice but we wasn't ready to access the services. And I am still not ready because... I am starting, a lot, to deal with shit myself. And it's not even that... I have to speak to the right person to be able to fucking... to be able to open up I need to be thinking.*


The idea of ‘readiness’ also linked to whether people needed to find solutions to their other needs before they could focus on their mental health. The reality of experiencing homelessness often meant that mental health issues were not prioritised as more immediate needs, such as accessing housing, or drugs and alcohol for those who were dependent on substances, took precedence instead.

 *Well, when I was homeless, I didn't see the doctor once. I just had too much on [my] mind and... It was just doing my head in. The only thing I could think of... What do I do to get off the street? What do I do? And I didn't know what to do.*

Participants reflected on how the lack of appropriate accommodation led to their mental health worsening while simultaneously making it harder for them to prioritise their mental health needs. This was particularly true for people who were sleeping rough, but also identified by those living in temporary accommodation that did not feel safe or meet their needs.


 *My life is in chaos; I am on the streets.*


 *Previous to that I was sleeping in bushes. And the depression really kicked in. I mean after midnight it is so unsafe on the streets. Wandering about. And that's when I thought to myself that things are very grim.*


 *But the way things are up here [in accommodation], I feel like doing myself in. Being up here. It's not good form, because I have got no one. And if I don't do it myself, I am going to get stabbed up anyway.*

What good would look like – safe and settled accommodation

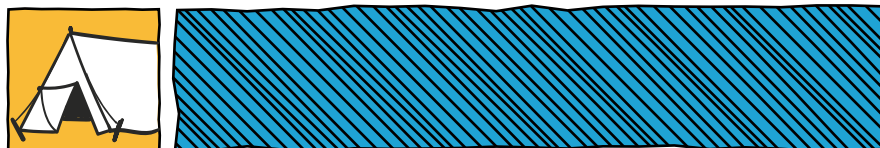
When participants spoke about what would most help people experiencing homelessness to address their mental health needs, they focussed strongly on the need for suitable and stable housing.

 *Make them not homeless. Give them a house, you know. Give them somewhere to live, somewhere stable, and the wrap-around support, the deed, to get their lives back on track.*

 *Help them get somewhere to live and a bit of support.*


 *Just to get more off the streets, because there seems to be more and more coming on the streets.*


Participants told us that that lack of accommodation or insecure, temporary or poor quality accommodation plays a role in mental ill health. They argued that providing appropriate housing would enable them to prioritise their mental health and wellbeing.



5.1.4 Trusting services and feeling listened to


Trust in healthcare services and healthcare professionals was paramount to those seeking mental health support and deemed an essential component of effective support. However, a lack of trust in statutory services was a key theme among those we heard from, with many people reflecting on poor experiences leading to mistrust in professionals, especially those working in statutory services.


 *I will put my trust into people, and it just went nowhere. Or they put us somewhere or they try to help us... And put us places where I don't want to be. They put us places where people... mixing around drugs again, mixing round the same sort of people. Oh, I am 30 years of age I am tired, I am drained I don't want to be in this life no more.*


 *...I don't trust people. Know what I mean? So, I can't...I am scared to open up to people now because every time I open up to people, it's ended up tripping us back. Know what I mean? And in the face. So, I am scared to open up to people and tell them what's going on in my head... I know now that you have got to help... Open up and be truthful. But every time I have done that...It's just come back and kicked us up the arse. I have been penalised for it.*

Several people told us that they would not attempt to seek help from mental health services at all as they felt it would be futile. This was often due to previous poor experiences of attempting to access support unsuccessfully.

 *I have tried. I have tried asking for help but it's like you hit a brick wall sometimes.*


 *I woke up and felt like that, I know very well I wouldn't engage with mental health Crisis because I just don't feel I had that support before so why would I have now?*

 *No because I knew even applying or asking for it, you wouldn't get it. You wouldn't get put on the waiting list. And the waiting list is going to be long as your arm.*


 *Listen to people. Listen to them... they are not telling you lies; they are telling you the truth. I had a guy the other week, right, he said no one listens to me, no one listens to me. I said oh don't do anything stupid. He said no, no, no, I won't. Walked round the corner, the guy hung himself. Know what I mean?*


The majority of people we spoke to described experiences of not feeling listened to by healthcare professionals and stressed the importance of feeling heard, especially about their mental health concerns. Experiences of feeling unheard were often more prevalent when people were engaging with professionals over the phone.



 *I have been telling them [GP] for ages, man. But it just felt like I was banging my head off the wall basically. Because I wasn't getting nowhere. And they weren't giving us nothing... Aye not listening... that's how it felt to me. Plus, it all being over the phone. I mean I like face-to-face. If you go and see a doctor, you want to be face-to-face because you want to tell them the problems. But I found that when you are on the phone to them, they just don't overtalk. While you're trying to tell them something and they just overtalk you.*


For some, interactions with healthcare professionals felt “cold” or “like a robot,” with one person stating they felt that “they are just paid to do what they do.” Conversely, people who felt listened to by healthcare professionals often described having greater trust in the relationship and consequently the treatment they were provided.

 *It's just about listening. It's just about listening and not feeling that if you say the truth you are going to be judged for it.*


 *[What would help is] Someone to understand, really understand. Really understand what the person is actually going through at the at moment in time, where they are at in that moment in their lives.*

People described feeling more listened to when they could develop a rapport and meaningful relationship with one person, although this was often only possible when they were using inclusion health services or those specifically aimed at people experiencing homelessness.


 *You have got to have a rapport with people. And if you don't, it doesn't work.*

 *Well, I see regular people myself. I am assigned to a certain person. Since I have been there, I have had three different people. So that's not bad. Because every time you change someone, you have to go through it again and again. You have to keep going through it. And sometimes it brings back memories that you don't want to remember.*


A lack of staff continuity was frequently experienced by many participants engaging in mainstream NHS services which led to further impacts such as re-traumatisation.


 *You end up having to share your story again and then go through that re-traumatisation of like ah well you have got to tell it to see if they think you deserve help or not. Which is just a bit of a nightmare.*

Feeling listened to was particularly important when making decisions about healthcare treatment. We asked people whether they were involved in decisions about their healthcare and a significant proportion said they were not. Many indicated that they did not feel they were able to be involved or that professionals made decisions without providing an opportunity to discuss.

 *My GP. He refer us... He done it all without... Even asking me. I just got a letter one day saying they were coming. But I'd been told... I get referred off your doctor.*

In contrast, those who had an ongoing relationship with a consistent mental health professional were more likely to feel that they had choice and control in their healthcare. The opportunity to work with one person for a period enabled a trusting relationship which meant people felt comfortable discussing what felt right for them personally.

 *I think if I was going to suggest anything, I think it would be like one key worker...Coming here on a regular Thursday, every week...So, we can get familiar with you and you can get familiar with us in that way. People can start letting down their barriers and talking a bit more. Or feeling... Not having to worry about how is coming to see me this week? Because I know that's a big thing as well. Once you build a rapport up with someone, you feel you can start a bit more trust. And reliability as well. And that is a big thing. Because I don't feel like opening up to people, I have just met.*

 *I see my own doctor, which is Doctor [name omitted] – I have known him for three years. I am comfortable with him, because he has helped me through quite a bit.*


Participants also described increased trust in the services and support provided from the voluntary and community sector. This was often in relation to the flexibility offered and continuity of support. This was particularly important for some people who said they just wanted to be listened to, regardless of whether it was by a mental health professional or not, feeling heard by someone was deemed as paramount.


 *It's just someone to talk to. Could be an organisation...Could be people for you to go and talk to, sit down, with a friendly face, to help you.*




What good would look like – the importance of lived experience


The importance of peer support from someone who has “been through it” was frequently discussed as an effective way to encourage people to reach out for support.


 *I could speak to you now, and it's now. Because you are a decent guy and I can tell, and I can speak to you. But there are certain people that I cannot speak to. Like the psychiatrist. The ones who come to see you with [unclear] kit and all that. They have not lived through what we have lived through, so they don't have a clue what we are on about.*

 *The only people I take advice off is people like yourselves. Been through it. I respect you. Massive respect.*

 *But obviously someone with lived experience of homelessness is going to understand and be able to – because I do think that when you go to something like therapy, that relationship that you have with a therapist is so important to establish. And if you don't have that you can't open up to them. So yeah, whatever lived experience it is that people have, it is so important to have that sort of representation and understanding of it.*

Participants also described feeling more listened to and able to develop trust with people who had shared lived experiences, rather than learnt experiences.

 *Because you guys are real, like. And these medical... these people... the doctors they don't know what real life is about. They might do, I am not saying all. But they haven't experienced the shit we have been through.*


 *Well, I would say... Their experience. Rather than someone reading out of a textbook, them having personal experience. I would rather relate to someone that knows what I am talking about, than somebody that has no idea what I am talking about. Because it's pointless, isn't it? So, I find that talking to people that I know, my friends rather than talking to a stranger, because I know that my friends have been through similar situations. So ... that's the only deterrent I have... Is talking to someone that they don't know what they are talking about.*


This illustrated how peer support and the role of people with lived experience could provide a mechanism for developing trust and reducing stigma, both tackling the systemic and individual barriers to accessing mental health services.




5.1.5 Inconsistencies in diagnosis

The need for, or impact of, receiving a mental health diagnosis was perceived differently by people we heard from. Some described how receiving a diagnosis helped them feel that their symptoms were legitimatised and ensured they were able to access the treatment they needed.


 *I got diagnosed paranoid schizophrenic. It wasn't nice...but it was all right. They helped me.*


 *Because I think...if you know what is wrong with you, you would have the proper medication, which would probably help you deal with things... I think you do need to know. What's wrong with giving someone a label as such and such? Sometimes you need that. Rather than just saying oh it's depression and anxiety. Because it's not, it's more than that. So yeah, definitely I think people do want it diagnosed. Because you want the proper tools to deal with it. And people aware of what you have got as well. They are more understanding and can help you in ways to deal with that.*

In several cases, however, it took a long time to receive a diagnosis and people received limited ongoing support and monitoring once the initial period of treatment was completed.


 *I was diagnosed with depression when I was wee. So, 17 years ago. So, I already knew. I just needed a new prescription, that's all I seen them for.*


A number of the people we spoke to described being confused about whether they had received a mental health diagnosis. Some people said they did not know if they had a diagnosis or what a diagnosis was, and others described receiving a diagnosis they did not agree with.

 *Well, I went to the doctor. They said I have got a personality disorder, bipolar, depression, anxiety, and they said I am schizo – but I don't think I am schizo. But I did hear voices, but I think it was somebody else. They don't really know I just had a breakdown.*

 *The initial thing I got told is I might be suffering from PD [personality disorder]. But that is all that they said. The medication they have put me on is for schizophrenia. And I don't know if I had got schizophrenia or if it's personality disorder or what. And I want to find out what it is so I can deal with it.*

The way that healthcare staff communicated diagnoses often increased confusion, resulting in people not understanding what their diagnosis meant. Participants explained how the use of jargon and inaccessible language often affected both the way they understood what professionals were explaining and their confidence to ask follow-up questions.


 *Yeah, they explained things to me. But half of it I didn't understand. It's just some things were said to me that went over my head...There probably was an opportunity to ask about it [diagnosis]. I just felt like... I probably feel stupid, know what I mean? Asking questions, feeling like... No one wants to look stupid. Know what I mean? You think no I had better keep myself quiet a bit. And I will just pretend I know what's going on.*


 *I mean, you get like 3-sentence psychiatric reports when you go to prison anyway if you go to crown court, and, that's just jargon to sort of decide whether you should be in prison or not.*

This reflects earlier narratives, where people discussed the negative impact that healthcare professional communicating in “robotic” or “cold” ways had on establishing rapport and trust. This is particularly concerning when a diagnosis is often a crucial aspect of receiving appropriate support and treatment. Furthermore, difficulties in receiving a diagnosis often impacted how trusting participants felt of healthcare professionals. Experiences of disagreeing with a diagnosis or receiving different diagnoses from different clinicians understandably led to decreased feelings of trust.


5.1.6 The reliance on medication

A significant proportion of people we heard from described being offered limited treatment options and often only medication for their mental health issues. Many said they felt their only option was medication and experienced having minimal communication with their GP about the implications or side effects of taking medication, or whether this option was right for them personally. This reflects concerns discussed previously about people not being listened to or involved in decisions about their care.


 *I don't know, it was literally... I am not being funny; I was on the phone for less than two minutes and he turned round and said 'OK we are going to put you in this and then review it in four weeks'. I would have thought, before you put someone on medication, surely you are supposed to talk to him.... Because when I had depression, it was just 'well go and tell the doctor' and he just prescribed me mirtazapine and said 'get on with it'.*


 *No [side effects weren't discussed] it's just here you are, take them, come and see us in a few weeks. Read the box and sort yourself out.*

Adverse side effects from taking medication were common, reinforcing how important it was for people to be aware of these before starting treatment. For some, repeat visits to the GP were necessary to change medication type. Despite this, continued reliance on medication as the main treatment option was prevalent.

 *Oh yeah, under ten minutes it's just like 'oh right, OK, how are you feeling, this, that, take them. And if they don't work come back and see us in a few weeks and we'll try something else'. So, then I have been through that process as well, where you are trying different medications. And one day you are up there, the next day you are down there. Some days you don't even know where you are. So, with the medication thing, I find that it is hit-and-miss. It's very hit-and-miss.*


Others said that they stopped taking their prescribed medication to avoid dealing with the side effects.

 *[They] just give me these tablets, antidepressant tablets. They made me feel quite worse sometimes. They never really ...I stopped taking them because they weren't doing me any good. They were doing me more harm than good.*


 *I am on all different anti-depressants, but I have not had them for a good while. To be totally honest, mate, I feel a bit better for it.*

People identified a clear need to be more informed about the medication they were prescribed and the side effects they may experience. This would ensure they were prepared for any potential side effects and may avoid people stopping their medication independently. It would also allow people to make more informed decisions about whether medication is the appropriate treatment for them.


In some cases, medication was deemed as a suitable treatment and experienced positively. For many, however, there remained a preference for a more holistic approach to treatment, and for a combination of different treatment options to be discussed and readily available.

 *[I] think medication is all well and good, but there is not like the ... holistic support? It's like what we were saying before like it's looking at the external factors of like.*

Overall, the perceived reliance on medication by healthcare professionals often reinforced people's perceptions that they were not listened to. People felt there was a limited acknowledgement of the role of alternative treatments and felt their concerns about taking medication were not adequately addressed.

 *Yeah, they have given me them before, but I wouldn't take them because... I keep telling them they are not working. But I just return them back to the chemists.*


In some cases, this led to people going to other services or disengaging with support from their GP.


 *I spoke with a different doctor. Because that doctor seemed to want to pump me with medication. He didn't seem to want to understand what my head was going through or how I was feeling. So, I thought fuck off, get another doctor. Get a second opinion.*

5.2 Difficulties when engaging with mental health services


5.2.1 Knowing where to go


We asked participants whether they knew where to get support for their mental health and which route they had taken when attempting to engage with mental health services previously. The majority of people we heard from described going to a GP or asking a support/case worker for help to access the appropriate services. However, we also heard from a significant proportion of participants who stated they would not know where to get support, despite already experiencing mental health issues.

 *Don't know where to go to get help, you are never going to get it.*


 *I don't know how to access them anyway, because I can't read and write. I haven't got a clue. I can't go on the computer.*

People told us they found it difficult to find clear information, especially in accessible formats. They also found the pathways to accessing support complex, particularly for those who were not already engaged in local support services or were new to mental health services.


 Yeah, I mean, there's a lot of it... based on sort of, you've got to have an understanding of the system and you've got to be, like, able to do things, to be able to read, to be able to write. You've got to have like sort of, digital access. And if you're sort of educationally excluded, or, you know, digitally excluded, you know, if you're like homeless living on the streets and haven't got, haven't got a phone, how are you going to get the help that you need? At least I was lucky, that I always had access to all these things. And sort of the know-how how to use them. Which, I've spoke to so many other people who just don't. So, it's relying on a lot of things before you can even get through the door.

 You do get passed from pillar to post. In the beginning. Because you don't really know that you are doing, you don't know where to go. They send you here, they send you there. Some of us get lucky, some of us don't get lucky.


Needing the ability and resources to navigate the complexities of the mental health system was a common theme, alongside the acknowledgement that people experience the process differently. Often people relied on support from a support/case worker to help advocate and guide them through the system or to provide “a bit of back up.”

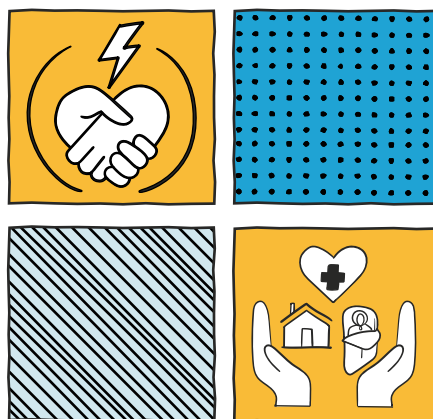
 I don't know. Like I say I have got a worker for them things. I can't do stuff like that. I have got... I find it difficult. I get agitated.

 The key worker helps me a lot. He gets in contact with them and makes another appointment.

 The only thing I would say is, if I hadn't been linked up with other services, I don't know how I would have been seen. Or even diagnosed. Probably not...Yeah... Because it's a nightmare to access mental health services, if you haven't got someone fighting your corner.


The appropriate support to navigate services was key to being able to access the right service. Those who did not have access to support networks described feeling “lost”, “in grey areas” or having very minimal information about where to go if they needed help. Several people described only having a list of numbers they could call and this being insufficient to support their ongoing mental health needs.


 At the moment I just have numbers. And it's, if I do attempt to kill myself, go hospital. That's pretty much all basically.




5.2.2 The role of the GP

The GP was often the first point of contact when people experienced poor mental health, but this often led to dissatisfaction. This was mainly driven by people feeling that GPs were unable to provide support promptly, and experiencing difficulties when try to make appointments.


 *I will be honest with you, half the time you can't get an appointment to see the doctor anyway. So, the GP practice is just a no-go.*


 *I have not seen him [the GP] for 12 months. I have gone down, but he is never in.*

People often told us that access to their GP had become more challenging due to the new remote ways of working brought on by the COVID-19 pandemic. This was in relation both to booking appointments and attending appointments remotely.

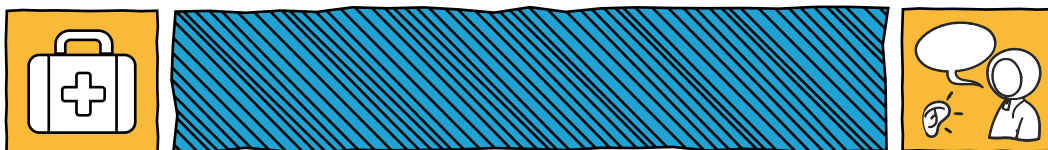
 *You can't get appointments anymore. It's very hard. Because of COVID. You ring up, and they say 'what's the problem?' And you get a video call. Sometimes video call is no good, you want to see the doctor face to face, but you can't.*

GPs were also deemed not to have enough time or expertise to support people with mental health needs and were often seen to prioritise physical health needs, despite people reaching out about their poor mental health.

 *They have been as helpful as they can be really. GPs been a bit... I wouldn't say slapdash, but they just don't seem to have the time really. Then I have been for appointments, it's sort of like... just seems a bit too quick.*

 *My doctor is more concerned about my blood pressure and cholesterol levels rather than my mental health.*

People also questioned the extent to which GPs were able to provide appropriate treatment for mental ill health, with many wanting their GP to be able to provide more than just medication and referrals to further services. However, people told us the support provided by mainstream GPs was minimal and largely self-directed, such as suggesting people self-refer to talking therapies. Experiences of accessing inclusion health practices were much more positive. People described increased continuity, levels of trust and timeliness of support.



What good would look like – flexible and alternative support

While it's important to address the barriers and negative experiences people had with many mainstream support services, we identified a clear need for more flexible and alternative forms of support, and services that can more than one thing at a time.



It's a good place. They do mental health there. It's a drink and drugs place as well. So everyone can help, with their drinking or drug taking. You can get your prescriptions there. So, I take a script as well there...The place is great. I go every couple of weeks, or once a month, sit down and have a chat with them. See what's going on with me. And I say I am all right. I have had my ups and downs like anyone.

Feeling part of a community could also improve people's confidence and self-esteem, contributing to improved mental health and reducing feelings of shame associated with mental ill health and homelessness. Often the main thing people described needing was simply someone to listen to them; positive experiences of feeling listened to were often described when engaging with community support. This poses important questions about the role of less medicalised support, community and social support networks.

Similarly, several people discussed feelings of boredom leading to an exacerbation in mental health issues. Narratives indicated that social prescribing as a form of additional mental health support could be beneficial, but awareness of this type of support was low.



I tell you that my biggest thing is – it's boredom creeping in. Because I mean, I know boredom is not classed as emotion, boredom is a state of mind. And it can affect your mental health.



Like even if we could do like activities, like try and block things out. Because I am really good at stuff like that, activities. I like reading. I like going for walks.

5.2.3 When at crisis point

The issue of timeliness was a common theme more generally across services, with many people feeling services weren't able to act or offer any support until a person was at crisis point.



Nothing helps. Doesn't matter what you say, doesn't matter what you do. You have to be nuts; you have to be crazy to get anywhere. Or in some cases you have to be slightly aggressive.

People experienced long waiting times to when referred to mental health support or to see their GP.

There has been times when I have been to places where I have been really bad. And I felt like I needed help and there was nowhere to go. You can't... go to places and say look... Just do a self-referral. There is nowhere you can actually go for help, just like that, and speak to someone, when you need it. It's not... They are like 'oh, well we have an appointment three months down the line'. Well, you are not bad then. You go there when you know it's going to happen.

Several people we spoke to described their first interaction with mental health services being through a mental health crisis or attempt on their own life.

No. I got found. Woke up in hospital, and then they sectioned me.

I just walked into hospital and explained that I was unwell. They got a doctor to come and speak to me and they sectioned me.

What happened was I had a mental breakdown when I was on the streets. And it was, er, my drug worker that actually spotted something was wrong.

Earlier support for mental health needs is evidently required to avoid exacerbation of mental ill health. Participants often described their route into mental health support as either through primary care services or emergency services, illustrating a clear gap in the role of, and access to, appropriate secondary or specialist care in a timely manner.

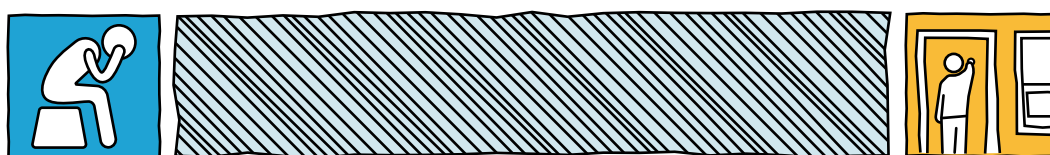
Similarly, upon discharge from emergency services following a crisis, people often described receiving no follow-up support or being signposted back to their GP. One person described having several suicide attempts and still only being provided ongoing support through medication and their GP.

They patched me up, stitched me up and discharged me.

I don't receive nothing now, no. Going... Through my doctor, she is asking me ... giving me what I am asking for. She has asked me if I want to do something, some self-help thing, but he is waiting for something I don't know when that's coming.


I was on the bridge right next door to them. All the police [unclear] blah blah, interviewed me and must have thought oh he's all right and let me go

Narratives indicate that mental health support is often only provided reactively when mental health has significantly deteriorated. This has significant implications for people experiencing homelessness who often face barriers to accessing services at an earlier stage.




What good would look like – early intervention

Many people identified that earlier intervention and responsiveness from services would have addressed their issues before they became more acute.


 *You just need the time. That's the main thing. You need - cause me mental health fluctuates, it's not like uh, it's not constant. So, if you need help with something now, you need help with it now. You don't need it in 6 months' time or a year's time or two years' time.*


Interviews with stakeholders reinforced the importance of a responsive service and being opportunistic in engaging people experiencing homelessness.

 *We don't have a waiting list. We will see someone the same day. We are in the hostel. We have a model where we don't have to operate a waiting list because we want to look for that window of opportunity. And sometimes, if there is that window of opportunity, you need to seize the moment there. You can't think 'oh I will come and see you in several months' time', when that person might have... Things might have closed back up for them, and they are back into their usual ways of coping. And the way we manage that, to not have a waiting list, is by being based on site. We can have light touch engagement, we can begin to build a relationship. We can begin to form contact and build that trust. And then when someone is ready, they can come into one-to-one or group therapy, individual specialist assessments, et cetera. But often we find it takes around four months of informal engagement for some to feel they trust or know someone well enough to come for a one-to-one appointment. (Stakeholder)*

5.2.4 Practical barriers to access


People identified several practical barriers to accessing mental health services, including lack of travel costs, and lack of access to digital devices and credit, especially as more appointments moved to remote methods of delivery.

 *If you are in a hostel or on the street, you are not going to... You've not got the money to get to these appointments.*


 *A lot of agencies just say oh go here, go there, but they don't realise that your travel costs are expensive Especially when you don't have much money.*

As discussed, often people relied on support from their case worker or an advocate to assist them to attend appointments. A lack of staff support to attend appointments was identified as another barrier to access.

Inflexible availability of services was often raised by those we heard from; many people described the 9-5 working hours model not meeting their needs.

 *And it's like you've got – like I suffer from insomnia, so I don't really sleep. So, the places you have to go to are like places before 12 o'clock.*


One participant described feeling suicidal and being initially offered support through a phone call, when they stated they did not have access to a phone, they were told to attend in person at 8am which was not possible.

 *I can't, I am up all night, so I can't get up for eight. So, I left it again.*

5.2.5 Challenges with transitions and consistency


While this research primarily focused on people's experience of initially accessing support, several people identified how transitioning between different services and localities made getting the support they needed much more challenging. This was particularly the case for people leaving the criminal justice system or moving between boroughs, where issues arose with the transfer of health records.

People often described having to begin the process of accessing support again, feeling that they had to start back at square one despite previously engaging with mental health support, leaving them with no interim support for their ongoing mental health needs.

 *Well, the real thing that was...when I got out of prison, I started going through the whole wash again of, going through my GP, him telling me that I had to refer myself to talking therapies... Having phone call assessment with them. But then luckily at the same time I was contacted by Crisis, and they were like: "Oh, we've got a psychiatric worker, therapist here".*

One person described consistently seeing a mental health nurse every week throughout their time in prison but receiving no mental health support on release. The need to begin seeking support and to re-tell your story all over again is particularly concerning given our finding that stigma leads to a reluctance to access support, and people face significant barriers to accessing the appropriate services in a timely manner.

Challenges in consistency of support also affected people who had missed appointments and were discharged by services, who then had to start the process again to be able to engage with support. One participant, who had ADHD and struggled to remember their appointments, was repeatedly discharged and had to be re-referred several times.

 *Well, the problem is I have problems with remembering appointments. And they keep like... discharging me off... Instead of contacting me and finding out why, what's going on. And then I have to go back to the doctor, get another referral...*

This is particularly concerning as the transient nature of homelessness, and the immediate needs people face while homeless, make it more likely people experiencing homelessness may miss healthcare appointments.

6. What change is needed

Through this research we have identified the need for focused action to ensure that people experiencing homelessness can access the mental health support they need. The statements below outline the key issues that must be addressed to ensure more equitable access to mental health services for people who are homeless, alongside solutions identified by #HealthNow peers.

1. Ensure everyone can access a safe, suitable and secure home

Safe, suitable and secure accommodation is an essential foundation for good mental health.

- The UK government must prioritise increasing social and affordable housing availability and meeting its commitment to ending rough sleeping for good by 2024. They should provide adequate housing benefit to ensure people can afford a tenancy.
- Statutory homelessness services should lower the burden of proof to be considered 'vulnerable' and therefore in 'priority need' for statutory rehousing.
- Local authorities should adopt evidence-based, housing-led solutions to prevent homelessness, such as Housing First fidelity models where people receive suitable accommodation and intensive unconditional support.
- Local authorities and housing providers should provide holistic, person-centred support and personalised housing plans to enable people to maintain tenancies, to prevent homelessness happening in the first place and to stop repeat episodes of homelessness.

2. Address the stigma of mental health issues and homelessness

- Healthcare services should adopt trauma informed and psychologically informed practices at an organisational level to ensure they provide a safe, non-judgemental space for all patients.
- Peers have identified the need for more robust staff training, co-designed and co-delivered by people with lived experience of homelessness, to help raise awareness and challenge judgements, especially in relation to mental health, homelessness and substance use.
- Healthcare services should make available training on tackling stigma to both clinical and non-clinical staff.
- Healthcare and homelessness services should consider using Groundswell's '[Clarissa](#)' video and accompanying resources in training for staff, to improve awareness of the challenges people experiencing homelessness face when accessing healthcare.
- Mainstream healthcare services should learn from and adopt best practice from inclusion healthcare services in order to deliver holistic and person-centred support.
- NHS and local authority commissioners should incentivise providers to work in a person-centred way. There is also a strong case for commissioning non-clinical services that can provide a safe space and listening ear when people experience mental ill health and are unable to access clinical services promptly.
- Peers have identified that providing designated mental health practitioners within GP settings would ensure people feel listened to when initially reaching out for help with their mental health.

3. Prioritise peer involvement in the design and delivery of mental health services

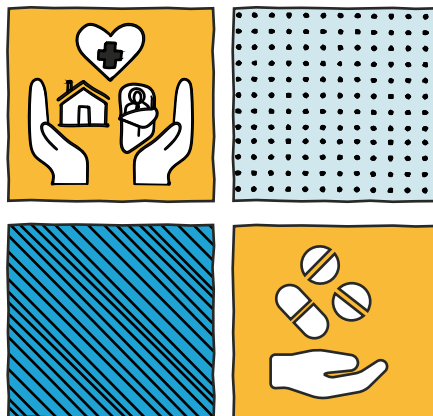
People with direct experience of homelessness and mental health issues must be involved in the design and delivery of mental health services.

- The Department of Health and Social Care must fully involve people with experience of homelessness in creating and delivering the Mental Health and Wellbeing Plan for England.
- Integrated Care Boards (ICBs) should ensure that people experiencing homelessness are meaningfully involved in the development of health inequality plans. Local areas should involve people experiencing homelessness in the co-design of their community mental health transformation programme.
- Mental health services should embed the NICE Guideline ‘Integrated health and social care for people experiencing homelessness’, with ongoing monitoring, to ensure peers continue to be involved in the design and delivery of services.²⁹
- Commissioners of mental health services should involve peers at a strategic level in the commissioning process.

4. Remove barriers for people using drugs and alcohol

There is a clear need for mental health services to support both people who are using substances as a coping mechanism for their mental health and those who are simultaneously accessing drug and alcohol services.

- Commissioners of mental health services should explore 24/7 crisis provision, in line with NICE guidance on ‘Service user experience in adult mental health’ and ensure services can support people regularly using, or under the influence of, substances.³⁰
- Services should develop a multi-disciplinary approach when people need both drug and alcohol support and mental health support to ensure people do not fall through the gaps in between services.



²⁹ National Institute for Health and Care Excellence (2022). *Integrated health and social care for people experiencing homelessness*. <https://www.nice.org.uk/guidance/ng214>

³⁰ National Institute for Health and Care Excellence (2011). *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services. Clinical guideline [CG136]*. <https://www.nice.org.uk/guidance/cg136>

5. Ensure people experiencing homelessness can access support with their mental health

- Mental healthcare in the UK needs urgent investment. The Department of Health and Social Care's forthcoming Mental Health Plan for England, and the planned update to the NHS Long Term Plan, must address critical shortages in support. This must include widening access to early intervention, as well as crisis support.
- ICBs should promote joint working relationships so both mental health services and homelessness services are aware of the local service provision and referral pathways.
- Commissioners should work with GPs to increase knowledge around homelessness and mental health and of the appropriate referral mechanisms.
- Local areas should consider funding care navigator roles to ensure people are referred to the most appropriate support, including services such as social prescribing and voluntary and community sector support. This would ensure people have a clearer understanding of the types of support available and may also provide crucial support for those awaiting NHS mental health support, to prevent mental health issues worsening.
- Commissioners and service providers should explore strategies to enable effective transitions between services, to avoid the need for re-referrals and maintain continuity of care when a person moves area or leaves the criminal justice system.
- Professionals working in mental health and homelessness services should share Groundswell's new collaborative [information leaflet](#), created in partnership with Mind, which provides tailored mental health information for people experiencing homelessness.³¹ This leaflet was informed by findings from this research and co-produced with peers.
- Increased funding for digital inclusion is required to ensure people can access services which are increasingly delivered remotely through providing digital devices and support to use them.
- Greater use of peer support could help address practical barriers to access for those who need support to navigate the system, attend appointments or require financial support to travel to healthcare settings.

Further considerations

While some of the research findings relate to issues faced by the general population, such as the importance of early intervention or support, long waiting times and high eligibility thresholds for secondary mental health services, people experiencing homelessness face significant inequalities in access to appropriate healthcare which are likely to compound these issues. There is a clear need for a cross-governmental approach to addressing health and homelessness, with targeted action to support those who experience the worst health outcomes.

This research largely heard from people who identified as White and male. There is a need for future research to explore experiences of accessing mental health support for women and people from minoritised ethnic groups to understand the specific barriers they face and what would help them to have equitable access to mental health support.

³¹ Groundswell and Mind (2022) *You have the right to feel OK*. <https://groundswell.org.uk/wp-content/uploads/2022/10/Groundswell-MentalHealth.pdf>

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