

# Mapping healthcare barriers for people experiencing homelessness in Cambridge

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People experiencing homelessness suffer over-proportionally from health problems, which leads to substantially reduced life expectancy in this group. A significant contributor to this issue is that people experiencing homelessness face an increased number of barriers when attempting to access healthcare. What are the specific barriers to healthcare that they are facing? In this report based on nine months of rapid ethnographic assessments and qualitative interviews, we examined this question in the local Cambridge ecosystem.

Throughout our empirical research, we focused on gathering data regarding both the experiences of people who are homeless themselves, as well as obtaining assessments from staff who provide support for people experiencing homelessness. We primarily documented barriers to accessing primary and secondary healthcare, across both physical and mental health as well as substance use and dual diagnosis.

## Primary Care:

- The Cambridge Access Surgery (CAS), which specialises in homeless and inclusion general practice, has registered the majority of people experiencing homelessness, providing a strong baseline of care for its patients. In conjunction with other service providers, including CGL, Street Outreach and Wintercomfort, CAS is both a major healthcare provider as well as a guide through the system.
- With some exceptions, other GP services are not providing the same level of flexible and specific support; and will usually refer people directly to CAS with the above positive outcomes.
- While CAS clinical staff provide high quality mental health support to its patient population, this support is provided by practice nurses and GPs and therefore cannot be considered specialised. The Dual Diagnosis Street Project (DDSP) supports a small number of individuals with more complex needs involving both substance use and mental health problems. Widely regarded as highly impactful, DDSP suffers mainly from being underfunded.

## Secondary Care:

A&E: Addenbrooke's hospital's A&E department was repeatedly highlighted as being 'hard to access' by people experiencing homelessness. People struggled with long wait times which are especially distressing for people who use substances and risk withdrawing), as well as stigma

and discrimination embedded within hospital processes (e.g. in medical notes and consultation practices) and poor coordination and communication between staff, indicative of a lack of trauma-informed care and necessary specialised expertise. The broader context of financial, and staffing pressures upon the NHS exacerbated these barriers further.

### **Alcohol and substance use support:**

Inpatient services, mostly facilitated by the Liaison team at Addenbrooke's, were seen as engaged and providing good support for the people they work with. However, patients who would benefit from review are not reliably referred to the team and the team struggle to overcome wider challenges, such as discharging people into situations of inadequate housing and lacking community support services.

Community services are provided by CGL who are the 'mainstream' support for substance and alcohol dependency in Cambridge. Historically CGL has struggled to engage people experiencing homelessness and to provide a flexible, fully trauma-informed service. The introduction of the HEART team from 2021 onwards has significantly improved service delivery by introducing a flexible, outreach-based approach, one-on-one appointments and peer working; accessing detox remains a major challenge, however.

### **Mental health support:**

mental health is one of the biggest and most underserved needs among people experiencing homelessness in Cambridge and beyond. Where specialised services are available and easy to access - such as DDSP or the Liaison Psychiatry team at Addenbrooke's - , there was a significant positive impact. However, many services suffer from a lack of staff and existing staff are stretched, leading to longer waiting lists and reduced access. People with dual diagnosis who use substances are often categorically excluded from accessing mental health services. Crisis care is often not only hard to access due to for example high symptom thresholds for referral and long waiting times for assessment, but is also possibly contributing further to patient's trauma particularly in the context of police involvement with section 136. The lack of appropriate mental health supported housing can further disempower patients experiencing both mental health problems and homelessness and provides strong long term barriers to recovery and healthcare access.

## Dentistry:

access to dental care appointments in Cambridge was described as being extremely limited, with patients waiting months for a routine appointment or simply being unable to register due to a lack of dental surgeries accepting NHS patients. As a result people experiencing homelessness were often referred to practices outside of Cambridge which are impossible for them to access.

## Palliative Care:

when people experiencing homelessness access community palliative care in Cambridge, their experiences are good. Unfortunately, our interviews show that there is a strong disconnect between the number of people who would benefit from palliative care services versus the number of people who access those services in Cambridge (~2 people in 2022).

## Non-healthcare providers:

- Non-healthcare providers were found to be filling in crucial gaps in service provision, especially in terms of coordinating and supporting people to coordinate across different support services. Accompanying people through the healthcare system often fell into the hands of key workers from housing providers and outreach workers from non-healthcare providers.
- Street Outreach: outreach provider CGL fulfilled a crucial function in terms of identifying people and helping them navigate the healthcare and support system in Cambridge. The outreach van bringing together various service providers under one flexible roof was especially impactful in bringing care to the people directly.
- Day Center and housing providers: WinterComfort and all of the housing providers were seen as enormously helpful both in terms of providing in-house support (e.g. mental health support) to fill existing gaps and to help people navigate other service providers.

## Deep Dive: Women's experiences

- Women not only have different overall experiences when homeless compared to men, they also have different healthcare needs, for example gynaecological health generally as well as sexual health in the context of engaging in sex work.
- We observed a 'double disadvantage' for women in terms of accessing healthcare services, due to the fact that there is additional trauma and stigma experienced predominantly by women, e.g. domestic abuse, sexual exploitation, engaging in sex work, and children being removed into social care. This can lead to further reluctance to access healthcare due to fear of stigma and negative past experiences within healthcare and other social care settings.
- In Cambridge, women-focused services such as the Women's Resource Center and specific women's groups at WinterComfort have been providing crucial support however there are still some gaps remaining particularly in gynaecological support specific to women experiencing homelessness, sexual health services and adequate numbers of women-only accommodation.



Image from Centre For Homelessness - Southbank, Leonie

# I Introduction

## I.I Overall context:

### Health and healthcare for people experiencing homelessness

People experiencing homelessness<sup>1</sup> can be defined as individuals whose basic needs of safe, stable and functional housing are not met, encompassing a range of situations from living on the streets, known as ‘sleeping rough’, to living in emergency and temporary accommodation, including temporary shelter with friends, known as ‘sofa surfing’. People experiencing homelessness are more likely to experience poor physical and mental health, as well as adverse childhood experiences and complex trauma. The situation of homelessness and the circumstances connected to it act to further worsen people’s health. People who are homeless are likely to have very complex health needs, often combining poor physical and mental health with substance use:<sup>2</sup>

**Physical health:** people experiencing homelessness show a significantly higher prevalence of a wide range of chronic and long term conditions (LTCs), including cardiovascular conditions, respiratory conditions and infectious diseases. In a representative 2022 Homeless Link UK report, 78% of respondents reported a physical health condition; more than 60% reported a chronic condition (three times more than the general population). More specifically, people who are homeless are 4 times more likely to suffer from Hepatitis and more than 30 times more likely to be infected with Tuberculosis. They are also three times more likely to suffer from a cardio-vascular disease, three times more likely to have asthma and more than ten times more likely to suffer from chronic obstructive pulmonary disease compared to housed people.

**Mental health:** Poor mental health is not only a key risk factor that contributes to individuals becoming homeless, it is also one of the main barriers preventing individuals from ending their experience of homelessness. A recent study found that 69% of people experiencing

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1 For the purpose of this report ‘people experiencing homelessness’ include: people sleeping rough as well as those in temporary accommodation and statutory homelessness. In our research, we encounter mostly these three ‘types of homelessness’.

2 A note on the references: while in general we try to refer to UK-specific and very recent data, in some cases, especially general health data, only meta-studies (across countries) are available. All references are academic articles and reports we directly link to.



homelessness assessed by St Mungos required mental health support, in line with 80% reported in the 2022 Homeless Link report. Similarly, several studies have demonstrated that there are significantly more cases of psychosis and personality disorders in people experiencing homelessness compared to the general population. Across studies people experiencing homelessness report very high burdens of trauma, anxiety/depression, schizophrenia, bipolar disorder and self-harm/suicidal tendencies.<sup>3</sup>

**Substance and alcohol use:** Almost 50% of people experiencing homelessness in the UK regularly use drugs or alcohol;<sup>4</sup> this increases to 60% amongst people who are sleeping rough. Substance or alcohol misuse is often used as a maladaptive coping behaviour, and dependency on substances is associated with raised (acquisitive) crime and violence rates, as well as secondary mental and physical health consequences e.g. depression, psychosis, and infectious disease transmission.

As one 2019 BMJ article concluded: “While differences in health between housed socioeconomic groups can be described as a ‘slope’, differences in health between housed and homeless people are better understood as a ‘cliff’.” This cliff in aggregate health issues of people experiencing homelessness leads to a similar observable cliff in adverse health outcomes:

**Very low life expectancy:** In the UK, the mean age of death for males who are homeless is 47 years and for females 43 years compared to a mean average age of death for people living in homes of 76 and 81 years for men and women, respectively. Overall, people who experience homelessness have a 2 to 5 times higher age-standardised mortality ratio than those who are not homeless, with very little improvement over the last decade.

**High likelihood of comorbidity:** People experiencing homelessness are very likely to be affected by a high number of health issues at the same time. A recent study of Scottish homelessness found that between 50-70% of homeless people had diagnoses from all three categories (physical health, mental health, substance use) combining between 2-10 LTCs. In the 2022 Homeless Link report, only 20% reported suffering from only one condition. The co-existence of mental health problems with substance use is sometimes known as ‘Dual Diagnosis’, and is particularly common, affecting ~20% of all people experiencing homelessness. This number skyrockets amongst those people experiencing a combination of homelessness, offending *and* using substances (all three types of what is called Severe Multiple Deprivations, SMD)<sup>5</sup>; 92% of this group self-reports to have mental health problems.

While healthcare provision for people experiencing homelessness has been identified repeat-

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3 With prevalence between 10-80% of the population reported depending on geography, definitions, methods used; see Hossain’s 2020 umbrella-review.

4 This is in line with Fazel et al’s 2008 meta-analytic review which found the pooled prevalence of alcohol dependence was 37.9%; Hodgson et al’s 2013 review found that between 11% and 43.7% had alcohol or other substance use disorders.

5 See more background on SMD in the 2015 Lankelly Chase Foundation report on the topic, including outcomes and costs.

edly as a crucial factor to tackle and reduce homelessness generally (including in the 2021 edition of the UK Homeless Monitor), the UK healthcare system is generally found to pose a variety of barriers and inadequacies for people experiencing homelessness. One of the biggest issues is the generally reported lack of (healthcare) capacity and resources for people experiencing homelessness. As the Homeless and Inclusion Health Standards clearly state: “adequate services are rare despite clear guidance [...] and in addition, austerity measures are having a devastating impact.” For instance, about 40% of respondents in the 2022 Homeless Link Audit reported inadequate support for their physical health needs and even more (50%) desired more mental health support.

Very often, the support which is available is rigid in nature, and does not have the capacity to create flexible treatment plans which meet the complex needs of people experiencing homelessness; this is further compounded by a lack of specialised education for healthcare providers around the complex social and public health issues underpinning homelessness. As a result people with dual diagnosis and complex needs are found to be especially excluded from healthcare service provision. In situations where competing needs such as accessing food and shelter further complicate access to healthcare, the aggregate barriers can be tremendous.

Negative experiences with healthcare services further contribute to a lack of engagement from those experiencing homelessness. People report issues with abrupt discharges into communities where patients did not have the resources to cope and subsequent re-referrals into the system. These issues are especially pronounced for people with multiple conditions and dual diagnosis ricocheting through the system. Over time, discrimination and stigma towards patients experiencing homelessness can develop amongst healthcare professionals which deteriorates doctor-patient relationships and leads to distrust towards healthcare professionals as well as decreased engagement with healthcare.

One problematic outcome of these aggregate barriers is that people who are homeless in the UK don't tend to access community care services and use emergency departments instead.



Image from Centre for Homelessness - Belfast, Cathy and Paddy

Not only does this make their healthcare more expensive (on average 1.5x more); most importantly it reduces opportunities for preventative medicine and continuity of care which results in worsened health outcomes. Some optimism can be found in research published in the UK which demonstrated the positive role that primary healthcare services, including outreach services, can play if they are *specialised* in supporting people experiencing homelessness and person-centred, holistic care.

## I.II Cambridge: The concrete context of the project

### Local homelessness and healthcare needs

Over recent years, homeless numbers in Cambridge have been steady; in 2021/2022 793 people applied for a statutory homelessness duty (six more than the year before) and on average 30-50 people per month were verified as rough sleeping according to Cambridge City Council data. As set out in the Cambridge City Council Homelessness & Rough Sleeping Strategy 2021-2026, a shortage of available (affordable) housing and a lack of funding to build new homes is a big contributing factor to the overall problem; accordingly, most priorities in the *Strategy* are focused on improving access to (permanent) accommodation and prevention of homelessness.

Priority 4 explicitly singles out issues with access to, and the effectiveness of, support services, however; especially mental health and drug and alcohol services are described as being in need of improvement to satisfy the local population's demands. A 2018 Cambridgeshire Commissioning Review confirmed that in the local group of people experiencing homelessness a high level of complex needs (including different healthcare needs) persists. 58% of the over 1100 respondents to the survey reported three or more support needs and 18% reported five support needs (the maximum number that could be recorded).<sup>6</sup>

The *Homelessness Strategy* concludes with the “need to move more towards a ‘whole systems’ approach across services, agencies and the wider community”, including interdisciplinary and cross-sector partnerships and collaboration with statutory services. This system-wide approach with a special focus on the connection between *health* and housing is also one of the explicit priorities in the County's Health and Wellbeing Strategy (in development).

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<sup>6</sup> In line with data, a local authority-level table by the Department for Levelling Up, Housing and Communities (on 2021/2022 data) reveals a support need for almost 50% (304) of all households owed a homeless duty; over 60% of the households (182) required mental health support and about 40% (117) households were identified as having substance and alcohol use support needs.

# The homeless healthcare map of Cambridge - the focus of the project

In Cambridge, as elsewhere, people experiencing homelessness are accessing different kinds of (healthcare) support across primary and secondary healthcare services as well as through non-specialised service providers. This project is based on findings from earlier CHIRN projects since 2018 and begins with a 'mapping exercise. Based on semi-structured interviews we created an overview 'Cambridge homeless healthcare map' which is informed by people with lived experience of homelessness and staff with experience working in homeless services.

Our work has resulted in the illustrated map<sup>7</sup> to the right which will guide us through the report over the coming empirical sections. It is important to note the limitations of our coverage when viewing the map: it does not claim to be a fully comprehensive outline of all possible healthcare provisions for people experiencing homelessness in Cambridge, but reflects real people's lived experiences and is therefore a temporary snapshot; it is limited in terms of time-horizon to data from 2022/2023 and is also limited by the specific experiences of the people we engaged with during our research.

**Primary healthcare** provision in Cambridge for people experiencing homelessness is for the majority of people provided by the Cambridge Access Surgery (CAS). CAS consists of three main service providers under one roof: a specialised GP service, the CGL street outreach team, and the HEaRT team (Homeless Engagement and Recovery Team, part of CGL Drug and Alcohol Support) specialising in drug and alcohol outreach services for people experiencing homelessness. A separate CGL street outreach team, verifies rough sleepers, assists and advocates for people to access accommodation, signpost to other services and facilitate people to register with CAS. A weekly multi-agency outreach van under the CAS banners additionally provides signposting to relevant services and charities, as well as providing basic medical care.

The first point of contact for people sleeping rough around **dual diagnosis** is the Dual Diagnosis Street Project (DDSP) providing both (low level) **mental health** and substance use intervention themselves and referrals to services (such as inpatient psychiatric support at Fulbourn hospital or community-based mental health support at Union House or (non-specialised) therapy at Mind).

With regards to **alcohol and substance use** in particular, CGL drug and alcohol services through both the HEaRT team and their non-specialised services are commissioned to provide key workers, group therapy, prescriptions (e.g. methadone) as well as outreach; the GP service at CAS runs an additional methadone clinic in collaboration with CGL.

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7 This map will also be made available as widely as possible to local service providers and people experiencing homelessness as a small way to help navigate the healthcare system in Cambridge; we are grateful for the support from a public impact grant to engage illustrator Sorrel Milne for this work.



**Secondary care** facilities, especially Addenbrooke's Hospital (or more rarely palliative services, e.g. at Arthur Rank Hospice, see below), are frequently visited by people experiencing homelessness in Cambridge; referrals both come through GP services (especially CAS) but visits are also often based on emergency needs.

**Housing providers** and the wider network of **service providers** play a key role both in sign-posting and referring to healthcare providers as well as providing in-house support for people experiencing homelessness in Cambridge. Regular exchange between Jimmy's, Winter Comfort and CAS, for instance, facilitates registration and simple care provision. Several housing providers additionally offer in-house specialised support and facilitate referrals into the secondary care network.

For **women** in particular, whose experiences are in focus in a deep-dive session in the later part of the report, several specialised service providers from the Cambridge Women's Resource Centre to Women's Aid offer specific support (while not necessarily specific to people experiencing homelessness), including certain kinds of health support.

## I.III Research methodology

The first goal for this report was to produce a high-level mapping document of the barriers people experiencing homelessness face accessing healthcare in Cambridge. In order to achieve this goal, we conducted rapid ethnographic assessments and interviews with local service providers and people experiencing homelessness over an eight month period from July 2022 - March 2023. The research focus and design were co-produced with and received (repeat) feedback from the Cambridge Access Surgery and Cambridgeshire's Council's Co-Production Group.

The research received ethical approval from the University of Cambridge Social Anthropology Department (2022) and the University of Cambridge Department of Land Economy (2023). We received support from King's College Cambridge via a summer research internship (funding for one research assistant in summer 2022) and from NIHR via their PPIE scheme (funding for research assistants (3x3 months) and final event); for the illustrations, we received additional support from a Cambridge University Public Impact Grant.

We observed and shadowed healthcare provision across four different locations and service providers and altogether spent 17 days conducting ethnographic research; we also conducted twenty-two separate interviews with people experiencing homelessness mostly focused on their healthcare experiences and thirty five interviews with local service providers. Before each interview, participants went through an (oral) informed consent process and were made aware of the goal of the conversation and that the information they shared during the interview would be included in this anonymised report. All interviews were voluntary and no incentives

were provided. Online interviews with stakeholders were recorded and transcribed. For people experiencing homelessness (and stakeholders who did not consent to recording), researchers took notes throughout the interviews which were written up afterwards. The analysis of the qualitative empirical material was conducted collectively by the research team between December 2022 and March 2023. A first round of informal feedback conversation with three high-level ecosystem participants in early 2023 was followed by additional interviews and a deep-dive into the experiences of women experiencing homelessness and people who identify as LGBTQ+.


Given the methodology and the time frame, we want to highlight four specific limitations of the final report:

Given the **limited time scope** (8 months) and capacity, our view onto and into the ecosystem is necessarily limited. While we are able to use networks built over four years of research in Cambridge, this report will miss (possibly important) details. We are very open to any comments and corrections and hope to update this report accordingly.

While our specific deep-dive (January - March 2023) was supposed to focus both on the experiences of women experiencing homelessness and **people who identify as LGBTQ+**, we were not able to find enough individuals during that time period in the second group. We hence were not able to gather sufficient data to justify the inclusion of insights in this report. We hope that future research will focus on the experiences of people who identify as LGBTQ+ explicitly.

This report is solely focused on **mapping barriers** to healthcare access. Suggestions for improvement are out of scope. We will touch again on this in our conclusions.

It is important to note that our research has been conducted during a **period when primary care provision in the UK is in transition**, including in Cambridge. Several years ago, the NHS underwent a transformation towards localised Primary Care Networks (especially the move from Clinical Commissioning Groups (CCT), towards Integrated Care Boards (ICBs)). This also happened in Cambridge with the establishment of four PCNs (Primary Care Networks) as part of the general move towards place-based interventions. Ongoing developments towards integrated neighbourhoods are currently ongoing to further link up NHS services as well as non-NHS service providers; the current movement is to further localise all service provision



58% of the over 1100 respondents to the survey reported three or more support needs and 18% reported five support needs.

towards the establishment of integrated neighbourhood teams including a specific focus on healthcare inclusion. In other words: the ecosystem we observed in a static, snapshot way is in constant flux and this report will not be fully up to date with all of the ongoing developments. Please keep this in mind when critically engaging with it.


As a result of these limitations, we don't consider this report to be a static document but hope that it finds its way into local conversations where it is used and updated however appropriate.

## II Empirical Findings

### II.I Primary healthcare:

#### Good coverage, good connectors

Since the mid-1990s, Cambridge has benefited from a specific NHS surgery for people with multiple disadvantages<sup>8</sup>, including many people experiencing homelessness: the Cambridge Access Surgery (CAS). CAS is the hub of homeless health in Cambridge and plays an important and very positive role to reduce barriers to healthcare access for a wide range of people experiencing homelessness. We found the influence of other local GP surgeries was not as unequivocally positive, however the work of the Dual Diagnosis team was seen as highly impactful in actively *decreasing* barriers to healthcare, especially for the most vulnerable people, despite the unfortunate funding cuts in 2019.



CAS also allows patients to choose the mode of engagement (telephone/video/face-to-face) and schedule longer appointments (on average 30 minutes versus 10 minutes in a normal GP practice).

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<sup>8</sup> For the context of the Cambridge Access Surgery, this is defined as: drug dependence, significant mental health symptoms, contact with the criminal justice system, domestic abuse



# a) Cambridge Access Surgery (CAS): the central hub of homeless health

The Cambridge Access Surgery (CAS) GP service consists of a team of five part time GPs, two nurses, two healthcare assistants, one drug recovery worker, one Social Prescriber and Pharmacist (employed via the Primary Care Network), one counsellor, and six administrative staff. CAS is open five days a week and offers a range of different appointment-based and drop-in-based services, together with outreach clinics covering all areas of health. While a focus is on physical healthcare provision (especially chronic wound management and chronic airways disease), CAS also offers mental health care (e.g. in the form of welfare clinics, social prescribing and counselling) and support for drug use (e.g. two GP lead drug clinics per week supported by a drug recovery worker (funded by CGL)). The team at CAS also tackle prevention - while tremendously complicated for people experiencing homelessness - mostly in the form of health screening and vaccinations. CAS caters to 740 registered patients and has over recent years been improving their coverage of local people experiencing homelessness.

Both service users and service providers, from secondary care providers to charities and community services, report overwhelmingly positive experiences with CAS. In general, service users perceive CAS to be a safe and supportive space, and report that they feel listened to and in control of their own health; they do not feel judged and are therefore more willing to access the service. One service user described their experience with CAS in the following way:



*They “don’t look down on you [...] they see you as a person rather than someone who is homeless”. They liked the “drop in centre” as it gives them flexibility to attend when they felt like they needed to.*

Overall, there are a number of best practices which we found contribute to CAS’ positive impact on the local ecosystem:

**Flexible appointments and approach:** CAS offers flexible drop in clinics, meaning patients can access on demand, same day appointments, which is particularly important for people experiencing homelessness who are struggling with competing needs. CAS also allows patients to choose the mode of engagement (telephone/video/face-to-face) and schedule longer appointments (on average 30 minutes versus 10 minutes in a normal GP practice).

**Continuity of care:** people visiting CAS usually will always see the same GP with whom they build up long-term relationships of trust. This relationship-first approach not only allows for better healthcare outcomes over time but also makes the CAS GPs important ‘hubs of healthcare’ for people experiencing homelessness in Cambridge.

**Go to and with the people:** CAS nurses and GPs actively engage in outreach five times a week (see section II.III) to ‘meet people where they are’. In addition, CAS staff support patients by advocating and attending appointments at other services (e.g. hospital, Union House), en-

sureing continuity of care beyond the boundaries of CAS. CAS staff often accompany people throughout their (healthcare) journey and coordinate care plans. Even where full accompaniment is impossible, CAS provides an invaluable source of advice, guidance and collaboration with other secondary care healthcare providers (e.g. hospital doctors) helping them to better understand the specific needs of people experiencing homelessness.

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We only observed a limited number of barriers to accessing CAS. A small number of service users reported that they had had a negative experience with the access surgery. In particular, providing flexible and longer appointments sometimes meant that patients were asked to wait for a greater length of time before they could be seen in the drop in clinic. As one service user describes:



*“I was 2nd in the queue and the person in front of me was still talking [...] I was thinking hold on what’s going on, why am I still here? If they need that long treatment, if it’s an emergency call the ambulance it’s been 1.5h.”*

While many service users also reported that they liked the more casual rapport that was built up between GP’s and patients, one service user felt that this made the consultation feel less professional.

*“Homelessness GP practices are too lax. In my experiences – it stops me from going [...] nurses know that I am one of the homeless people that can’t be moulded or persuaded [...] I feel that the nurses were patronising or talking to me outside of a professional capacity [...] in homeless services there is much more non professionalism than anywhere else but you can get away from it.”*

The service user stated that it made them feel as if they were receiving a lower standard of care than patients at other GP practices, therefore they preferred to attend a different GP practice that did not specialise in supporting people experiencing homelessness.

While not limited to CAS (see section III), some women reported to feel that drop-in sessions do not provide a safe space; gynaecological issues in particular often remain untreated. One specialist service provider described this barrier in the following way:



*“Having drop-ins are great. But what it ends up being is a room full of pissed men being loud. And girls don’t want to wait in that because it’s scary. So, they’re sort of disenfranchised simply by the way the system is set up in instances like that.”*

In addition, mental health support (technically outside of the remit of GP support) has also been flagged as an area of improvement. More research needs to be done to further investigate the barriers in these areas as they explicitly relate to CAS (see section II.III below). One last question was flagged around the pathway to ‘leaving CAS’ - how can CAS help to transition patients to a ‘normal’ GP service when they are no longer in situations of homelessness. The

process of transitioning to a mainstream GP practice might present patients with a degree of conflict. By leaving CAS, patients will escape any possible stigma associated with being a CAS patient, however they miss out on the significant benefits we have highlighted above, such as short waiting times, flexible drop-in clinics and longer appointment times.

Overall, Cambridge Access Surgery plays a crucial role in the reduction of barriers to health-care for people experiencing homelessness in Cambridge. Not only does CAS offer a wide range of healthcare services in-house, it is also a major force in ensuring 'continuity of care' across the ecosystem. Built around trusted relationships, CAS makes patients feel that they are in a safe and non-judgmental environment, increasing the likelihood that they will engage with the service and therefore improve their health outcomes.

## b) Other local GP services: limited benefits, switching encouraged

Not all people experiencing homelessness in Cambridge are registered with the Cambridge Access Surgery; while CAS have been widening their coverage of the ecosystem (see above), some people have relationships with other GPs based on legacy or local connections. The general overall experiences with these non-specialised GPs are unsurprisingly not as positive as with CAS GPs.

We heard from several people experiencing homelessness in interviews that they changed their registration from other local GPs to CAS due to frustrating experiences, e.g. long waiting times, majority telephone appointments, lack of specialised knowledge and support. Several non-healthcare service providers reported positive experiences with some specific GP practices which are either willing to make the necessary concessions (e.g. flexible or longer appointments) or pro-actively encourage patients to register with CAS. Some service users talked about the negative experience of 'switching doctors constantly', further highlighting CAS as the primary care provider that can best ensure long-term continuity of care for homeless and vulnerably-housed patients in Cambridge.

## c) The Dual Diagnosis team: Crucial impact, but underfunded

Dual Diagnosis refers to the concurrent occurrence of substance use and mental health issues in a person; according to a survey from Homeless Link 45% of people experiencing homelessness struggle with dual diagnosis. However, our interviews suggest that this number may be far greater.<sup>9</sup> A local service provider working with ~50 individuals agreed, explaining that *'almost all [of their patients] have both'* substance use and mental health issues, with only 4 out of 48 clients reporting mental health issues without substance use issues alongside. The need for specialised support is further aggravated by specific barriers associated with dual diagnosis:



*"Because they have got personality disorders and drug problems [...] that will mean that they can't make it to appointments, or lots of services just won't even see them or accept them."*  
(Community psychiatrist)

As an answer to this problem, the Dual Diagnosis Street Project (DDSP) was first installed in 2017 as a community based service focused primarily on people experiencing homelessness and dual diagnosis. While the service was originally commissioned with two specialist nurses, a social worker, and an occupational therapist, it was reduced to 50% of this capacity in 2019. Now, the two specialist nurses cover an annual caseload of 26 service users who are all either entrenched rough sleepers or have only recently accessed accommodation.

Often, the people engaged with DDSP have had negative experiences with other services and/or have been refused treatment by other services based on their 'complex history'. Service users are provided with short term therapeutic interventions (usually over 3 months). These interventions range from 'CBT light', brief psychological interventions (BPI), personal or sleep hygiene and pastoral care, to the development of a support plan involving secondary health services such as drug and alcohol support services. During the time of engagement, DDSP also supports service users to engage in meaningful activities such as going swimming with one specific person, and supports people to register with CAS.

The impact of DDSP has been described unambiguously as positive. One specialist secondary healthcare provider explained:

*"The Dual Diagnosis Street Project just needs to continue. You know, because that is a way to pick up on people who've got serious mental health problems, and without that, I just wouldn't see them at all."*  
(Community psychiatrist)

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<sup>9</sup> A recent Scottish study found closer to 60% of respondents struggled with co-morbidities from all three fields (physical and mental health and substance use). Moreover, the general tendency to 'underestimate' issues around homelessness (including the number of homeless individuals in a country) has been well-documented and is often attributed to political unwillingness ('you can't change what you don't count').

Overall, the DDSP provides a holistic, informal and longitudinal approach, which sees people when and where they are. This approach contributes to a more well-rounded understanding of the person and their needs; whereby symptoms can be more easily contextualised and more restrictive outcomes such as sectioning become less necessary. The DDSP offers an accessible alternative to secondary dual diagnosis / mental health provision (e.g. at Fulbourn Hospital) and has a positive 'halo' effect connecting people to other health services.



Image from Centre for Homelessness - Belfast, Sharon and Billy

## II.II Secondary health care: Limited capacity, often struggling

### a) A&E: long wait times, stigma, exclusion and a lack of trauma-informed care

People experiencing homelessness are known to have higher mortality rates than the general population, approximately 8 times higher for men and 12 times higher for women. They also experience a higher burden of cardiovascular, respiratory, cancer and infectious diseases and struggle with multimorbidity. 90% of people experiencing homelessness have more than two long term health conditions and these long-term health struggles lead to many acute presentations requiring A&E attendance. As a result people experiencing homelessness utilise A&E hospital services up to 60 times more than the general population. They also account for an increased proportion of the so-called “frequent attenders” (>6 attendances in 6 months) and tend to have longer stays due to multiple unmet needs.

From our interviews, there was an overwhelming consensus that patients experiencing homelessness often have poor experiences of emergency services and in-patient care in Cambridge. These negative experiences are centred around three key themes: long wait times, stigma and exclusion, limited communication and a general lack of trauma-informed care.

#### 1. Long wait times in A&E as a major barrier, especially for people who use substances

During and post Covid, the NHS has been struggling to provide adequate medical care with limited resources, “experiencing some of the most severe pressures in its 70-year history”. According to the recently published Hospital Accident and Emergency Activity Report by the NHS, attendances to accident & emergency departments have increased by almost 40%, to 24.4 million between 2020 and 2022. As a result, emergency service waiting times have increased significantly across the UK.

This has also been noted at Addenbrooke’s, with instances of patients waiting over 60 hours to be seen. A recent evaluation by the Care Quality Commission determined Addenbrooke’s accident and emergency services “required improvement” in order to meet the national standards

for providing safe care. The report highlighted that time to treatment<sup>10</sup> was significantly longer in Addenbrooke's than the national average.

While long wait times can be incredibly difficult for all patients, long wait times are even more challenging for patients experiencing homelessness, particularly if they have substance use or alcohol dependence. Throughout our interviews people highlighted that busy waiting areas are especially distressing for patients with mental health problems, one person explained:



*“Waiting around to get seen is difficult [...] it's hard to sit around with anxiety and depression. [...] I would much prefer having a telephone appointment to discuss any results from the hospital.”*

As a consequence, while people experiencing homelessness attempted to access A&E, they would often leave before being seen by a healthcare professional because they were unable to cope with the environment.



*“We get a lot of letters saying that patients attended A&E but did not wait for assessment or treatment. They are kept waiting [...] And you have to ask why [...] that setup doesn't suit our patients [...] it's a tricky question to resolve, but it doesn't suit them to be waiting in this really busy area” (Project worker)*

One of the greatest concerns highlighted by respondents was issues specific to substance and alcohol users. Using substances and drinking alcohol is prohibited in the emergency department and our interviewees described several cases of people experiencing homelessness entering states of acute drug or alcohol withdrawal while waiting in the emergency department to be seen.<sup>11</sup> The resulting symptoms are not only debilitating but can be incredibly embarrassing for patients; the onset of such withdrawal symptoms is another reason why people leave the emergency department before being seen by a medical professional even if their life is at risk. One support worker described one such case:

*“They're at risk of losing a foot and they've been in and out of hospital. Now there was meant to be a planned admission and access surgery had contacted A&E. They went up there on Friday, but they just didn't get past A&E. I spoke to the A&E lady, she said that they presented on the Friday she could see that, but then they left [...] If they start withdrawing from drugs, they are not going to stay. Even if they've got risk of sepsis and at risk of dying. [...] It's not that rational. The fact is withdrawal hurts. You get stomach cramps. I don't think the nurses realise, they don't want to lose control of their bowels*

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10 This is defined as time from arrival at the emergency department to the time when a patient is seen by a decision-making clinician.

11 According to the NICE guidelines, symptoms of heroin withdrawal typically begin 8h after the last dose and peak at 36-72h, however the exact timings often depend on the type of drugs taken and an individual's level of dependence. The symptoms of drug withdrawal can include nausea and vomiting, anxiety, hot flushes, muscle cramps and late onset loss of bowel control.

*in the waiting area. You know, they're sitting there sweating, stomach cramps [...] these are things that aren't considered."*

Lack of awareness and understanding by healthcare professionals about the degree of distress that drug withdrawal causes often means that people experiencing homelessness feel that their needs and concerns are not being listened to or addressed appropriately by A&E staff.

*"Unfortunately, the pressures on the NHS have created a culture where compassion comes last, because there isn't time for it. So I think medical education is really important. But not just a doctor level, throughout, you know, through healthcare assistants, through nursing staff. Because these are all the people that will interact with our service users and with our homeless users. And if they had more of an understanding, they'd probably be a little bit more patient and understand the priorities of the patient more, which is often at odds with what they may see as medically important. Because they don't really understand what drug withdrawal is like and the effects that that has on an acute presentation." (Non-NHS healthcare provider)*

Additionally, people going through withdrawal may occasionally become irritable, disoriented and aggressive. These behavioural changes often lead to patients experiencing homelessness being labelled as "difficult to manage" by healthcare professionals, which can lead to a breakdown in trust and communication.

*"We hear a lot of times that people are aggressive and difficult to manage. I don't think they are. I think they're being neglected and they're in withdrawal and in pain." (Medical professional)*

Understandably to protect its staff, the NHS takes a 'zero-tolerance' policy to violence or aggression against healthcare workers. Therefore, people experiencing homelessness may be approached with more caution by healthcare professionals or simply be asked to leave the hospital because of withdrawal-induced behavioural changes. Overall both the direct and indirect consequences of long waiting times, especially on people suffering from alcohol and substance withdrawal from, represents a significant barrier for access to emergency services.

## 2. Stigma and discrimination within hospital processes

Throughout the interview process there was an overwhelming consensus that stigma<sup>12</sup> and discrimination were two of the most important barriers to accessing hospital healthcare. In general this issues has been documented with extensive evidence<sup>13</sup>. The National Institute for Health and Care excellence guidelines on homelessness acknowledge that people experiencing homelessness are often treated poorly by healthcare professionals:

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12 We will use the following definition of stigma: Stigma is "a multi-step process involving firstly labelling and separation of the stigmatised individual or group which causes status loss and discrimination in a context of power differentials".

13 Further evidence is available in Martins 2008; Skosireva et al 2014; Purkey/McKenzie 2019.



*“Many people experiencing homelessness encounter or perceive stigma, discrimination and lack of understanding from health and social care practitioners.”*

Our interviews confirmed this experience across a variety of aspects of their hospital experience, from the way the patient’s medical notes are documented, to the doctor-patient interactions themselves.

## **Medical notes**

Several staff members highlighted how biases in medical documentation can lead to negative preconceptions and stereotyping before people experiencing homelessness are even seen by a medical professional. As one person explained to us:

*“There’s patients that frequently attend [...] and they have a little dossier on them, that a doctor or a nurse would read before interacting with them just to get their background [...] when we read that dossier, they basically painted that person in a really bad light, very negative [...]so if I was a clinician going to see that patient having read this, I would be like, Oh, my God, this person is a threat.”* (Non-hospital health care provider)

*“Often, if you just rely on the medical notes from what’s gone previously, you will get a very biased picture. You will hear a lot of negativity, a lot of problems. So lots of difficulties with this patient, difficulties with behaviour. Whereas actually, if it came from the service user and the people who know them and support them in the community to write what is going on for them, I think you’d get a much more honest picture.”* (Non-hospital health care provider)

Several studies have demonstrated that biases in medical documentation influence physicians’ attitudes towards patients. Not only did these studies show that biases can be passed on from one clinician to another, but a recent study by Park et al also notes that “use of stigmatising language in medical notes can influence decision-making of clinicians”. Concerningly, a [2018 randomised control study](#) found that by simply changing a hypothetical patient vignette to include more stigmatising language, medical professionals would change their prescribing behaviour; in particular high levels of stigmatising language was often associated with sub-therapeutic pain management. These findings, together with our interviews, confirm that people’s health dossiers and how they are perceived, establish yet another barrier to healthcare access for people experiencing homelessness.

## **Consultations**

Prejudice and dehumanisation during consultations is observed most frequently when there is concurrent substance use and homelessness.<sup>14</sup> As one support worker explained:

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14 These findings are in line with a [2022 systematic review](#) evaluating the effects of stigma on health for people experiencing homelessness. Also, a [2014 study](#) by Barry et al demonstrated that the general public holds significantly more negative views towards people with drug addiction compared to those who are struggling with mental illness.



*“There is a shame associated with being on drugs [...] ‘drug users are criminals’. ‘Drug use is bad’. You know that that whole thing that we’ve been fed from when we were kids, which is a message to encourage kids to stop doing drugs which is fine. But we’ve criminalised addiction [...] we’ve made it something to be ashamed of, rather than something that we are all potentially at risk of acquiring [...] look at gambling, I know gambling, it also has a bit of a stigma, but we’re positively encouraging people to do that. And alcohol is probably worse than heroin. You know, the amount of money that’s spent on it by the NHS, but it’s just, people are ashamed [...] we dehumanise addicts [...] we should look at people by how they are presenting, not their substance use. You assess what’s in front of you. And do you not always consider an individual’s journey to that point? How do they feel about being in that situation?”*

As emphasised by Volkow et al, prejudice often stems from the idea that addiction is not a disease. There is often a perception that individuals should be able to manage their substance use through self control. Collective stereotyping of people experiencing homelessness based on such assumptions has frequently been observed throughout the interview process. Several respondents stated that once the status of patients as being homeless was revealed, healthcare professionals would draw assumptions about their past medical history and healthcare needs.

*“If a patient is admitted to hospital and they are at the Access Surgery, there is an assumption that they are homeless, drug user or drinker if they are at the hospital.”* (Support worker)

Stereotyping can be incredibly degrading for people experiencing homelessness. A recent study emphasised that these types of behaviours from healthcare professionals can be incredibly damaging for the doctor-patient relationships, and often leave patients feeling “insulted and devalued”. From our interviews, service users reported that healthcare professionals often made their concerns feel overlooked or dismissed. They emphasised that this style of communication was often very demeaning, and contributed to negative perceptions about accessing healthcare.



*“They made me feel like a child [...] We’re there because we don’t want to be here and we’re spoken to like shit”* (Person experiencing homelessness)

Unfortunately, negative perceptions about substance use can lead to patients being labelled as “drug seeking”. Respondents highlighted numerous examples where people experiencing homelessness were denied pain medication or underdosed because of their status as having substance use needs.<sup>15</sup>

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15 Within the literature there is extensive evidence that shows that medical professionals are more wary to prescribe pain medication to people with a history of substance use. Clinicians face difficulty distinguishing between pain relief and drug seeking behaviour, and have been shown to misinterpret drug dependency as drug seeking behaviour or relapse. A 2011 study looking at barriers to managing chronic pain among homeless patients found that from the 61 physicians interviewed as part of the study, only 51% reported treating the patient’s pain due to concerns about the patient’s history of substance abuse and psychiatric comorbidities.

*“There is continuing stigma and discrimination that we hear tales of [...] I’ve worked in hospital medicine for 15 years, and I’ve seen it actively. So I do believe what our service users say when they report a really poor experience. They get accused of using substances within hospitals even without any evidence. They get accused of sort of taking extra medication demanding extra medication, when actually they may actually be genuinely seeking pain relief, because of medical conditions. And it seems to be a barrier to actually getting their medication, even if they’re prescribed it in the community.” (Non-hospital healthcare provider)*



*“[People experiencing homelessness], they are highly unlikely to be given pain medication even if they have a broken leg but are a drug user”  
(Support worker)*


Inadequate pain management not only raises concerns about discrepancies in care provision for patients experiencing homelessness; but pain is also well known to make people more irritable and distressed. As a consequence people experiencing homelessness who are in pain may present as being confrontational towards healthcare professionals which further perpetuates the idea that people experiencing homelessness are “difficult to manage”.

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Throughout the interviews, the consensus was that stigma and discrimination from healthcare professionals may in part arise from a lack of exposure and formal medical training in managing patients experiencing homelessness who have concurrent alcohol and substance use needs.



*“That’s lack of education, that’s just lack of understanding and education, and maybe a bit of being judgmental [...] even getting people to understand that they’ve got an addiction, [...] for someone who maybe injects heroin three or four times a day, to go into hospital and have a little pot of methadone is a massive ask. [...]so they sneak off, they use and come back, and then they’re thrown out of hospital? There’s definitely huge gaps around how to support some of our patients through the hospital journey.” (Non-hospital healthcare provider)*




*“I think a large part of it comes down to poor education in substance misuse and the challenges the subs, the people who use drugs and alcohol face, especially the homeless population, and I can understand to a certain degree, because if you’ve never actually witnessed it, talk to people and listen to them. Then you go along with the preconceived ideas that most of society follow, which are these are the down and outs, you’ve got to be wary of them, they’ll mock you X, Y, and Z, they’re given a lot of negative press, and a lot of that is believed without actually being challenged or looked at a personal level.” (Non-hospital healthcare provider)*

This observation is heavily supported within the literature. Studies evaluating medical school training within the UK and US have identified key gaps in medical teaching around substance use and homelessness. The degree of teaching and expected knowledge on these areas varies greatly between medical schools. While ongoing efforts have been made to create a more comprehensive and coordinated teaching curriculum within the UK for substance use, further studies have suggested that there are still significant gaps particularly around care for people experiencing homelessness.

However, if we are aiming to reduce stigmatisation of people experiencing homelessness in hospital settings, efforts must not only be focused on healthcare staff but on all patient-facing staff. Throughout the interviews there were several instances of service users experiencing discrimination and poor treatment from other staff members. For instance, one service user who had attended Addenbrooke’s in a mental health crisis was told by a security guard during their visit: *“Well if you want to go and kill yourself just don’t do it here”*.

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The consequences of the stigmatisation and stereotyping can be twofold: people seek healthcare less often, and/or will self-discharge from healthcare services early. This means they will be more likely to eventually attend A&E in an acute health crisis, increasing the pressure on an already overstretched A&E service. Most dangerously, several interviewees emphasised that women in particular were more vulnerable to intimidation and stigma by healthcare providers leading to reluctance to re-access services as one key worker explained:



*“We’ve got a girl at the moment who was suffering from very heavy bleeding. We suspected she was haemorrhaging. It was so severe the hospital was desperate to get hold of her. But she had walked out of hospital because she’d gone outside to have a fag. Been given an absolute bollocking by the security guard. So she just did the classic well fuck you and walked off. And now won’t re-access [...] It’s understanding that you can’t shout at people that have gone through trauma, well you can if you want but it’s not going to get anywhere, it’s not gonna go anywhere useful.” (Key worker)*

Even individual negative experiences can ‘spread’ across the community perpetuating a cycle of distrust; as one non-hospital healthcare provider explained:

*“It really requires a culture change [...] if you talk to service users, they talk amongst themselves, they tell each other these stories. [...] So they go in biased as well, to a certain degree, new people coming in hear all these horrible stories about treatment and how to go and see this doctor and they impose this upon you. And then you need to go to hospital, but when you do get horrible sort of care, they come in fresh, but with fear of services, and unless we break that cycle, it’s just going to continue.”*

### 3. Poor coordination and communication indicative of a lack of trauma-informed care

Within emergency services and in patient settings, there was a general consensus among staff and service users that limited communication and inflexibility were important factors that led to negative experiences of healthcare and poor care outcomes.

Poor coordination across the system starts at the point where patients try to access secondary care and encounter a rigid set of requirements and conditions. When patients are initially assessed by healthcare professionals, they are often required to re-tell their story repeatedly, often further complicated by a lack of trust resulting from experiencing stereotyping or stigmatisation as mentioned previously. Not only can this ‘retelling’ cause frustration, it can also be traumatic and is not in keeping with trauma informed care principles<sup>16</sup>. One person who had recently accessed the hospital told us:



*“I find it annoying having to repeat my story to every doctor [...] It gets a bit tiring and it’s quite a lot to talk about.”*

This experience was mirrored by the observations of a non-healthcare-specific support worker:

*“I’d love to have sort of like an information pack for service users, for if they have to present a hospital, which spells out a lot of their background that they don’t want to talk about that they don’t feel comfortable talking about to strangers, who ask them repeatedly the same questions time and time again, and it frustrates them.”*

A further problem arises due to the frequent brevity of consultations; even if people are willing and able to (re)tell their story, the short average consultation times reduces the opportunity to listen to people’s priorities and make the care patient-centred. As one non-healthcare staff member described:

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<sup>16</sup> The six key principles of a trauma informed approach are summarised by [SAMHSA](#) as safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical, and gender issues.



*“It’s about having a better understanding, a bit more compassion, and actually talking to them about what their priorities are right at that moment, and managing them in that order rather than the order that they think they should be managed medically. [...] we need to have different flexible approaches, and it needs to be patient centred.”*

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A conversation we had with one person experiencing homelessness about their hospital experience adds another dimension to the problems stemming from lack of coordination and communication.



During previous admission, the person was advised to visit A & E if they felt anything was wrong, due the concern around blood clots (which they had been admitted to ICU for previously). When concerns arose and they presented to A & E, a two hour wait time preceded a blood draw. After an additional three hour wait, they were told that they had been taken off the waitlist - before having been seen by a doctor and having been informed about the change. After complaining and another three hour wait, a doctor did see the person, but without reading their prior history; the conversation was very focused on discharge. Advocating for themselves and explaining their patient history led to the arrangement of a CT scan the next day. The person was eventually discharged after blood results came back normal despite ongoing abdominal pain, twelve weeks loss of appetite and weight loss. In summary, the person concluded that they had “*lost confidence in the hospital’s judgment*” and that “[A&E] *didn’t have much time[...] and they didn’t really listen to me*”.

This person’s experience and concerns were shared by other people we encountered; healthcare professionals under time pressure often do not have the time to read notes or address patients’ concerns adequately, further contributing to the lack of a trauma-informed environment and making inadequate outcomes more likely. Limited time for consultations can also affect communication around treatment plans and lead to a subsequent lack of compliance e.g. with medication. One non-NHS healthcare professional described the possible consequences:

*“Because they don’t get proper treatment, they get serious complications down the line. You know, an abscess turns into a femoral artery issue. Then it becomes a major vascular problem where it gets worse year on year until they start having bits chopped off their feet all the way up. The DVTs don’t get treated, so they extend fully and then they get chronic mobility problems, venous eczema, poor circulation ulcers that don’t heal. [...] So it’s about early intervention, really, and they miss all of that. They miss those windows of opportunity. And it ends up with serious problems. Same with chest infections, it turns into a full blown pneumonia, that then leads them to an ICU admission. Whereas they could have been, you know, treated in the community or in hospital on a normal ward with different treatment.”*

Poor communication also occurs between hospital teams, leading to patients' needs being missed in transfer. This contributes to subsequent complications such as patients going into alcohol withdrawal. One support worker explained to us how this is especially detrimental for people who use substances:

*“Information about alcohol dependence going into hospitals is poor. There’s been a number of occasions recently where we’ve had to sort of inform the hospital liaison that it is likely that this patient is alcohol dependent. And then they’ve looked at the notes and that’s not even being asked, and they’ve not, they’ve not so they’ve not started treatment, and they start going into withdrawal [...] our hands would be tied for most of them, because they quite often will not detox people unless they’re housed. Because the way they say is they’re gonna go back to the street, they’re going to relapse.”*

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A last area of concern and another one indicative of the lack of trauma-informed principles at work in secondary care settings, is the issue of inadequate discharge plans for people experiencing homelessness who are leaving hospital. People often self-discharge, which further exacerbates poor follow-up and after-care. One non-hospital healthcare provider explained:

*“A lot of our [people] [...] even if they get into hospital [...] for life saving treatment, or very serious illness [...] will leave the hospital before their treatments are completed. Perhaps because they feel unsafe into or degraded, or aren’t able to take their drugs in a safe way”*

A support worker added further detail to the situation and explaining the consequences: the lack of a discharge summary, of medication, or handover - possibly leading to a complete loss of care continuity and a return to sleeping rough (rather than into housing):



*“Anecdotally, it seems like probably 80 to 90% of our homeless service users, if they’re in hospital will probably self discharge, whenever they feel they’re able to do so, but often before medical advice [...] this causes problems because we don’t get a discharge summary [...] They don’t get medication [...] They often self-discharge on a weekend and then no one’s there to follow up to speak to the pharmacy in the community and allow them to get continued medication and then they go AWOL. And we lose track of them. And then we have to start the process all over again.”*

Even when people are discharged by hospital staff, communication with GPs or other homeless services (e.g. key workers in housing providers) was often non-existent or poor. Communication and planning are critical to ensure good (health and housing) outcomes as one support worker described:

*“To manage that discharge to work with the hospital before they’re discharged for discharge planning, go out to their house, make sure that it’s actually clean and tidy. So they’re not going back to a property that’s just filthy and not that, you know, that doesn’t support recovery. Or working with people who*

are known to be homeless to say, well, it's not good for you to go back onto the streets, let's actually get something in place whilst they're still in the hospital so we can get you some housing. So that actually, your wound can consequently heal because you're in the conducive environment rather than out on the street. So I think, coming out of the hospital, there's definitely areas to improve."

## b) Drug and alcohol services: New approach but historically struggling

Drug and alcohol use among rough sleepers is increasing even further as a recent St Mungo's study shows; 62% of rough sleepers assessed by street outreach teams in London had a recorded drug or alcohol support need in 2018-19 (from 52% in 2014-15). Recent local authority-level data by the Department for Levelling Up, Housing and Communities (for 2021/2022 data) shows strong local support needs around substance and alcohol use for about 40% (117) households owed a homeless duty. Our qualitative interviews confirm this tendency and likely suggest an even higher prevalence of substance and alcohol support needs. As a healthcare provider at the Access Surgery put it:



*"If I was to say, I'd say I would be surprised [...] if a patient doesn't have an alcohol or substance misuse issue."*

Given the well-documented negative effects of alcohol and substance use on people experiencing homelessness, adequately addressing the growing support need in this area is important for people's wellbeing.

In Cambridge, community support for substance and alcohol use in adults is primarily provided by Change - Grow - Live (which will be referred to as CGL throughout this report), a charity organisation offering services across the UK to support people experiencing homelessness and other marginalised groups. In-patient support is provided by the Liaison Drug and Alcohol Team with close links to CGL.<sup>17</sup>

### 1. In-patient drug and alcohol services at Addenbrooke's hospital engaged but struggling to overcome some systemic barriers

The in-patient team at Addenbrooke's consists of 20 people (not all full time) of qualified specialist nurses, psychiatrists and psychologists who are tasked with supporting any patients admitted to hospital who have drug and alcohol use needs. They also perform opportunistic

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<sup>17</sup> Cambridgeshire has received an addition £2.2m of (central government) funding for drug and alcohol services (starting in July 2022); the impact of this is already visible in the HEART team (see below).



inpatient detox (symptom controlled detox) and psychological interventions (motivational interviewing) while patients are in hospital for separate treatments where possible. A CGL link worker provides the necessary connection to follow on community services provided by CGL (see below) and the team is also in contact with the local council as part of the “duty to refer scheme” for anyone in unstable housing.

First barriers to access the team and their services occur with the referral system for people experiencing homelessness in the hospital. They are more likely to be missed or not picked up by the liaison psychiatry team based on a lack of adequate coding available in the emergency department. As one person we interviewed described:



*“[They are] not very good on the Addenbrooke’s system at coding homelessness [...] if somebody is sofa surfing, or if they are able to get an older address or something similar to that, then they don’t get they don’t get coded as homelessness [...] if you if they say no fixed abode, then that gets put on their record. But, we see a lot of people [...] who we would describe as homeless where actually it won’t flag up necessarily, that they’re homeless on the system.”*

Similar issues revolve around people who use alcohol or substances who are often not referred to the relevant team, an issue that is made worse by guidelines pointing towards not admitting people purely based on alcohol / substance support needs. As a member of the Liaison team explained to us, the hospital is not a place where detoxification is supposed to take place:



*“A component of our alcohol care team is trying to prevent inappropriate admissions to hospital [...] if people are alcohol dependent; [...] they come to an acute hospital and say, ‘Look, I’d like to be admitted. I want to stop drinking. And my body needs a detoxification for that’. [This is] often true. [But we explain to them] you’re actually at an acute hospital isn’t the place where you’re likely to be helped for your alcohol dependence. Alcohol dependence is a psychological illness. And the treatment for that needs to be with community alcohol services.”*

We observed a further barrier for good care towards the end of people's hospital stays – often preventing people from agreeing on a detox to begin with: a lack of appropriate alcohol / substance-supportive accommodation often means that individuals are discharged back to hostels or street homeless. These environments can not only be social stressors but also make it hard for people to disengage from using. More generally, earlier studies show that returning to an environment providing strong social support post detox is a positive predictor for the (longer term) success of detox. Embedding in-patient drug and alcohol support in both adequate accommodation and community care are hence crucial taking us to the second part of this section, focused on CGL, the provider of community care in Cambridge.<sup>18</sup>

## 2. Community drug and alcohol services: CGL – two teams with different reviews

### Positive experiences with CGL often related to strong support worker relationships

Service users who had positive experiences with CGL often cited these experiences as being pre-pandemic, when the majority of services were provided in face-to-face format, with regular follow up. One service user who had been working with CGL for over 15 years was overall happy with their experience. This person found that having one on one, in person meetings with the same key worker was particularly helpful. When we interviewed them, they were accessing CGL on a weekly basis and were in the process of cutting down their heroin use without active support from CGL. For them, having a flexible, patient directed approach to managing their substance use was the best way to meet their needs.

*“I have always had a good experience [...] they are behind me 100%. [...] I can contact them [CGL] when I need to [...] they [CGL] just let me get on with it. That works, I am not feeling pushed”*

Having a strong trusting relationship with their key worker was repeatedly quoted among service users as being a critical factor to allow people to remain motivated to reduce their drug use and alcohol intake.

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18 Further to the barriers above, a significant barrier to treatment independent of the hospital setup, prevents possible interventions: the patient's mindset. When arriving at Addenbrooke's for treatment, patients are likely to be at the precontemplative/contemplative stage of their alcohol use and therefore not in a place to look to change (this may be due to other competing problems). One of the Liaison team members pointed this out in an interview: *“We see quite a lot of people in the pre contemplative and contemplative stage who have quite limited insight into their alcohol or drug dependence and might not be looking to change substantially. And so that's a part of the condition, you know, resistance to change as part of alcohol or drug dependence, and so with them, we might make very limited progress.”* We also observed this problem first hand during a shadowing shift. The patient who was hospitalised with a 'collapse' and who had already been planning a detox with CGL was willing to begin a detox in hospital. The patient was complaining about a lack of chlordiazepoxide in their ward leading to a significant tremor and their demand to self-discharge to eventually start their detox in the community. This need was even stronger because of the patient's fears to lose their housing based on forthcoming court orders. With the uncertainty of the patient's primary needs (e.g. housing) not being met the patient's mindset was not ready to focus on detox.

*“I had a really positive experience with CGL before Covid [...] I had a good relationship with my key worker and weekly meetings.” (Service User)*

Unfortunately, the pandemic led to a number of changes to services which have contributed to patients’ negative experiences. Repeated lockdowns and strict hostel regulations often meant that clients with substance misuse needs were “hurt twice”, firstly through loss of peer support networks and secondly through more complicated access to methadone and other substances.<sup>19</sup> During the COVID pandemic, CGL services such as group work were temporarily suspended before switching to an online platform with telephone interviews replacing face to face contact. In line with official guidance, and health services shifting their mode of delivery more generally, some of CGL’s services such as harm reduction and scripting, were offered directly in the ‘Everyone In’ accommodation, laying the groundwork for the emergence of the HEART team (see below).

## **Two key issues with CGL mainstream services emerged**

Our interviews with service users and stakeholders who reported negative experiences with CGL’s mainstream services, highlighted two main issues: lack of follow up and the overall inflexible conditionality of services.

**Note:** CGL (as well as the commissioners) were aware of these issues and had already started to put measures in place during the COVID pandemic to counteract them; you will find more on the effectiveness of these measures in the upcoming section on the HEART team. A spiral of hiring problems and staff shortages led to very high caseloads and the inability to focus on outreach and flexible case work.

### ***1. Staff shortages lead to lack of relationships and regular follow-ups***

Respondents frequently reported that poor follow up left many clients feeling disconnected from their key workers, often directly connected to lack of CGL staff.

One service user who had a positive experience with CGL pre-pandemic stated: *“Since COVID I have been assigned a new key worker who wasn’t as good.”* Over the last 2 months they have had no interaction with CGL, now they feel as if *“I am unsure who my key worker even is.”*

From the literature, the importance of the quality of therapeutic alliances in successful drug and alcohol treatment interventions has been shown to be a positive predictor of ongoing engagement and success in drug treatment programs. Unfortunately, with limited continuity of care from CGL, people experiencing homelessness are unable to form these key therapeutic

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19 During Covid (March 2020 onwards), many support services shifted to an online model - at times with delays - leading to decreased engagement from some people (who e.g. did not / could not shift online).

relationships with key workers, leaving them feeling unsupported and unmotivated.

A specific case includes methadone prescriptions. For substance use services, both service users and staff members have described several instances where clients have been left on the same script of methadone for months without follow up.



*“Patients with substance use are not seen very regularly, which is a big issue [...] [at GP practice X] we see our patients here for drug clinics weekly or fortnightly? Very few were seen monthly, and I know that one of the patients went over to CGL because they said [...] well, I’ll probably only have to see them once every two or three months.” (Non-hospital healthcare provider)*

According to the National Institute for Health and Care Excellence guidelines (NICE), flexible dosing regimes of methadone and buprenorphine should be regarded by clinicians as the first line, most effective method of managing opioid dependency. Research succinctly shows that especially for methadone scripts, if service users are to work effectively towards a goal of safely cutting down their substance use, clients must be followed up on a regular basis. Unfortunately, respondents have highlighted that the responsibility of following up<sup>20</sup> often falls on other healthcare providers such as GP’s or emergency services in the absence of CGL support. One primary healthcare professional explained:

*“There’s a [person] that I’m seeing [...] their scripts were reviewed in April [...] I did call CGL if they had updated the script more recently [...] they said, ‘Oh, they didn’t, the telephone number that they had from them was out of date or whatever, and that their address had changed.’ Hence they had no follow up [...] they just continued the methadone script, basically, without really, without seeing him.”*

Often the responsibility of follow-up or the handling of emergency situations then falls on untrained hostel staff members. As one hostel staff member described, directly linking the problem back to CGL:

*“The other night my colleague and I took that person up to A&E where they quite rightly said, this isn’t what we’re here for. We’re not here to detox people [...] The process within CGL drug and alcohol is not working for access for our people [...] with one alcohol nurse, trying to get anything done in the school holidays is impossible, because there’s so many people off.”*

## **2. Inflexible conditionality of services - at CGL and beyond - can contribute to bad outcomes**

Inflexible service provision poses a solid barrier for people experiencing homelessness trying to access healthcare. Interviews with stakeholders and service users highlighted this issue

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<sup>20</sup> We did not record any incidences where GPs have actually been prescribing methadone; GPs and nurses, however, encounter people who have not been reviewed by CGL and try to ensure continuity of care (e.g. by calling / re-connecting with CGL).

amongst CGL services across a number of conditionalities.

The first instance is inflexibility in re-scripting methadone. Many clients who are prescribed methadone must do so under daily supervised consumption; if clients do not pick up their prescription for 3-4 days, they are deemed to have “fallen off their script”. Rescripting clients was highlighted as being a difficult and lengthy process which often leads to gaps in care provision and a higher risk of relapse.

*“It’s easy for service users to fall off their scripts on bank holidays due to changes in pharmacy opening times [...] it’s difficult to get people rescripted [...] we need more systemic flexibility...”* (Person experiencing homelessness)

A second instance are the conditionalities surrounding detox. For people to be eligible to undergo detox/rehab, they are expected to demonstrate their commitment by engaging with pre-rehabilitation work, typically including intensive group sessions (up to 4 sessions a week), a psychiatric assessment and the completion of a drinking diary. Throughout our interviews, the pressures of managing an intensive treatment regime on top of co-occurring mental health and physical co-morbidities was often deemed unmanageable, leading to people dropping out of the treatment program prematurely.

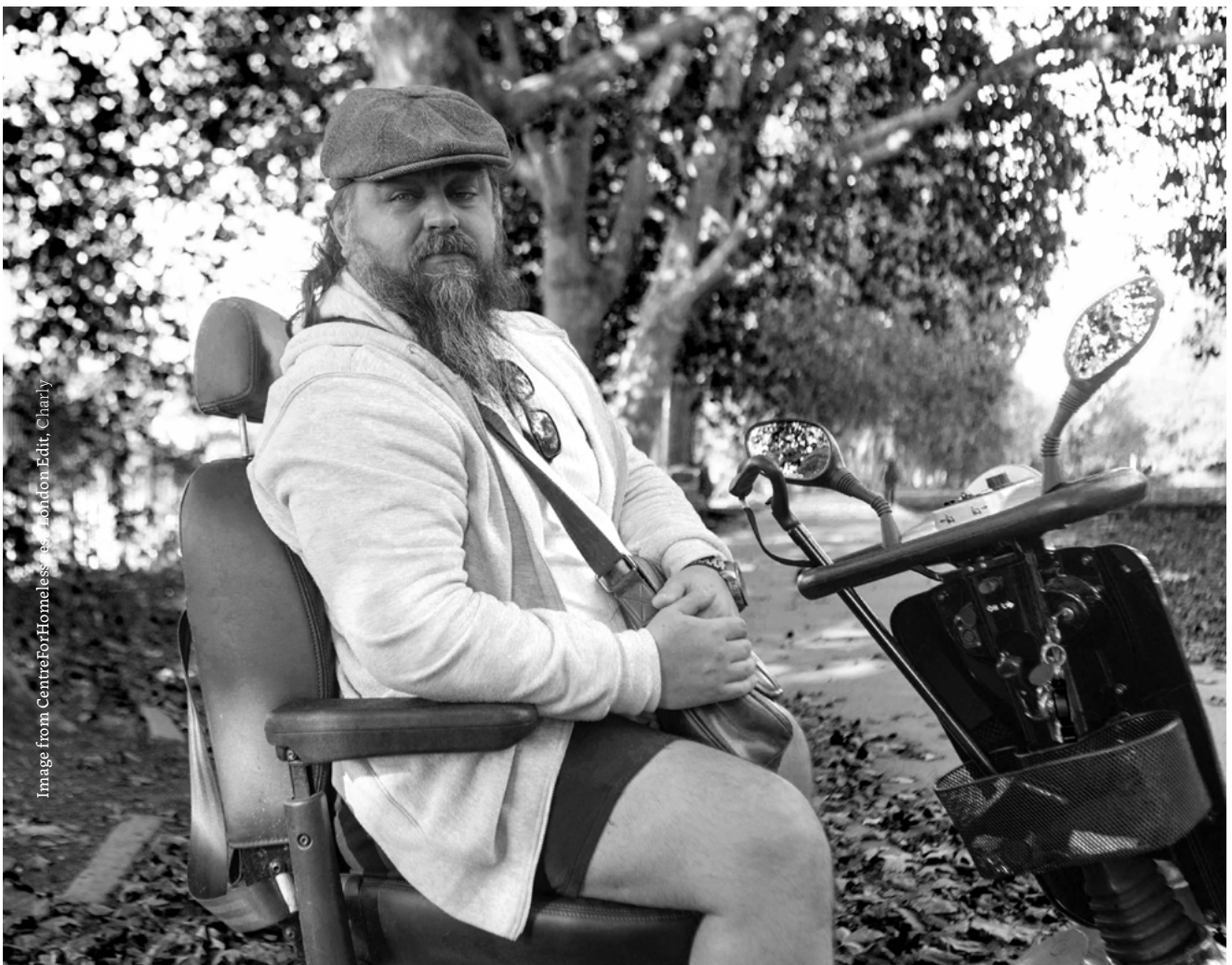


Image from CentreForHomeless as London Edit, ©Charly

*“A patient must attend four groups a week and reduce down drinking, create a drink plan [...] then they went to detox, unfortunately now they are back with [Housing Provider] after a stint in detox and a stint in prison, drinking and using substances on top – it just becomes a cycle.” (Housing service provider)*

*“Alcohol is generally the most that we put through [...] just because of how common it is [...] is a slow process, and it’s almost, can be impossible for the homeless population [...] because they’re expected to, engage with pre rehab work groups, post rehab work groups or post detox work groups [...] And that work is important but expecting them to do it in a group fashion [...] is unrealistic [...] And it kind of sets them up to fail.” (Outreach worker)*

As part of the interview process, we were introduced to person X who had been working with CGL for a number of years to reduce their alcohol consumption.

*“Sometimes I go there, and [person X] is literally nodding off because they have had such broken sleep for such a long time now [...] they have been sick. They are trying to get vodka in them, they’re, they’re heaving, they’re all sweaty [...] they wake up in the middle of the night...they’re partner says they’re watching them and [...] you can start seeing them withdrawing. ...they’re in such a poor physical state [...] They’re desperate for that detox, but that process is just insane. And now they missed their appointment today. There will probably be another three, four weeks for the next appointment” (Housing service provider)*

For many clients like person X who are coping with severe alcohol dependence the nature of their condition alone can be a significant barrier to attending appointments, even if service users are motivated to make a change. Very often service users require additional support from staff members and volunteers to access their appointments.

Inflexibility in managing missed appointments was repeatedly emphasised as one of the greatest barriers to ongoing engagement with drug and alcohol services. If clients missed a single appointment, they were often asked to wait for several weeks for the session to be rescheduled. As discussed previously, inconsistent follow up and prolonged breaks in care provision increases the risk of relapse and unsafe withdrawal, which Person X’s case has demonstrated can be debilitating and potentially life threatening. This inflexibility is also a break with the principles of trauma-informed care.<sup>21</sup>

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21 A note on trauma-informed care: overall, experiences of psychological trauma and adverse childhood events are very common in people experiencing homelessness. A 2015 study noted that 85% of adults facing multiple disadvantages (defined as experiencing one or more of: homelessness, offending or substance misuse) will have experienced one or more traumatic experiences in childhood. Trauma, poverty and homelessness are heavily intertwined and being homeless in itself is a traumatic experience. As noted within a recent report produced by the CHIRN network, the gold standard for building rapport and therapeutic relationships is through face to face consultations. While digital consultations can be highly successful with the correct infrastructure and training, for clients to wish to continue engaging with services, the mode of consultation

## **The CGL HEART team is bringing significant improvements – flexibly removing barriers**

The Homeless Engagement and Recovery Team (HEART) was started based on insights during Covid in order to try to improve access and engagement with the (mainstream) CGL community team, especially for people most at risk and in need. While the team started small, new central government funding (provided by OHID) allowed for a dedicated team to start in 2021, integrated with the Street Outreach Team in Cambridge. The team, which is located in the same building as CAS, houses a dedicated clinician, a dedicated nurse as well as two psychologists and peer mentors, a women's recovery worker and front link outreach workers, including a dedicated womens-only worker.<sup>22</sup>

The setup and staffing of the HEART team allows it to approach support in a different way, both with a smaller case load (40 instead of 80) and a bigger focus on face-to-face interaction and assertive outreach (including house visits and visits to other support organisations, such as Wintercomfort). These measures, and the flexibility of the team, produces stronger relationships between clients and key workers and improved recovery outcomes. We encountered several examples of where this approach has yielded phenomenal results, very explicitly decreasing barriers to healthcare access for people experiencing homelessness.

**Case 1:** One person, who is in a wheelchair, was found to not have accessed CGL services for a long time; they were visited at home by the HEART team. The ramp to the person's home was broken and wires were hanging down in the hallway making access complicated; the team not only contacted the council to arrange this to be fixed but also managed to rescript the person on-site.

**Case 2:** Young service user who has been injecting for years, and had developed a swollen arm; they came to the outreach van for help, were taken to Addenbrooke's but escaped because of fear of the police presence. Subsequently, the person's father came to the outreach van to ask about his child. A member of the HEART team found the service user, talked with them, got them rescripted, and the arm examined by a nurse at the access surgery. The father collected the person's script the following morning.

The above cases, and the general observations from talking to members of the team and service users, clearly demonstrate strong benefits of the HEART team's approach; being flexible and 'going to the people' directly helps the team to piece together a better picture of what people's lives are like overall, assess their needs and support them exactly where they want and where they are at.

We observed another example of positive benefit in terms of support offered and overcoming barriers:

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22 In March 2023, the team is still developing and e.g. a further social worker will be added.

**Peer working – example:** A person who is alcohol dependent and wants detox, but at the same time doesn't feel they can cope without alcohol, proves hard to engage for mainstream CGL. What helped this individual was to start working with a peer mentor provided through the HEART team who themselves had lived experience of alcohol and crack cocaine use..

**One-to-one psychological support - example:** A 'hardened', previously 'angry and violent' person with extensive criminal justice history wants to engage in therapy but struggles with previous trauma. Ongoing and flexible 1-on-1 meetings helped this person to open up about this, and now engages regularly with a psychologist.

**'No discharge policy':** the HEART team tries to keep people on without discharging them onto different key workers for as long as possible to provide continuity of care (even when housing situation changes). **Case:** a person with complex physical health history (long hospital stays) who was originally assessed on the streets disappeared for four months; the person re-appeared on the street and the same key worker continued working with the person (incl. taking them to hospital, getting rescripted). This had a strong positive impact (interview quote): *"I was sat in ED waiting for ages to be seen. I fell asleep and dreamed that [HEART team] were with me. I woke up and you weren't there and I cried. Feel so supported by you, you're the only people who care. I feel privileged and a bit embarrassed as I feel you dedicate so much time to me."*

People experiencing homelessness typically regarded as hard to reach groups. However, the strong engagement which the HEART team achieves shows that the issue is not necessarily with people experiencing homelessness not wanting support but with accessibility issues within mainstream services. The HEART team's results are positive:



Of 120 total people the team works with only 6 have not seen any engagement over the past 90 days.

7% overdue review rate amongst opiate users under care of the HEART team, versus 13% for the mainstream team, versus 12% across Cambridgeshire



For specific groups, however, there are still barriers to access drug and alcohol support. We want to point at some of the barriers that we observed and heard about in the remainder of this section.

**HEART team not accessible for all:** anyone who is under probation services will currently be assigned to the mainstream team (where we know the higher case loads, and subsequent inflexibility are causing the same ongoing problems as pre-pandemic)

**Accessing and completing detox is a major challenge:** people can no longer directly access in-patient detox *in Cambridge* post-COVID.<sup>23</sup> The requirement is now that people sign up to obtain a place in a CGL-run detox centre located outside of Cambridge. In order to access this service, people must complete a range of pre-detox requirements including: proof of management of substance use, a drink diary, and a psychological assessment. Moreover, the detox itself usually follows a rigid and lengthy schedule which many people are unwilling to sign up to and the service lacks provisions to cater for complex needs (e.g. additional mental health support). The CGL detox service in its current form mostly involves group sessions, which are perceived to be triggering for many of the people we spoke with (see above). For people living in supported accommodation, such as hostels, choosing to undergo rehab poses a further risk. Detoxification programs can last 6-12 weeks, and are often in tension with keeping their accommodation secure (beds are usually held for less than 13 weeks). **Case:** 60 year-old person who recently moved to Cambridge (after escaping from a violent partner) who struggles with excessive drinking is supported by the HEART team. They fear that accessing treatment will leave them homeless at the point of discharge as they are currently staying at a winter provision accommodation, which would close during the proposed detoxification programme.

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23 Fulbourn hospital (in Cambridge) stopped providing detox services already in 2018/19.

## c) Mental health support with long waits and not enough capacity leading to big gap

### Mental health is one of the biggest problems among people experiencing homelessness

In the majority of our interviews<sup>24</sup> mental health emerged as one of the most important concerns yet it was consistently felt to be an under-supported area of healthcare for people experiencing homelessness. A recent analysis of 31 Homelessness Needs audits found that 82% of participants within the 2018-2021 cohort reported a mental health diagnosis, which is a substantial increase from the 45% reported between 2012-2014, but in line with a recent government audit. This is true for diagnoses such as depression and schizophrenia but also bipolar disorder and trauma<sup>25</sup>. Furthermore, many people struggle with a dual diagnosis (co-existing mental health problems and substance use - see above)<sup>26</sup>. Our interviews in the Cambridge ecosystem add further support to this data, as the following observations from service providers demonstrate:

*“The majority of rough sleepers in Cambridge have mental health concerns”* (outreach worker)

*“90% of my time is spent helping support people because of their mental health and past trauma[...]2/3 of patients specifically come to see me about their mental health”* (healthcare worker)

*“The majority of people will have complex PTSD, so 60-70%. Then a small amount of people will have psychosis on top of that. But I can’t really give a figure on that, maybe about 10%.”* (healthcare worker)

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24 This report is limited to mental health provision in Cambridge for adults (>18) with experiences of homelessness. We do not cover Peterborough, elderly or child and adolescent psychiatry and services specifically supporting people who are neurodivergent, or the specific experience of ethnic minorities. The majority of our insights have arisen from primary care (e.g. CAS), community service provision (e.g. CPFT, Union House), Addenbrooke’s Emergency Department and insights from hostels and local organisations; fewer insights have been gained from inpatient secondary care services (e.g. Fulbourn Hospital).

25 SAMHSA defines individual trauma as the result of ‘an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.’ A recent Evolve study revealed a high prevalence of trauma amongst people experiencing homelessness. Notably, childhood trauma is also directly correlated with the experience of homelessness later in life.

26 While the reported numbers vary between 10-30%, a recent Crisis study explains this vast under-reporting: papers usually “apply a strict definition for disorder – many more individuals will have a diagnosis of mental illness and have a coexisting substance use problem, but these do not amount to the threshold for diagnosis of a disorder.”



## EXPERIENCE OF MARY

One of the informants we spoke with kindly agreed to share their story so that other people could understand the lasting impact that their mental health and the subsequent care they received had on their life. This person's journey with mental health problems and homelessness began several years ago. They had been accessing mental health services for around one year whilst living outside of Cambridge. During that time they were passed between multiple specialists whom they felt did not listen to their needs. They received various diagnoses, which left them unable to stay on a waiting list long enough to access any form of long-term psychological therapy - a common phenomenon as a [recent Groundswell report](#) shows.

*"The mental health services are the reason I was homeless. Because they failed me so badly, I ended up not being able to cope, because I was begging and pleading for help from them. And they basically ignored me."*

*"I was initially diagnosed with Post Traumatic Stress Disorder. But I was told that I couldn't have CBT because I actually had complex post traumatic stress disorder and that was then passed on to a psychologist who then decided I didn't have Post Traumatic Stress Disorder [...] instead I had a personality disorder, and that's a whole different type of treatment. So she didn't give me any treatment for post traumatic stress disorder."*

Eventually, unable to balance the overwhelming stress of supporting their deteriorating family situation, their ongoing struggles with their mental health, their job and a tenancy, this person felt as if they had no options left.

*"I felt like I was fighting fires on all fronts [...] And I just couldn't deal with not being listened to or trusted. I just felt like I was wasting my time and money. I was getting worse during that period. My health was deteriorating, my ability to maintain a tenancy also deteriorated."*

Subsequently, Mary destroyed her apartment and was arrested.

*"I had a choice to make: to hurt myself, to hurt someone else or to damage property [...] I chose the lesser of two evils. [...] I should never have been put in that situation in the first place."*

For the next few months, Mary was moved between prison and in-patient psychiatric units. Despite her attempts to make a complaint about the care she had received, she felt that her concerns were dismissed as being part of her diagnosis of personality disorder\*. Eventually, she was referred to *Every Adult Matters* in Cambridge, which connected her with a community mental health practitioner and groups like the Cambridge Arts Centre, where, for the first time she began to feel supported.

*"The approach of the 'Counting Every Adult' team has been excellent. They are amazing. They don't treat people like naughty children. They treat them like human beings with difficulties, which is exactly what we are. My support worker saved my life. I have no doubt if I didn't meet her if I hadn't met her I'd probably be dead by now. It's really difficult to survive."*

For this person, it took over 8 years before they were able to begin receiving treatment for their mental health diagnoses and history of trauma. The negative experiences they had in the interim had a profound impact on their willingness to access any services in the future.

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\* A recent BBC report observed similar problems for patients in other psychiatric units. Similarly, prison settings have been found to be generally detrimental to people's mental health: increased exposure to violence, very variable levels of mental health support/healthcare, higher risk of bullying can create an experience which further increases trauma [must be patient-led](#).

*“It’s very rare to not have a dual diagnosis because [...] what comes first? It’s like chicken or egg. Really, if you are using substances as a means of escape, it’s either you’ve got some mental health issues going on, already, and if you haven’t yet then an addiction to a substance is going to give you some mental health issues.” (psychiatrist)*

There is a complex interplay between poor mental health and homelessness, as having mental health problems increases the likelihood of people becoming homeless<sup>27 28</sup> and subsequently the experience of homelessness can further exacerbate mental health problems and lead to additional trauma.<sup>29</sup> Despite mental health being one of the biggest challenges people experiencing homelessness face, and one of the biggest needs in the ecosystem, our interviews clearly point towards difficulties in accessing mental health support in Cambridge<sup>[SB1]</sup> for this cohort.

*“I help them with managing their behaviour and how to manage their anxiety, you know, different coping strategies, while we’re waiting for the correct services to support them. Because I can only do so much and they need that professional mental health help. Which is one of my frustrations because it’s not out there. That’s one of my core frustrations.” (Healthcare Professional)*

*“We still hear a lot of reports from service users that they want mental health support, or they want to have a mental health assessment [...] either there’s a barrier to initially getting that, or even if they’re successful in getting that they often then get turned away, because of their substance use issues with the message to get yourself clean, or sober [...] there obviously are service users with significant mental health problems, some of which may have even been diagnosed before. Yet, they still seem to struggle to get the support that they need” (Support Worker)*

### **Barriers to access make it even harder for people to enter an already under-staffed system**

Despite additional funding in place since the 2019 Mental Health Investment Standard and improvements as part of the NHS Long Term Mental Health Plan, prior funding cuts (including locally in Cambridge) hollowed the system out leaving only a fraction of the mental health services in place. This will likely take time to rebuild, especially for the specific needs of people who are experiencing homelessness. To give an estimate of how stretched mental health services are, a report by the Care Quality Commission revealed that in May 2017, 36 per cent of NHS and 34 percent of independent core mental health services services were rated

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27 A 2019 meta-analysis study looking at 116 independent studies highlighted that two out of four of the statistically significant individual predictors of homelessness were adverse life events (e.g. episodes of trauma) and psychiatric problems.

28 Additionally, evidence is emerging that a higher proportion of people experiencing homelessness are classified as being neurodivergent – including those who have autistic traits or ADHD, something we also observed during our interviews. This in turn has an effect on people’s ability to engage with services e.g. as a way of avoiding social anxiety and sensory difficulties. Mental health issues generally can make engagement with services harder and self-exclusion more likely.

29 Focusing on the experience of women, a recent Groundswell study shows that for some women, their mental health only began to deteriorate once they became homeless.

as “requires improvements to be classified as safe”. A national shortage of mental health beds continues, leaving the system as a whole at breaking point. As explained above, the cuts to the Dual Diagnosis team in Cambridge are a good example of this.

The mental health system is additionally complicated to access for people experiencing homelessness. One common problem is the ‘underdiagnosis issue’. The people who we interviewed exhibited ‘low level need’ and did not have symptoms which met entry requirements to access specialist services. They are instead referred to low intensity psychological wellbeing services, where in turn referrals are frequently rejected due to concurrent substance use which precludes them from having psychological therapy. One healthcare professional explained this conundrum to us:<sup>30</sup>



*“The community mental health team take the threshold of severity of illness, which is if you have depression, if you are suicidal, and you’re severely depressed, or perhaps have psychotic symptoms [seriously]; I don’t think they then would modify that for people with significant social adversity. So they wouldn’t take on someone [...] who has [...] moderate depression, who needs an antidepressant who normally would be treated in primary care, but actually, they have significant social issues, which contributes to their complexity.”*

People with dual diagnosis particularly struggle to access mental health support services.<sup>31</sup> Support services for mental health and support services for substance use are often siloed, as is their funding, and this has to do with the commissioning structure as a local psychiatrist explained:

*“Drug and alcohol services are under the control of local councils. So the funding comes from the local council, it doesn’t come from mental health services. So when local councils receive less money from the government, they’ve got less money to give to drug and alcohol services. [...] Also, drug and alcohol services are less highly valued by the public, it’s seen as a patient’s own problem. [...] So it’s really easy for local councils to cut the money to drug and alcohol services, which means that even if there’s some people who might be able to cure addictions before they get their mental health issues dealt with, there are just no services. [...] Reintegration of mental health and drug and alcohol services would be good, but*

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30 To address the gap between low level and high intensity support, a new psychological Skills Service was piloted in Peterborough and is now being rolled out across Cambridgeshire; additionally, there is a pilot in Peterborough for Mental Health Support for flexible Rough Sleepers. The ICB is looking at the wider needs for this group and some interviewees expressed hope for these services to be rolled out across Cambridgeshire.

31 Similar problems occur for people struggling with neurodiversity who are unable to get appointments; one psychiatrist explained to us: *“So for neurodiversity? And even if you’re not homeless, it’s a two year wait on the NHS minimum? So I’m not sure I think it might be even more for adult autism. Because particularly adult autism incurs, you’re eligible, rightly so for a lot of support and, and benefits, etc. Access to those kinds of assessments are virtually impossible. You know, you need to be in the same place. You need to fill in forms, your GP needs to be on board with it [...] maybe the appointments are virtual? How are you going to attend an online assessment meeting? If you’re street homeless?”*

*they'd have to give more money."*


Overall, we heard from many mental health community services, including psychological wellbeing and therapy services, who had a policy of refusing referrals from people who have dual diagnosis. This leaves other services such as GPs or the Addenbrooke's Liaison psychiatry team unable to refer people onwards. This means that people who enter A&E with acute mental health problems might be discharged 'into the community' without adequate mental health support available. Even in cases where referrals are accepted by secondary mental health teams, patients usually encounter long wait times as a result of the overall budget cuts. At times, this can leave people waiting for appropriate mental health support for years.

**Barriers continue within the mental health system: lack of staff, inflexible processes, trauma resulting from restrictive measures e.g. sectioning**

Our interviews reflected a general lack of flexibility within mental health services, from A&E to mainstream CGL services, with accounts of how services often struggle to recognise and accommodate the complex needs of people experiencing homelessness, unless the service has been specifically designed with this patient group in mind.

One example of this is how the COVID-19 pandemic triggered many services to transition towards predominantly using digital and telephone appointments (including the mental health referral system). The people we encountered often missed telephone triage appointments with mental health services which can delay their access to treatment, and often leads them to be discharged prematurely from services due to non-engagement. This demonstrates how telephone appointments can be detrimental for people experiencing homelessness (e.g. lack of available phone / service). Additionally, with complex histories and diagnoses (e.g. schizophrenia), telephone interviews can often not unearth the full picture and people want to avoid telling their stories multiple times in depth.

**Case 1:** One person experiencing homelessness we interviewed went through such a convoluted and complicated referral pathway in Cambridge. *"I saw a psychiatrist after 3 years waiting at Union House who prescribed medication. The psychiatrist referred me to a social worker who made me*



People who experience homelessness have a 2 to 5 times higher age-standardised mortality ratio than those who are not homeless.

*an appointment with another psychiatrist. This process made me revisit trauma each time.”*

**Case 2:** A support worker described the problems encountered during lockdown, indicative of a general problem with telephone appointments: *“Problem with lockdown – lots of people left post in CPFT so they went from visiting to phoning people [...] people with schizophrenia can’t cope with phone calls as there are too many voices. [...] If voice is not attached to the body [it is hard]; phone calls for people with schizophrenia don’t work as a result during lockdown lots of patients left CPFT and those that were left only able to do face to face in an emergency context.”*

Staff shortages (mostly based on workforce shortages) exacerbated the inflexibility within services and made assertive mental health outreach services increasingly rare; this leaves many of the most vulnerable people unseen. People experiencing homelessness are viewed as being complex and difficult to engage, making it more unlikely for their referral to be accepted by overstretched community services. A psychiatrist described the catch-22 situation in the following way:



*“If the service that I’m referring to is not flexible, with some ability to do what we call assertive outreach [...] then it’s likely the patient would not be able to engage with that service [...] It’s kind of like a catch 22 situation [...] the services will say, well because of our resources, we’re not going to give you an appointment if you’re unlikely to come anyway. And it’s just chicken and egg, round and round.”*

For people who are eventually accepted, large caseloads mean that the lack of flexibility continues. Missed appointments are frequently not followed up and people’s mental health can continue to deteriorate. As one support worker describes the downward spiral that missed appointments can cause:



*“If they start getting quite unwell again, they don’t turn up their appointments with their CPN and then everything just gets worse [...] and so what I’d love to see is a bit more pro-activity. [...] What happens is they miss their meds or they miss their depot and then it just gets worse and then they still miss more appointments and then it gets worse again, and then we’re in a position where we’re going to be calling 999. Because you know, the person is being violent or a danger to themselves.”*

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In situations of an acute mental health crisis, 111 (option 2) is often the only possibility (see A&E above for emergency hospital care barriers generally). Long waiting times are also an issue faced by the 111 service and crisis solutions are often not offered quickly.<sup>32</sup> Similarly, for people who are held under a section 136 in acute mental health crisis by the police,<sup>33</sup> support and care provided is often inadequate. One support worker explained how especially for some women the section 136 turned into a traumatic situation:

*“I think it’s been a real struggle, particularly where people have felt they have been criminalised or dealt with by the police, when actually, it’s been a mental health issue. So, certainly a couple of women are a bit traumatised by their experiences with police where they were really struggling, and have then been arrested and found themselves, you know, in a cell when actually, they’re really unwell.”*

The problem of police involvement leading to traumatic experiences for mentally unwell patients is reflected in wider research: notably instances of Section 136 detention increased by 8% in 2022. Most detentions happened in a police vehicle (54%) rather than an ambulance and for 1% of people (264 people), the detention ended in the police station. Mental health charity MIND finds this number highly worrying, as their Head of Legal explains:



*“Although just under 1% of detainees were taken to a police station as a place of safety, this still means that 264 people, while at their lowest, were for all intents and purposes treated like criminals. This can be deeply traumatising and humiliating for people in crisis, who have not committed a crime and instead need therapeutic care in an appropriate environment.”*

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Post-crisis care continues to be hard to access. As described before, a general lack of services in Cambridge make onward referrals by e.g. the Liaison Psychiatry team complicated, often leaving people without specialist follow up support. This can leave people completely without medication as one A&E practitioner described:

*“From A&E, we generally don’t start medication there. Partly because when people come to A&E they’re in crisis. It’s not the best representation of how people are managing on a day to day basis. But I’ve got no way of following them up at all.”*

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32 We know that this situation is not unique to people experiencing homelessness – a recent report from the [CQC Mental Health Survey](#) highlighted that in a crisis “almost a quarter of respondents did not get the help they needed (22%) or could not make contact with this person or team (2%)”.

33 Section 136 is part of the Mental Health Act that gives police emergency powers. Police can use these powers if they think you have a mental disorder, you’re in a public place and need immediate help. They can take you or keep you in a place of safety, where your mental health will be assessed.



The current gaps in service provision in Cambridge are caught partly by the CAS team, both in flexible outreach and in the practice. However, their interventions are not focused on providing continuous mental health support and this puts unjust pressure on staff who are themselves not adequately trained. Barriers of communication in particular are also addressed in regular (first Wednesday of every month) mental health meetings with participation from all key stakeholders. The housing providers and Wintercomfort additionally employ in-house mental health workers and provide counselling (all self-funded). These additional services - while unable to 'close the gap' - are very well received in the community.

**Case example** of person helped by Jimmy's: A person who was initially reluctant to address their mental health began engaging with the (at the time reasonably new) mental health support worker at Jimmy's. *"A lot of people didn't want to talk about their past because it brings up a lot of things – I bottled a lot of things up – but it screwed things up [...] I met the mental health worker at Jimmy's– I was put through to a psychiatrist after 3 days– we would talk through anger management – this therapy was incredibly helpful."*

Overall, wider research suggests that for people who are sleeping rough in particular (but also for people experiencing homelessness more widely) dealing with their mental health is not only especially complicated given the above barriers it is also often not their highest priority. A recent study looking at mental health support for people experiencing homelessness identified that if individuals basic needs were not met (e.g. housing stability) they were unable to focus on their mental health. Therefore a lack of adequate supported housing will continue to pose possibly the biggest barrier for people to access good mental health support.

## d) Dentistry as a further area of concern – more capacity needed

Throughout the interview process, there was an overwhelming consensus from both stakeholders and people experiencing homelessness that poor oral health and lack of access to dental services were key concerns mirroring broader research findings. Interviews with service providers suggest that poor dental health is incredibly common for individuals experiencing homelessness in Cambridge.

*“I would say every single person that we work with needs some dentistry, you know, every single person”*  
(Senior support worker)

Unfortunately, to our knowledge no quantitative data exists on the current dental care needs for the homeless community in Cambridge, hence it is difficult to estimate the true extent of this problem. However, studies from both Scotland and London have demonstrated that oral health is a very common concern for people experiencing homelessness; across both studies over 90% had experience of dental decay which is far higher than the general population (estimated by the Adult Dental Survey 2009-2010 to be 31%). Many risk factors contribute to the poor dental hygiene amongst people experiencing homelessness, from poor diet/nutrition and lack of regular brushing to substance and alcohol use, including the use of (oral) methadone.

*“Methadone rots teeth, we’re all encouraging people to go on methadone as an opiate replacement. And, you know, actually, that has quite a negative impact on people’s teeth.”* (Housing service provider)

If these risk factors are not addressed, poor dental health can have negative consequences on people’s physical and mental health. Severe pain, which can cause discomfort when eating resulting in a cycle of inadequate nutrition and poor physical health, at times further linked to increased alcohol and drug consumption to reduce their symptoms. Poor dentition is furthermore often associated with a high degree of shame and embarrassment. In fact, as part of this project, one person experiencing homelessness asked to be interviewed over the phone rather than in person because they felt too self-conscious about the appearance of their teeth. As their support worker described:



*“They are just so sick of the pain [...] the way that their teeth look and the shame that comes with that [...] you are judged on that, you know, daily. So they have quite a lot of shame associated with that [...] [Person] wants their teeth out [...] [they] got some broken ones at the back [...] there’s a couple of like misshapen ones at the front [...] [they] feel like a monster.”*

However, access to dental care appointments in Cambridge is very limited with patients waiting months for a routine appointment. Often people experiencing homelessness must be referred to dental practices outside of Cambridge which are impractical to access.



*“I have been waiting for a dentist appointment since lock down [...] my key worker has tried a few different places but even Ely was fully booked [...] my only option is to go to Brooksfield emergency surgery” (Person experiencing homelessness)*



*“The lists for dentist appointments are open, and then they’ll close very quickly..there was one in Wisbech [...] Now for Cambridge person, that is not manageable” (Support worker)*



*“I have tried to contact many dentists but no treatment options have been available [...] isn’t it illegal what they’re doing [...] don’t they have some sort of duty of care.” (Person experiencing homelessness)*

Lack of availability of dental care puts additional pressure on other healthcare providers including GP’s and emergency services which are unable to meet their needs.

*“Most people contact their GP first [...] but [they] are not trained or insured to treat teeth.” (Non-hospital healthcare provider)*

As a result of the high barriers to access care and frustrations with long waiting times, people experiencing homelessness frequently resort to removing their own teeth.



*“There are people who have been waiting for over two years to get their teeth removed [...] I’ve got clients pulling their own teeth out” (Support worker)*

*“Lots of people pull their own teeth out [...] they just aren’t able to receive the support quickly enough” (Support worker)*

## e) Palliative Care producing good outcomes – but not with nearly enough capacity

People experiencing homelessness have a significantly reduced life expectancy; the mean age of death for males who are homeless is 47 years and for females 43 years compared to a mean average age of death for people living in homes of 76 and 81 years for men and women, respectively. Overall, people who experience homelessness have a 2 to 5 times higher age-standardised mortality ratio than those who are not homeless, with very little improvement over the last decade. We know that it is factors such as substance use that contribute to this low life expectancy, but is it also the higher burden of disease that homeless people carry. As a consequence, the need for palliative care within the homeless community can be assumed to be high.

Unfortunately, our interviews show that there is a strong disconnect between the number of people who would benefit from palliative care services versus the number of people who access those services in Cambridge. A conversation with a local palliative care consultant suggested that only two people experiencing homelessness accessed the palliative care service in 2022. Very few homeless people are referred to the community palliative care team: perhaps due to healthcare providers feeling reluctant to refer people experiencing homelessness due to high likelihood of missing appointments, or because the practitioners do not often encounter homeless people in their practice, due to people experiencing homelessness being less likely to access mainstream health services. As a result, many people experiencing homelessness die in the hospital without palliative care input.

A lack of communication between primary and secondary care perpetuates the issue, as one example from a healthcare professional demonstrates: *“The patient hadn’t been given a prognosis from the hospital [...] their GP had to speak to the person about end of life and the prognosis as there was no communication between them and the hospital [...] if the patient is terminal, they are entitled to extra benefits to make their last few weeks of life more comfortable such as attendance allowance [...] however due to poor communication the patient was not offered anything.”*

In cases where providers worked together and displayed evidence of joined up care, there were more positive outcomes. One case of a person referred to hospice care illustrates this:



*The person was in a situation of poor housing (sofa surfing) and suffering from complex mental and psychological symptoms when their bodily functions started to deteriorate quite quickly; the hospice team saw the person in several home visits before they admitted them into the hospice. “Because of the housing situation and the complexity of their symptoms, both physical and psychological, they ended up just staying in the hospice for [...] three months [...] they basically lived [there] for the last three [months] of their life [...] it was clear that discharge was not going to be practical for a multitude of reasons.”*

Overall, we observed that the palliative care services faced a number of challenges regarding the provision of care for people experiencing homelessness:

- **Unsafe and cluttered accommodation:** justified unwillingness of community teams to support at home; as one palliative care consultant described to us: *“in terms of thinking about putting care in place, I would be asking relatively untrained staff to go into potentially quite a difficult or possibly unsafe situation.”*
- **People not attending appointments:** unclear if this is because they have missed it or if there is a concern which needs to be addressed
- Need for **opioid prescribing**
- **Limited capacity in the hospice** (12 beds) meaning demand is always greater than supply; how do we choose who is receiving support?

## II.III Non-healthcare providers: Attempting to bridge the gap

### **Outreach groups doing a great job - providing immediate care and triaging people**

In addition to the aforementioned street outreach work provided by both CAS and the CGL HEART team, two further outreach providers are key actors for people experiencing homelessness in Cambridge. Both the CGL Street Outreach Team and the outreach van, which is manned by a number of different professionals, provide an important service helping to identify homeless people and establish their needs, provide (basic) healthcare during their outreach and support people in navigating the healthcare system.<sup>34</sup>

The CGL Street Outreach Team received consistently positive reviews throughout all our interviews. One service user described how before talking to street outreach:

*“It [had] been a long time since I’d felt heard.”*

*“It’s starting to feel like it’s having an impact. ...there still remains this barrier at the clinical interface, but going out and actually sitting with people on the street at their begging site [...] talking to them helps to break down those barriers. It shows that we’re interested and we will sit with them and treat them like a normal human being [...] so I think outreach is really good.”* (Healthcare Provider)

The outreach van, which was initially loaned to Cambridge Street Outreach in 2019, is officially run by CGL and has helped many people with both accessing immediate healthcare and navigating other parts of the healthcare system. Staffed by members of CGL, CAS, the HEART team as well as the Dual Diagnosis Street Team, the outreach van goes out every Wednesday afternoon from 3pm into the early evening. In line with general research, the outreach van’s work was widely welcomed as very positive by people we interviewed.

### **Charities and voluntary sector utilise in-house support to bridge gaps**

Throughout this report (e.g. Section II.II. C. Mental Health) we have highlighted the vital role which non-healthcare providers play in assisting people experiencing homelessness in Cambridge with navigating and overcoming healthcare access barriers.

While housing providers, such as the Cyrenians and Jimmy’s Cambridge do not have a mandate to provide healthcare, they identified several unfulfilled healthcare related needs among the people they housed and supported. Accordingly, both Jimmy’s and the Cyrenians fund-

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34 They also help people navigate other parts of the homeless sector, including benefits and housing.

raised for and started providing dedicated mental health support in-house within the last two years. While the support is generally basic (e.g. anger management), we heard from several people that benefited from these interventions as a way of starting to address their mental health challenges.



*“If it wasn’t for [the in-house mental health worker] I wouldn’t be who I am today”*

*(Service User)*

In addition to this dedicated mental health support, housing providers in Cambridge generally support their residents with navigating and accessing the healthcare system. This support, which is usually provided by key workers, can range from signposting people to appropriate healthcare services, to arranging and accompanying people to appointments (e.g. at CAS or the hospital).

Wintercomfort fulfils a similarly important function and serves both as a place for direct welfare support (e.g. in the form of meals, clothing and showering facilities) and as a hub for advice, information and dedicated healthcare drop-ins. Wintercomfort works with around 750 homeless or vulnerably housed people every year and provides named project worker support for every person who visits. Additionally, specific project workers support people around topics such as Inclusion, Women and Health and Wellbeing among others.

Healthcare specific services at Wintercomfort include weekly drop-in clinics with a nurse and doctor from CAS (Thursdays), weekly drop-in sessions with CGL drug and alcohol service (Tuesdays and Thursdays), in-house counselling sessions (Tuesdays and Wednesdays) and weekly drop-in with the Dual Diagnosis Street Project (Wednesday and Fridays). Wintercomfort workers also attend the outreach bus to assist with locating harder-to-reach people and to maintain direct links to Community Psychiatric Nurses at Union House. Similar to the housing providers, Wintercomfort also provides more general wellbeing support (e.g. cooking lessons, swimming lessons, podiatry services) which are seen as tremendously helpful for people struggling to access such services.

## II.IV Deep Dive: Barriers for women experiencing homelessness

### Introduction: the different experiences of women

We have known for a long time that women experiencing homelessness have very different experiences to men. However, there has consistently been a large gap in research about women's experience of homelessness and their differing needs.

Women typically have different trajectories through homelessness compared to men. For instance, women are more likely to be 'hidden homeless' and are less likely to be visible on the street but instead rely on support from family or friends and sofa surfing. This 'invisibility' can lead to underreporting the issue of women's homelessness. Furthermore, a larger proportion of women compared to men who experience homelessness will be involved in sex work or survival sex which was also mentioned during our interviews with women in Cambridge.<sup>35</sup>

Lastly, women are very likely to experience more than one episode of homelessness as described in a 2021 report based out of Camden, London. One women's support worker explains a reason for this 'falling back into homelessness' in an interview with us:

*"I think people assume that once you're housed [...] that's your work done [...] they'll be able to manage their bills, they'll be able to negotiate contracts with utilities providers, open mail and buy food and keep the house clean [...] because they're a woman. It's a myth...women need a lot of nurturing and a lot of support because often there's childhood trauma that they've gone through."*

Homelessness among women has increased during Covid, in part caused by rising incidence of domestic abuse, which in itself is one of the three major reasons for women to become homeless, and this link was also observed in Cambridge directly. Overall, women experiencing homelessness are more likely to have children (47%), either with them or separately in social care (23%). In 2021, the number of homeless families rose in Cambridge.

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35 Survival sex can be defined as the process of engaging in sex to meet their immediate needs, this can include sex for rent – using sex to remain in accommodation or sex for drugs. A 2018 study by Shelter found that over the last 5 years 250,000 women had been asked for sexual favours in place of rent and others conclude how vulnerable such practices make women experiencing homelessness more widely. Unfortunately, during our interviews we were unable to understand how women in Cambridge experience sex work or survival sex directly; our interviews with service providers also described how 'reading between the lines' was required to understand people's experiences of sex work.




## The healthcare needs of women experiencing homelessness

In line with most people experiencing homelessness, women have significant mental health, substance use, and physical health needs. In particular women who engage in sex work have disproportionately worse health relative to the general population, this includes both their mental and physical health.

A recent study by Groundswell illustrated that 74% of women experiencing homelessness had a current physical health issue frequently exacerbated by their living situation. STIs are especially prevalent among women with up to 50% of women affected. The same Groundswell report found that 64% of women experiencing homelessness struggled with mental health issues compared to 20.7% of the general population of women. The most commonly diagnosed issues include depression (45%), anxiety/phobia (29%) and post-traumatic stress disorder (PTSD) (18%). Different studies show that women experiencing homelessness are 1.82x more likely to have tried to commit suicide in their lifetime and 2x as likely to have a psychiatric hospital stay. Substance use is also high among women experiencing homelessness, with a recent BMC report finding that 37% of women used drugs other than alcohol daily or almost daily (13.5% weekly, 18.5% monthly).

Trauma plays a significant role in the lives of women with experiences of homelessness with some studies suggesting that 100% of women in situations of homelessness have experiences of trauma; this was also the consensus among all our interviews. Trauma can include experiences such as adverse child experiences, domestic abuse or the loss of a loved one. Domestic abuse is another prevalent source of trauma with studies concluding that over 90% of women experiencing homelessness have suffered from domestic abuse often contributing to development of complex PTSD and a variety of physical symptoms.



over 90% of women experiencing homelessness have suffered from domestic abuse

# The double disadvantage: Women face gender-specific barriers when accessing services

Overall, we know that women have a considerable need to access healthcare services for both physical health, mental health and trauma; yet in addition to the normal barriers affecting all people experiencing homelessness, our interviews highlighted that women face additional gender-specific barriers.

## a) 'Tough behaviour' and attachment to men to stay safe

Overall, women are more vulnerable on the street to abuse and violence. To protect themselves, women can be found to develop 'tougher behaviour' as one support worker explained to us:

*"Women are more vulnerable – just because women are at higher risk of abuse, [they] must have a tough exterior [...] Many women [...] are far tougher than the men – if they are soft they get taken advantage of [...] Women typically come alone or with men typically."*

The support worker and others also pointed towards a particular type of relationship that can be formed between women and men, at times formed for the purpose of protection for the woman. Not only can this lead to the threat of additional abuse and violence but it can also lead to isolation, as another support worker described to us:

*"Isolation is a massive issue for women [...] a lot of women [...] don't create community amongst themselves in the homeless community, because the men do. So you'll find one woman in a group of men, you'll find a group of men, but you won't really find a group of women supporting each other, because the women need protection on the street, and so they attach themselves to a man."*

## b) Impact of trauma and perceived safety on attendance of services

Women may not access certain homeless services, or access them less frequently, depending on the perception of the safety of the service and the group that attends it. This was often seen at Wintercomfort where it was noted that there was a higher ratio of men to women. One support worker described:

*"Women tend not to spend as long here [Wintercomfort], the guys see it as a social hub. Some women stay for the whole day but it is quite rare, they often come for a meal and then leave immediately."*



The same problem was also highlighted with regards to healthcare settings such as the drop in sessions offered by CAS. One support worker argued:

*“Having drop-ins are great. But what it ends up being is a room full of pissed men being loud and lairy. What girls don’t want is to wait in that, because it’s scary. So they’re sort of disenfranchised simply by the way the system is set up in instances like that.”*

Unfortunately, women may not always be able to vocalise these fears, hence their reason for not attending may often go unnoticed or staff must read between the lines. This issue was noted by a number of different staff members.

### c) Stigma/Prior negative experiences

Trauma from prior experiences can make interacting with healthcare professionals more challenging. Previous negative experiences with healthcare professionals can lead to distrust and quick decisions to disengage from the service. One service provider described this to us:



*“I think these women are acutely aware of judgement and acutely aware of the language that you use. [...] The experiences that they have may have been incredibly negative in the past, from professionals. Many of the women will talk about previous admissions to the hospital where they felt [...] that things were said to them that were incredibly judgmental.”*

Additionally, women are seen to have a tendency to be more easily intimidated by disciplinary action from healthcare providers than men, resulting in a possible reluctance to re-access the services. One support worker brought one person’s example up in our conversation:



*“We’ve got [a woman] at the moment who was suffering very heavy bleeding. We suspected she was haemorrhaging. It was so severe that the hospital was desperate to get hold of her. But she had walked out of the hospital because she’d gone outside to have a [cigarette]. [Afterwards, she was] given an absolute bollocking by the security guard. So she just did the classic ‘Well fuck, you’ and walked off. And now she won’t re-access.”*

### d) Sex work and stigma

Support workers explained to us that many women who have experiences of sex work will not admit this to healthcare professionals for fear of judgement and discrimination. As a consequence, they may not present to healthcare services and health problems remain untreated. One service provider described one woman’s experiences to us:

*“Last week, I dealt with a woman who’d been stabbed in the head, she’d been stabbed in the chest, stabbed in the back [by a sex work client]; the hospital discharged her. She was still bleeding.”*

The wider literature confirms that women who have undertaken sex work are often discriminated against in healthcare settings. A recent seminar by Homeless Link highlighted the direct

implications for women engaging in sex work when trying to access healthcare. The study found that female sex workers received judgement and stigma when accessing and engaging with healthcare services and also concluded that prior negative experiences of healthcare services had a significant impact on women's motivation to engage further.

### e) Impact of trauma from the removal of children or prior and ongoing abuse

Women experiencing homelessness face challenges when accessing healthcare which are often connected with previous experiences of having a child removed from their care by social services, which is in itself a traumatic experience. One healthcare provider described to us:



*“One of the biggest barriers is that women will very likely have been through the incredibly traumatic experience of having a baby removed. They may be very, very reluctant to engage with care, because they’re very fearful of social services. that’s a really difficult barrier to cross.”*

The example of one service user makes this barrier especially visible. Kate (name changes), a female service user in her 50s had both experienced abuse and the removal of her child into foster care. Before our conversation, Kate had recently lost her husband and was struggling with grief and ongoing trauma. Despite multiple episodes of attempted suicide (“I overdosed seven times”) and self-harm, Kate remains unwilling to talk to any doctors or health professionals about her ongoing grief.

A second woman we interviewed who was a survivor of sexual abuse was struggling to access healthcare services and unable to vocalise her fear of being seen or treated by a male doctor or male support workers in particular.

*“When my new [male] doctor touches me I just freeze. [...] I don’t mind if I have a male or female doctor...I have a male doctor now and he is a nice bloke – sometimes it feels wrong and I get paranoid and I freeze [...] If I am with a bloke I am scared; I can’t explain it, when I was little [...] I always look behind my back seeing if anyone is coming.”*

Ongoing coercive or abusive relationships can also have a direct impact on women's ability to access services. Such relationships which are paradoxically often part of a supposed protection mechanism for women (see above) can have direct implications for women attending appointments. A controlling partner may gatekeep access to healthcare and which health issues are addressed. As one women support worker described to us:



*“A lot of [the women I work with] are forced to miss appointments by their boyfriends. And what happens is they’ll get a phone call or a letter from the hospital giving them a [warning] about wasting people’s time. And it’s not them that’s wasting the time, it’s the boyfriend. But the letter will totally intimidate them in a way it doesn’t seem to men as much, so they simply won’t re-access.”*

# Changing the narrative: Women's services in Cambridge help to overcome gender-based healthcare barriers

Within Cambridge, a number of services are already available that are creating safe, trauma-informed spaces especially for women experiencing homelessness. The Women's Resources Centre, for instance, provides everyday support (e.g. clothes, household items, support worker) as well as more specific project-based support (e.g. around employability). Many women accessing the service are victims of crimes and sexual abuse and support is offered specifically around the termination of pregnancies and support with stillbirth and miscarriages. Safe spaces for women are also created at Wintercomfort (e.g. women's evenings every Tuesday), at Edge Café (e.g. women's sessions) and at the Freedom Project. These spaces provide chances for women to 'relax more' and speak to other women with similar experiences in an informal environment. Women's only housing is currently provided by Corona House, a project of six self-contained flats for women (and women with children). Several activities are offered locally there, too (e.g. allotment sessions) and support is offered around mental health and substance needs. For women with low support needs, the Cyrenians women project also offers specific, safe accommodation.

When it comes to healthcare, a special ante-natal care is offered specifically for women who use drugs. New people are introduced to the service usually via a trusted person (e.g. CAS nurse) enabling the forming of the necessary close relationship. Overall, the feedback on this service and the referral pathway was very positive from other service providers. Unfortunately however, we were not able to hear from a person who used the service first hand. One issue with the maternity service is the lack of continuous care. As one service provider explained:

*"The maternity services finish at 28 days, postnatal, so after the baby is born, that is the end [...] which is kind of odd [...] sometimes it is quite difficult because [the people are] really involved and then [they] literally just have to walk away."*

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The impact of the women's only services and safe spaces in Cambridge was seen as enormously positive throughout our conversations. It was felt to be especially important and impactful when long term trusted relationships were built between women and service providers. People who accessed the women's spaces described above mentioned in our interviews that they particularly benefited from having the possibility of speaking about their experience of domestic violence and they also felt that by bringing women together from all backgrounds it empowered them to share experiences more generally. One women's support worker explained:

*“The actual experiences are so similar across the board with the diverse range of family dynamics, and I think that is very liberating for everybody to see [...] that crosses all barriers. [...] The bonding is really, really amazing to watch.”*

Sharing experiences was overall seen as having a very positive impact on women experiencing homelessness accessing healthcare. Another support worker explained one example of this:

*“There was a new lady at the [women’s group] who’d never been before, and there was another lady there. She wanted to go to the access surgery, but had never been, and so, the woman who’d come for the first time was like, Oh, I’ll walk that way with you and show you where it is. [...] Because of that space where they met that was enabled. So that’s the sort of thing it sounds like really baby steps but that’s the sort of thing that [is happening].”*

## Ongoing challenges remain around gynaecological and sexual health services and the lack of supported women-only accommodation

Our interviews pointed at the low number of women-specific accommodation in Cambridge and especially the lack of accommodation for women with complex needs. This lack of adequately supported accommodation linked with the lack of available childcare causes many women to be in a position where taking care of their own health needs is seen as secondary.

Overall, our interviews pointed to the need for more women-only or women-specific health-care service provision. Given the observed access barriers (e.g. past and ongoing trauma), the available healthcare both at CAS and the hospital was perceived to be less focused on women’s health or mental health as one service provider concluded:

*“CAS, while it is amazing, is not a specialist women’s service. So often, women’s issues, whether they’re gynaecological or mental health, are regarded through the lens of ‘you are a drug addict and you’re homeless’, so they won’t necessarily get the best advice.”*





# III Conclusions

**People experiencing homelessness suffer disproportionately from health problems across the spectrum of physical and mental health and substance use. In this report, we focused on mapping empirically which barriers to healthcare access exist for people experiencing homelessness in Cambridge.**

Our observations, based on both experiences of people who are or were homeless in Cambridge and service providers, point towards a number of healthcare barriers, five of which are particularly prevalent:

- **A&E:** access remains a large barrier as a result of a systemic lack of trauma informed care, and the long wait times have shown to be inaccessible to people with substance use
- **Dentistry:** despite being one of the largest areas of demand, inadequate numbers of practices frequently results in service users forced to attempt to access services outside of Cambridge
- **Palliative care:** while the service itself works extremely well with trauma informed care, referrals to palliative care are infrequent despite the large demand
- **Mental health care:** although specialised services were often viewed positively, these were underfunded, with the inflexibility of mainstream services making them frequently inaccessible
- **Women-specific care:** while the available support (e.g. by Women's Resource Center) is well-received, specific gynaecological care among others remains hard to access
- There are multiple key contributors for people to overcome healthcare access barriers in Cambridge and we want to highlight three of them in particular, also as possible models for addressing problems in other parts of the ecosystem.
- **HEART team:** since 2021 CGL's HEART team's flexible substance and alcohol use support delivered mostly in an outreach capacity was seen very positively
- **CAS:** as principal primary care practice, CAS not only provides high quality healthcare directly but also plays an important role for people to access other healthcare services
- **Housing providers and day centre:** filling ecosystem gaps, non-healthcare providers support people to access other healthcare and provide in-house support (e.g. around mental health)
- Overall, we observed the lowest barriers for people in Cambridge when (healthcare) services were offered flexibly, delivered where and when people needed and demanded them (e.g. during outreach) and provided in a way that was specific for people experiencing homelessness (e.g. specific service or space or time period).

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Within the limited scope of this nine month project, we were not able to address all crucial questions and leads. We want to point towards several areas of research which warrant further scrutiny based on our observations:

**Experience of other groups, especially through the lens of intersectionality:** our broad approach while allowing for a large variety of observations prevented us from going deep into the experience of specific groups, beyond those of women. Despite our best attempt to also e.g. understand the experience of people who identify as LGBTQ+ we were not able to collect enough data. A longer follow-on project is needed to focus on experiences of specific groups, which could also include observations on the role ethnicity plays in people's experiences of healthcare barriers in Cambridge.

**Moving from identifying barriers to providing solutions:** the sole focus of this project and the final report is to identify healthcare barriers for people experiencing homelessness in Cambridge. In order to productively move forward from the identified barriers, the focus needs to eventually shift to best practices in the respective areas. Providers such as Pathway could provide these kinds of insights, based on their extensive experience working with NHS

We hope that our research and the final report will provide insights and observations which are helpful for further improving healthcare provision in Cambridge for people experiencing homelessness.

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