

#HealthNow

West Yorkshire:

Understanding homeless health inequality in
Calderdale, Kirklees and Wakefield



Groundswell

Out of homelessness

Acknowledgements

We would like to say thank you to everyone who contributed thought, time and local knowledge to make this research possible. In particular, thanks to those at the following services in Calderdale, Kirklees and Wakefield who supported us to arrange interviews: Bridge-It Housing, The Basement Recovery Project, Clare House, Craven Mount, The Gathering Place, Huddersfield Mission, Leeds Women's Aid, Marsh Way House, Ryburn House, Together Housing and Wakefield Council. Thanks also to Gill Leng for her advice, support and involvement throughout this project. Finally, we are extremely grateful to all those who participated in the research; thank you for sharing your time and stories with us. We aim to ensure that your contributions count towards making a positive change.

This work was funded by West Yorkshire Health and Care Partnership.

About Groundswell

Groundswell works with people with experience of homelessness, offering opportunities to contribute to society and create solutions to homelessness. Participation is at our core because the experience of homelessness is crucial in making decisions that affect lives and ultimately help people to move out of homelessness.

Groundswell exists to tackle:

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

We achieve this through:

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

Contents

Executive Summary	5
Background	6
Understanding Homelessness	6
Homelessness and Health.....	6
Homelessness and Health in West Yorkshire	7
What we did	8
Peer elements.....	8
Who we heard from	9-10
Findings	11
Barriers to accessing treatment	11
Prioritising health	12-13
Digital exclusion.....	13-14
Transport costs and mobility	14
Dentistry.....	15-16
Mental health treatment.....	16-17
The role of relationships	18
The relationships with mental health practitioners.....	18-19
Relationships with GPs	20-21
Diagnosis and coordinated care.....	22
Community Pharmacies	22-23
Drug and alcohol dependencies as a barrier	24
Experiences of discrimination at pharmacies.....	24-25
Mental health access for people with drug and alcohol dependency issues.....	26
Drug and alcohol dependency and GPs	27
Unmet mental health needs and consequences	28
The perceived role of GPs and consequences on physical health	28-29
Unmet mental health needs leading to homelessness	29-30
What works: overcoming barriers	30
Support from accommodation providers	30-32
Specialist homeless health support	32
Peer support.....	33-34
Next steps	35



Executive Summary

Between July and October 2021, 75 interviews were carried out with people experiencing homelessness in Calderdale, Kirklees and Wakefield.

The majority of these interviews were conducted by researchers with lived experience of homelessness and explored experiences of using health services and the barriers to accessing them.

The research was aimed at creating a better understanding of health inequalities in order to create a local-level action plan for eradicating the barriers identified.

The key findings were:

- **Prioritising health:** Financial barriers and the stresses of homelessness often prevented health needs from being met. A lack of access to nutritious food worsened existing health conditions.
- **Access to dentistry:** A lack of information about access, and the challenge of remaining registered while homeless, meant that few participants had seen a dentist in the previous year, despite a clear need to do so.
- **The effects of the pandemic on relationships with GPs:** The frequent need to change GPs when insecurely housed, coupled with restrictions on face-to-face appointments, exacerbated existing difficulties with establishing trusting relationships with GPs. Those who had maintained long-term relationships with an individual doctor reported the most positive experiences.
- **Patient-led treatment:** Feeling listened to and involved in treatment were highly valued. Many participants felt uninformed about treatment, test results and diagnoses, resulting in feelings of disconnection and disempowerment.
- **Positive relationships with pharmacies:** Consistent relationships with pharmacy staff were sustained throughout the pandemic and these staff were highly praised, particularly for their non-judgemental attitudes and personalised advice.
- **Stigma of drug and alcohol dependencies:** Accident and Emergency units and GPs were often identified as exhibiting discriminatory behaviour towards those with addiction issues.
- **Addiction as a barrier to accessing mental health services:** Participants experiencing drug and alcohol dependency were less likely than others to successfully access mental health services. They felt that GPs and mental health services often misunderstood the relationship between mental health and addiction.
- **Untreated mental health conditions affecting trust in health services:** Expectations of GPs' role in referring to mental health services were high. When these expectations were not met, it could lead to a loss of faith in the NHS and a consequent disengagement from services. In turn, this led to a worsening of physical health conditions.
- **Unmet mental health needs leading to homelessness:** Around half of participants thought that their homelessness could have been prevented if their health needs had been better met beforehand. Women were twice as likely as men to believe this. The unmet needs discussed in relation to this almost exclusively related to mental health.
- **Praise for specialist homeless services and peer support:** Dedicated health outreach services, especially in homeless daycentres, were positively regarded. Some support and advocacy, however, exposed power inequalities and feelings of helplessness. Support from people with lived experience of homelessness and addiction was enthusiastically supported as a solution.

Background

Understanding homelessness

This research explores how people experiencing homelessness engage with and experience health services in Kirklees, Calderdale and Wakefield. In order to explore this topic, it is important that we first outline what we mean by 'homelessness'. Within the context of this research, homelessness is considered broadly and encompasses a range of unsafe, insecure and temporary accommodation. We therefore aimed to reach people in various accommodation situations, including, but not limited to, those who were rough-sleeping or staying in temporary accommodation, hostels and emergency accommodation.

This understanding of homelessness is reflected by FEANTSA's European Typology of Homelessness and Housing Exclusion (ETHOS), which covers four different situations that amount to homelessness, including rooflessness, houselessness, living in insecure housing and living in inadequate housing.

Homelessness and Health

Health and homelessness are fundamentally linked. People experiencing homelessness are more likely to experience poor physical and mental health and comorbidities. In addition, people experiencing homelessness frequently encounter heightened challenges when accessing and using health services due to practical, social, systemic, administrative and attitudinal barriers. These factors and increased levels of need lead to significant health inequalities for people experiencing homelessness. Consequently, people experiencing homelessness are more likely to require urgent and emergency care due to advanced illnesses or conditions, rather than accessing preventive and primary health services.

It was [reported](#) that deaths among people experiencing homelessness rose by more than a third in 2020, equating to someone who is homeless dying every nine and half hours. The Office for National Statistics reported in 2018 that the mean age of death for men who died while homeless was 45; for women it was 43. This already stark picture became yet more concerning when [research from UCL](#) found that one out of three people experiencing homelessness die from treatable conditions.

While good work has been done across England in

carrying out Homeless Health Needs Audits, it is difficult to develop concrete actions to improve health for people experiencing homelessness without exploring trends in patient experience. Discourse about the premature death of rough sleepers has mostly focused on a lack of housing.

The Government's [Rough Sleeping Strategy](#) recognises that, 'there is a clear link between homelessness and health and wellbeing which is not always being made at the local level, which we are keen to address'. Despite pockets of commissioning for specialist homeless health services, there is a lack of strategic joint-action planning to address the barriers to using mainstream services that lead to inequalities.

In the first year of this project, Groundswell completed a [literature review](#) to gather and understand patient experience to inform the #HealthNow research and overarching campaign. The key issues identified were:

- People experiencing homelessness often have poor experiences of accessing and interacting with healthcare services and when leaving treatment. This is experienced throughout the healthcare system, but the evidence is particularly strong in primary care.
- People experiencing homelessness often felt dismissed by healthcare practitioners based on discourses of drug addiction, stigma and discriminatory attitudes and behaviours.
- The coordination of healthcare plans for those experiencing homelessness are fragmented and paternalistic and often fail to consider the barriers to accessing appointments and long-term treatment.
- Key barriers to accessing healthcare include lack of phone credit, poor access to the internet, lack of ability to travel to healthcare centres, lack of accessible information and assumptions that a fixed address is needed to access services.

Furthermore, Groundswell's [research](#) has demonstrated that COVID-19 and the response to the pandemic have significantly impacted the ways in which people interact with healthcare services. In some cases, this has led to increased challenges for people experiencing homelessness when accessing support and treatment. However, new ways of working have also illustrated the flexibility of the healthcare system and presented valuable learning on how to address broader health inequalities. These issues will be reflected upon alongside the empirical findings from this peer research and used to inform the subsequent action plan locally.

Homelessness and Health in West Yorkshire

West Yorkshire is a county in England comprising Leeds, Bradford, Wakefield, Kirklees and Calderdale. Research conducted by Shelter (2018) found high levels of homelessness across the West Yorkshire region and estimated that almost 1500 people were either in temporary accommodation or rough sleeping. Across this region, Wakefield was identified as having the highest estimated levels of homelessness, with one in 862 people experiencing homelessness. This estimate did not include people experiencing 'hidden homelessness', such as those who were 'sofa-surfing', so the scale of homelessness is likely even higher.

In their [five-year plan](#), West Yorkshire Health and Care Partnership outlined key commitments to be adhered to by the Integrated Care System (ICS) to address health inequalities. They committed to:

“Work with specific population groups about planning and priorities. We will start with population groups we know to be greatly affected by inequalities in health; those living in poverty; people living with learning disabilities, those living with serious mental illness, unpaid carers, veterans, and those in contact with the justice system, ethnic minority groups and homeless people to help tackle health inequalities.”

A Homeless Health Needs Audit has not been conducted to date in West Yorkshire but significant local-level work has been done to understand the complexities of 'street deaths' and how the system can most effectively respond to the needs of people with multiple and complex needs (MCN) including homelessness. The ['Burnt Bridges? Thematic Review'](#) illustrated the complexities that arise in relation to supporting people with MCN productively and in a joined-up way. Among several recommendations to arise from this work, service and commissioning processes were urged to consider MCN to ensure that those experiencing barriers to health services get their needs addressed. [Work](#) by West Yorkshire – Finding Independence (WY-FI) illustrated the prevalence of MCN – or multiple disadvantage – across the region, and estimated that the number of people accessing homelessness, addiction, re-offending and mental health services was nearly 44,000. Almost 7000 of these people were likely to be accessing three or four services.

Meeting the needs of those experiencing MCN was central to the work of the WY-FI Programme which, until the project came to a close in 2021, was operating in West Yorkshire as one of the 12 Fulfilling Lives Partners. Throughout the duration of the programme, WY-FI supported over 800 adults facing multiple disadvantage, and in the final year of delivery aimed to “support a collective and strategic approach to ensure people experiencing multiple disadvantage continue to receive effective support”. A key outcome of this aim was the establishment of West Yorkshire Multiple Disadvantage Consortium which brings together experts by experience, delivery partners, and statutory organisations to ensure the system works as one for people experiencing multiple disadvantage.

What we did

We carried out 75 interviews with people who were, or who had very recently been, homeless in West Yorkshire. We asked them about their experiences accessing and using specific health services and about their overall feelings about healthcare. This research was carried out during the COVID-19 pandemic, between July and October 2021. Because of COVID restrictions, we planned to carry out all the interviews by phone but, as restrictions eased, it became possible to meet participants face-to-face. In total, about two thirds of the interviews were conducted in person. Interviews generally ranged in length from about 20 minutes to well over an hour.

The interviews were based around a survey format but also included open-ended questions. This meant that we were able to gather statistical evidence, but we could also seek to understand the feelings and stories that lay behind the numbers.

We asked participants to give a rating out of 10 for each of the health services they had used. So that we could better understand when issues and barriers were brought on by the unique circumstances of the pandemic and when they were ongoing problems that had already existed, we also asked them to give ratings out of 10 for their experiences before the pandemic.

Statistical analysis of responses to survey questions was carried out alongside thematic analysis of interview transcripts. Using these two methods together enabled interpretations of statistical data that were informed by explanations and elaborations given by participants in their own words. We stored personal data in line with our data protection policies.

Peer elements

The majority of interviews were carried out by researchers with lived experience of homelessness. The survey was based on the research tool used in the #HealthNow research in Greater Manchester, Birmingham and Newcastle, which benefitted from extensive peer input. People with lived experience of homelessness co-designed and piloted the survey tool. People with experience of homelessness were also invited to stakeholder engagement workshops and findings workshops to help inform the scope and direction of the research and its findings.

Who we heard from

We arranged interviews via eleven services, some of which gave us access to several individual projects. We also carried out eight interviews with people we met in the streets, some of whom were sleeping rough and not accessing homelessness services. However, accessing this group of people was challenging and most participants we spoke to were currently accessing support from homelessness services. This likely means that those who were most disadvantaged and struggling to engage with services were under-represented.

25 participants were staying in supported accommodation or hostels, 16 were in temporary accommodation, 1 was staying in a hotel (provided under the ['Everyone In'](#) initiative), four were accommodated in a women's refuge, 2 were informally and insecurely housed by friends or family (sofa-surfing) and six were sleeping rough. We also interviewed 9 people in social housing and 7 in private rented accommodation. Although those people were not currently homeless, all of them had been until shortly before the time of interview. This provided a unique perspective on homelessness and healthcare; participants could reflect on how their situation had changed and what had helped them to make those changes. They were also still experiencing many of the same issues as they had done before, including poverty, recovery from drug and alcohol dependencies and ongoing health problems.

In terms of geographical location, we attempted to match approximately the distribution of recorded homelessness for each area. The numbers of people we were able to speak to though was partly dictated by practicalities such as the capacity of services to support recruitment under COVID restrictions. In some cases, we were forced to abandon visits to projects because of localised COVID cases, which also affected the eventual numbers of participants reached. In total, we spoke to 32 people in Wakefield, 19 in Kirklees and 24 in Calderdale.

40% of participants identified as female, 58% male and one participant identified as non-binary. 99% told us that their gender was the same as that assigned at birth. 4% of participants were aged 18-20. 14% were aged between 21 and 30, 41% 31-40, 22% 41-50 and 18% were over 50.

71% of participants identified as being of White-British ethnicity. Only five participants were born outside the UK and none of those people answered that they were ineligible for public funds.



These numbers are unlikely to represent the nationality and ethnic make-up of people experiencing homelessness in West Yorkshire. We made efforts to rectify this as the data collection progressed by, for example, contacting services dedicated to supporting refugees and asylum seekers but, despite their efforts, we were largely unsuccessful in reaching these groups. Reluctance to share information and wariness of unfamiliar organisations are understandable for people of uncertain legal status. There are many reasons to believe that these groups experience, or are at risk of, homelessness, and that they are victims of the health inequalities that this research addresses. For these reasons, a local needs assessment of the experiences of refugees and asylum seekers that seeks to address the issues we encountered seems like a clear need.

We also tried to reach people who were staying in the more rural areas of the region but, again, were largely unable to do so. Although we did manage to speak to people staying in some smaller towns, most participants were currently living in Halifax, Huddersfield or the city of Wakefield.

Some participants chose to avoid certain topics or found the survey overlong, which sometimes meant that researchers did not ask every question. Participants who, for example, struggled with particularly poor mental health or were suffering from fatigue because they were sleeping rough may have answered fewer questions. Some of the statistical data, therefore, may not reflect the views and experiences of those with the most disadvantages.

We took care to ensure that the anonymity of those who took part was preserved. We have not used participants' names in this report and have made every effort to exclude other information that might identify them. Where participants have been directly quoted, we have noted their accommodation situation and geographical area, but we made exceptions in a few cases when this information might reveal their identity.

Findings

It became clear from our analysis that experiences of engaging with individual services could not be interpreted in isolation. People's experiences of engaging with the healthcare system are complex, and often include interactions with several services. Access to adequate mental health treatment, in particular, was central to many participants' experiences of the healthcare system as a whole. For this reason, mental health treatment is discussed here in several different contexts. The Findings section is structured according to themes that arose from our reading of interview transcripts that cut across answers to questions about all the health services we asked about.

Some of the issues identified in this report are not exclusive to people experiencing homelessness but could apply to anyone. This research, however, explores how people who are homeless not only encounter more barriers to such opportunities for improved healthcare but are also disproportionately affected when those standards of healthcare are inaccessible.

Barriers to accessing treatment

Nearly all the people we spoke to had had some form of engagement with health services over the previous year, and most participants (97%) were registered with a GP surgery. By comparison, our previous research had revealed that 94% of people experiencing homelessness in Greater Manchester were registered with a GP, 88% in Birmingham and 81% in Newcastle. As with those areas, some participants in West Yorkshire told us they had struggled to register in the past because they had lacked identification or a home address, despite the illegality of refusal on these grounds.

"I couldn't register before because I didn't have an address... I tried it and stuff, but I couldn't give them address; they wouldn't accept me."

(Social housing, Kirklees)

This participant told us that, had he been registered with a GP and had "a medical every three or six months", a recent admission to a hospital Accident and Emergency unit might have been prevented. But, if unnecessary use of A&E is a good indicator of failures in effective health engagement and treatment, simply being registered with a GP is only a small part of the picture. Despite the high level of registration, 39% of participants had used A&E in the year before they were interviewed.¹ Of those, 29% answered that they had used urgent and emergency services at some point in the past because they were unable to access community healthcare. Few of these participants, however, had strong opinions about what could have been done to prevent them needing to use these services. Some accepted serious health problems as an inevitable consequence of homelessness.

"When I ended up on the streets... and the pandemic hit, I was drinking regular. And I just didn't have anywhere to go apart from my bench, so I ended up in hospital ... and they said, 'you have been in a coma for two days with a collapsed lung'."

(Sofa-surfing, Kirklees)

But while rough sleeping and other forms of homelessness certainly do have negative impacts on health, and while access to primary health services was sometimes an issue, our findings suggested that the barriers to accessing adequate healthcare were often far more complex and subtle.

¹ This number is likely to be higher; this question, which asked participants to choose from a list of urgent and emergency care services, had no option to say "none". We therefore cannot know how many participants had not used emergency services and how many were not asked the question.

Prioritising health

We asked participants about health conditions that they were currently experiencing or had experienced in the last 12 months. Among numerous conditions mentioned in response, the most common were muscle and joint pain – especially back pain – and respiratory conditions such as asthma and Chronic Obstructive Pulmonary Disease (COPD). In its [Core20plus5](#) approach to reducing health inequalities, NHS England identified COPD as one of five clinical areas of focus that lead to avoidable deaths among the most deprived 20% of the population. **64%** of participants said that they had had some sort of physical health condition but this figure is likely an underestimate, not least because many participants told us that homelessness had meant they were unable to take their health seriously. For some, only the most pressing of health needs seemed important and even those often went unaddressed. One participant, recently moved into her first rented accommodation following 11 years of homelessness, told us that her health had only now become a priority:

“I have had a lot of pain issues, but I didn't go and see anybody... because I had a broken femur when I was young and I have had a lot of health issues with that. But with being homeless it was just – I never even went to go and try and get any help, care with it. That is the last thing you think about when you are homeless.”

(Private renting, Wakefield)

Homelessness is stressful and traumatic, and the need to relieve these stresses often trumps any other needs. The most obvious priority is to find somewhere to live, and we often heard how that meant that health became a secondary concern.

For some, drug and alcohol dependencies could be a more pressing concern than physical health problems. This did not mean that health concerns were seen as less important, but that meeting the needs of addiction had to come first. Those needs demanded time and money, and ignoring them meant could mean feeling unable to engage with health services.

“I am supposed to be in hospital this month for keyhole surgery – gall bladder. But I might not make it. I might make it if I have still got time, and I get paid. So, I should have stability to get to the hospital.”

(Sofa-surfing, Kirklees)

As health conditions worsened over long periods, this pattern could become life-threatening.

“If I hadn't stopped, hadn't been put in hospital with blood clots in January, I would have just carried on my life. Which is scary.”

(Support housing, Calderdale)

48% of participants said that they had missed a healthcare appointment in the previous year. The way this question was asked did not account for how many appointments participants had made or whether appointments had been made on their behalf. This meant that conclusions about what influenced the likelihood of missing appointments were hard to draw out, but sleeping rough was mentioned as presenting some specific reasons why attending appointments was particularly challenging.

“Recently, because I have been on the streets, I have contracted some disease against the sun – I am allergic to the sun. From being on the streets, no shade, nothing. Baked all day in the red-hot sun. My skin blistered and I get heat exhaustion. I am in bed for days. So if I have got an appointment a day later, I am knackered. I can't get there.”

(Temporary accommodation, Wakefield)

As in this case, non-attendance of appointments was not always because health problems were ignored; participants were sometimes very conscious of their day-to-day health needs but felt unable to address them.

Homelessness had other effects on health prioritisation. When we asked participants whether their health had been impacted by access to sufficient food, many told us that they had been unable to prioritise spending on it.

“I only get £208 a month from social. All my fines and things get taken off, so it doesn't go far once you have paid what you borrowed to get your food the next month. It's not a lot of money. I can go two or three days without eating sometimes.”

(Temporary accommodation, Wakefield)

Poverty and insecure housing made eating nutritiously problematic for many participants, and this had consequences for health. Those staying in temporary accommodation might find that “there were only a kettle as a facility”, but the challenge of maintaining a healthy diet was perhaps hardest felt by those sleeping rough or with certain existing health conditions. One participant had recently moved into temporary accommodation where he had access to cooking equipment for the first time in several years:

“My diet, it’s been shocking... you are drained, you feel right lazy, right achy all the time... With my IBS, there is only certain things I can eat, but when you go to a soup kitchen you get what they give you to eat, so you have to eat it. So to have pain for ten hour after going to a soup kitchen – I did that solidly for five years.”

(Temporary accommodation, Wakefield)

Another told us how the long-term malnutrition had prevented him from having a critical operation:

“It took them six months for them even to get to see a consultant about my hernia. It took longer, more like eight months before I even got to see anybody to have my operation. And then I gone to have it and when I went in that morning, they said we have sent you a text and that. And I said I haven’t received no text. That morning they cancelled it because they said I weren’t well; my heart weren’t strong enough for me to have the operation. I have got to wait till next year now, see if my heart has improved because it hasn’t repaired itself like it should. It’s not going to repair itself when I am not giving it the right protein and vitamins and everything else what it needs.”

(Rough sleeping, Wakefield)

Also mentioned here is a text message with important information that the participant did not receive, a reminder that this form of communication may not be inclusive of everyone,

Digital exclusion

This research was conducted during the COVID pandemic, a time when the NHS was increasing its use of digital communication. Participants were divided on whether digital communication was a good way for healthcare services to get in touch about their care and treatment. We asked them to choose as many means of communication as they liked from a list of options, which also included letters and contact through family or support workers. 51% listed text messages as one of their preferred contact methods and 29% included email. 80% included contact by phone. The majority of people we spoke to were currently accommodated, and this may explain why digital communication means were not seen as less desirable. Accommodation type (including rough sleeping) or length of time spent homeless did not have a statistical effect on how people said they would like to be contacted, but many participants’ accommodation situation had recently changed. Several participants who had experienced rough sleeping, either currently or in the past, told us about how difficulties obtaining and keeping a mobile phone had represented a barrier to accessing services.

“I know about [healthcare] because of word of mouth. That’s it. You haven’t got a phone when you are homeless. You can’t plug it into grass on side of bank of the river, can you? You can’t cook your meals and go on internet for half an hour while you are sat there next to fire.”

(Temporary accommodation, Wakefield)

“I am phoning ... in the morning; you can never get through. I have not got a phone. I am homeless; you know my situation. How am I meant to ring them every morning at 8am and I don’t know where I am going to be?”

(Rough sleeping, Calderdale)

These participants had no access to a phone, and they were frustrated that health services seemed unwilling or unable to adapt to their needs. Others who had experienced homelessness long-term may never have owned a mobile phone at all and felt alienated by an increased reliance on this technology.

“I have never even had a touch screen phone. I wouldn't know how to work one. Never sent an email, never had a laptop, never had a tablet. I don't know how to do any of this stuff. Social media – I have never been on any of it. I am analogue. A lot of people on the street are analogue ... I don't know anything about these things. I'm not joking. This phone I have got now: that is the first telephone I have had.”

(Social housing, Kirklees)

For another participant, the issue was not an inability to access or use a phone, but the feeling of being overwhelmed by the number of text messages he received from different health and support services:

“I seem to get a few different texts. I don't know what to do; I have got all these appointments. If I am honest, I just deleted them all because they confuse me that much and I can't concentrate on it, and I am sick of getting stressed out over it. And I have actually just deleted all my messages because of that.”

(Private renting, Wakefield)

Transport costs and mobility

Because Calderdale, Kirklees and Wakefield cover a broad, dispersed area, much of which is rural or semi-rural, we asked participants whether they thought their geographical location affected their access to healthcare. Most people we interviewed were living in Halifax, Huddersfield or the city of Wakefield – likely the reason just 20% answered yes – but there were some specific circumstances when location and transportation became an issue. The financial cost of attending health appointments created problems when people needed to move to another area to access accommodation. One participant, for instance, was given temporary accommodation in Wakefield but her GP was in Pontefract. Since she had “very limited money,” she had to “budget specifically for that train journey”.

The problem of transport costs was most discussed, however, by participants who had needed to visit a hospital. In some cases, participants were grateful to have received help by hospital staff to meet these costs, but others had been less fortunate.

“I were in pain but they kicked me out... My legs, they were killing. I have got an ulcer in my leg... They just had me waiting about nine hours. Give me some antibiotics and told me to walk home; 40 miles, 30 miles.”

(Rough sleeping, Wakefield)

Mobility problems caused health service access issues for several other participants, also unable to meet transport costs, and the consequences could be far-reaching.

“Because I have these leg problems I couldn't walk hardly. Sometimes I couldn't even get out my front door, and I kept falling off my prescription all the time, because if you don't pick it up for three days on the trot they kick you off. So, I couldn't get there and I phone them up – ‘I can't get there, I can't get there!’, so then my scripts would be stopped.”

(Supported housing, Calderdale)

For this participant, being often unable to walk meant being unable to pick up his prescription. He told us that he had not been able to find a solution to this problem and not yet received support to resolve it.

Dentistry

“If you are homeless and you haven't got an address, you can't get a dentist. Or it's very, very, very hard.”

51% of participants attempted to access a dentist in the year before they were interviewed. **34%** of those – just 11 people in total – were successful. Because this number was so low, it was difficult for us to understand what made successful access possible. The remaining **66%** of those who attempted to access a dentist were either told that NHS patients were not being accepted or that waiting lists were extremely long. Only a few asked to be put on these waiting lists. One participant said, “There [was] a year plus waiting list, so I registered with three. It was like whichever one comes up first.” He told us throughout our interview that he considered his support needs low; he did not, for example, suffer with long-term issues with mental health or drug dependency.

Those experiencing more complex challenges, however, often told us that they did not consider waiting lists an option. As with other health needs, many said that they had never felt able to prioritise dental treatment above more immediate needs. We often heard that people had become resigned to poor dental health.

“My teeth are not in great shape... I never had the money because I spent it on my house, drugs and alcohol... That is how I live my life. If I get toothache, I ring 111 or whatever it is, and they put you in touch with one nearby and they yank it out. I have never had – I suppose once I get myself on my feet and get sorted, I probably might have something with them.”

(Supported housing, Calderdale)

But participants were not unconcerned with dental problems. **30%** of participants said they would like to access a dentist but haven't tried. This was often because of embarrassment about their dental health, especially when drug-use was a perceived cause. Over time, this fed a cycle in which asking for help became more and more difficult.

Some participants, having experienced many years of homelessness and poverty, had already lost most of their teeth.

“I wasn't having any major problems, abscesses, toothache. It was just basically wanted to get some teeth because I struggle to eat proper food. I manage like, but it's just a bit hard for me.”

(Temporary accommodation, Wakefield)

This participant did not consider dentistry a priority because he had no teeth. Perhaps just as alarming as the number of people who told us that they were not able to access a dentist was how many said that they did not need one. This accounted for **19%** of participants. Some of these felt that their teeth did not need treatment, but they had not seriously considered the idea of regular check-ups.

Another reason why participants did not look for dental treatment during the year before we spoke to them was because they believed that dentistry had not been available during the COVID pandemic. We heard this surprisingly frequently.

“I didn't know what they were doing. I thought - I'd read somewhere that they'd stopped - dentists had stopped it doing because of spraying out of your mouth and stuff like that.”

(Supported housing, Calderdale)

Lacking information about dentistry and being unable to communicate with dentists made for uncertainty even among those who were registered. We also heard from several people how difficult it was to stay registered with a dentist without a phone or a fixed address.

“Since I lost my old flat... I don't know where letters are getting sent to. And I don't know if I am missing appointments and I am being booted off... Been the last thing on my mind really. It's all been waking up wherever you are, trying to find a place to sleep, trying to find money for food.”

(Rough sleeping, Wakefield)

This person referred to the common practice of deregistering patients who miss appointments. The complexities and stresses of homelessness made staying registered a challenge for many.

“I had a dentist but they said I missed appointment just before pandemic and I hadn't spoke to them for a long time. I did phone then up, because I have got half a tooth and I were in a lot of pain... Because I missed that one appointment and I hadn't had contact with them, they classed me as not being there anymore. They took me off list. They said they were fully booked so I can't go back now either.”

(Temporary accommodation, Wakefield)

The inability to access dental care had long-term consequences for many people. Some resorted to performing dental work on themselves, while others relied heavily on inconsistent and inadequate emergency treatment.

“I pull my own teeth out... It's not an OK solution but it's the best solution I can find. I just take a shedload of pain killers and then get to work at the tooth myself... The amount of work that needed on my teeth, I would need to go under a general anaesthetic.”

(Temporary accommodation, Wakefield)

“Through the pandemic they haven't been able to do any work. I have just struggled for two years with infection. I have just had to keep trying to fight it with antibiotics. It got to one point where the infection was that bad that the abscess went into my eye and I had to go into hospital and on an antibiotic drip. They could have stopped me from being in hospital with a big abscess if they had helped. Because it went on for a full year. Because I had different emergency dentists. They were sending me all over the place. And none of them did anything different to the other one, just left me to get well.”

(Temporary accommodation, Kirklees)

Mental health treatment

80% of participants said that they had had challenges with their mental health. Many told us that their conditions were undiagnosed. Among those with diagnoses, depression and anxiety were most common, followed by Post Traumatic Stress Disorder (PTSD) and schizophrenia. Precise figures for each of these conditions were not possible to obtain because many participants were wary of revealing information about some of their personal issues. This meant that we were unable to find out whether some conditions presented more challenging barriers than others.

Of the barriers to accessing mental health services, drug and alcohol dependence was by the far the most pronounced barrier that we uncovered, and this will be explored in detail below. Among other barriers was difficulty accessing support via the phonelines that participants had been signposted to. A few participants told us about struggles that they had had with triage processes.

“They were asking me lots of questions. I said I didn't know specific dates, times or... and he kept repeating it. And I... maybe I am getting a bit aggravated... And then he said 'right, I am hanging up on you'. And I'm like, if you put the phone down that means I have got no support, no mental health, I can't progress. So, you are scaring me and saying you are going to put the phone down, but I am under pressure because I don't know all the dates and things you are asking for and you keep repeating it.”

(Sofa-surfing, Kirklees)

This participant, who had been sofa-surfing for several months at the point we spoke to him, explains here how his insecure housing situation made being organised enough to be prepared for a triage assessment particularly challenging. Few participants mentioned this aspect of trying to access mental health services though. More common was frustration with waiting lists.

“I saw one a few weeks ago... because I took an overdose. I were on their list but they didn't get back to me. [If they'd helped me sooner] I wouldn't probably have taken the overdose.”

(Hostel, Kirklees Calderdale)

This participant, like several others, was confused at why she had not been prioritised earlier, despite having explained her symptoms at assessment stage.

Calderdale: mental health waiting lists for prison-leavers

18% of respondents across all areas mentioned having recently spent time in prison. There were no survey questions on this subject, so it was likely that other participants had also been in prison but did not talk about it.

Two participants in Calderdale told us that short prison sentences had meant they had lost their places in a mental health service waiting list.

“I have been waiting for about five years now because I go to prison. I go to the bottom of the list and then it's like restart.”

This participant felt that he may not have returned to prison if his mental health challenges had been addressed. While we heard several stories from prison-leavers in other areas who had been unable to access mental health treatment, Calderdale was the only place where being removed from waiting lists was talked about. General difficulties with accessing mental health services were also more commonly discussed in Calderdale.

Prison-leavers were slightly more likely to report mental health challenges than other participants and, across all areas, talked more about their mental health issues remaining undiagnosed.

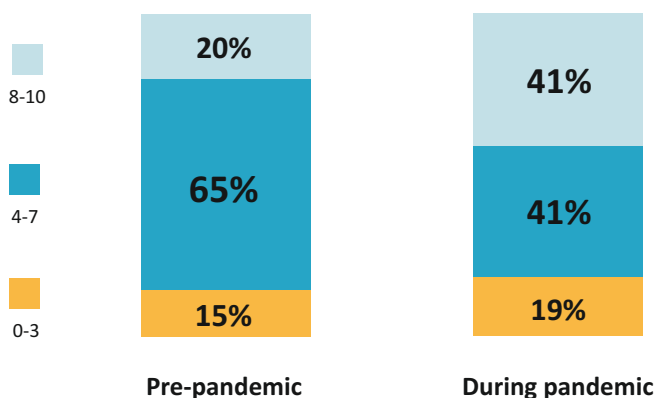
The role of relationships

The presence or absence of ongoing positive, trusting relationships with health professionals was a recurring and cross-cutting theme throughout several health services.

Relationships with mental health practitioners

Responses to questions about experiences of mental health services, when they were successfully accessed, were mixed. Of those who had accessed them, **55%** said that they had seen mental health services often enough to meet their needs.

Mental health service ratings (out of 10)



Experiences of mental health services were generally not reported as negatively impacted by the COVID pandemic; in fact, the reverse appeared to be true. Ratings out of 10 were generally higher for experiences during the pandemic than before it. However, this improvement was likely influenced by whether patients were able to engage with technology when services shifted to phone and online treatment during the pandemic. One participant – who rated mental health services highly both before and during the pandemic – told us how she had struggled to adjust to online sessions:

“Well yeah, things were on Zoom and that was quite hard. As I said I didn't have internet but... before the pandemic I would go to the library and use the computer there. But of course, the library is all shut so that was massive for me really, because everything I did online would be at the library.”

(Hostel, Kirklees)

This participant, who was relatively technologically capable, was eventually able to access these meetings and, at the time of interview, was beginning to take part in socially distanced group sessions. But this might not have been the case for others who were more digitally excluded. 79% of participants who told us that text messages were a good way for health services to get in touch said that they had seen mental health services often enough to meet their needs over the previous year. However, only 35% of participants who did not list texts as a good way for health services to get in touch said that they had seen mental health services enough. There are likely to be additional reasons behind these numbers, especially as few participants spoke specifically about digital issues in relation to mental health, but the data does suggest that digital exclusion may have been a barrier to effective access of mental health services during the pandemic.

While the effects of remote contact varied, one factor that more comprehensively affected how positively participants regarded their experiences with mental health services was the strength and longevity of relationships with the professionals who supported them. Getting “settled in” with a practitioner was likely to allow participants to feel more comfortable expressing themselves, and a change of practitioner might present challenges.

“When you get swapped over to somebody else, it's not a bad [thing]. But it's also very hard to get over because I was speaking to her for so long, so I had grown attached to her. She was like a bit of a family member, who I could just have a natter about something. When you are talking to somebody new, you feel vulnerable.”

(Supported housing, Wakefield)

When these trusting relationships develop, they can have wider, positive repercussions throughout engagement with health services.

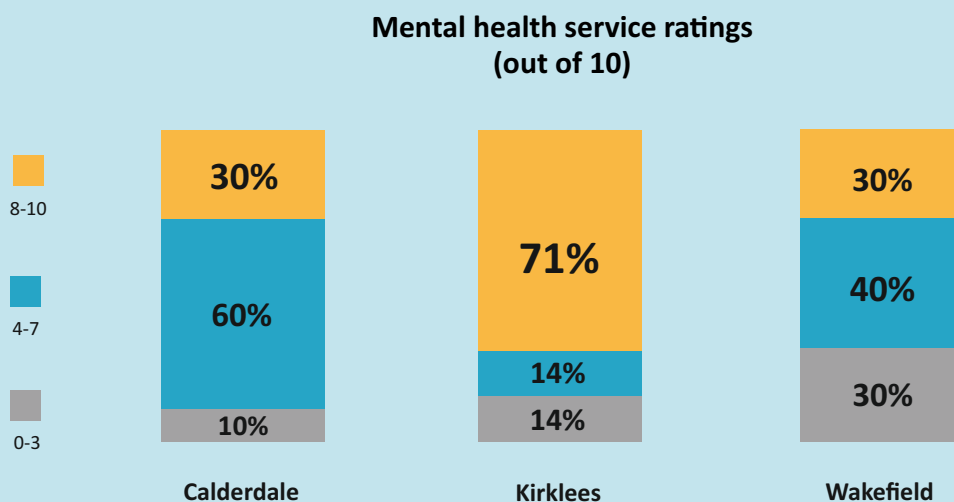
“Obviously with mental health services you learn to communicate with the doctors, GPs, crisis team, the psychologists. You learn to open up about certain things that you would never speak about. And then go into drugs relapse course now, which I am doing with [recovery service], it's a lot easier having to open up because I have had to experience it with somebody that has been higher up the chain so to speak. To get to where I am now it has been a bit of a rollercoaster ride as far as the GP, the mental health teams, the drug counselling. It's all been at the top end of the scale. It's all been great. And I haven't got a bad word to say about any of them, to be fair.”

(Temporary accommodation, Wakefield)

In this case, a positive experience of mental health challenges being addressed before drug dependency issues perhaps meant that subsequent engagement with drug recovery services was more willingly undertaken. The ability to build relationships with health professionals was developed in a relatively safe space and this seems to have created a solid foundation for trust in other health services.

Wakefield: continuity of mental health treatment

Participants in Wakefield were more likely than those in other areas to have had very negative experiences of mental health services.



Positive experiences tended to be reported when participants spent a relatively long period within a particular service. Negative experiences often related to transitions between services. When people had switched between services for young people (CAMHS) and adult services, they experienced a decrease in contact time and were expected to take more personal responsibility, but these changes were not made clear. Other participants were disappointed by the Crisis Team, with one participant feeling “belittled” and another feeling let down following a discharge from a psychiatric unit: “There were meant to be all sorts of therapy and all sorts of things going on, but I never heard anything.” The common theme was that participants “got no communication” when they were between services. By contrast, a participant who had previously stayed in a psychiatric unit in Kirklees praised services' continuity, telling us, “They have worked with me since leaving.” Mental health service ratings were far higher in Kirklees.

Relationships with GPs

Relationships with GPs were particularly important in terms of how they influenced engagement with other services, but building these relationships was challenging for many. Participants who had maintained long-term relationships with their GP almost invariably had positive things to say.

“I do suffer with mental health, depression or anxiety, so I am in constant contact with my GP. Every four weeks I will have a review to see whether my mental health is getting better or declining; the medication – is it working? I have been with the same doctor since I was a child, so they understand from me being an infant, a junior, going through high school, becoming an adult.”
(Temporary accommodation, Wakefield)

When participants had lost this relationship with a GP, however, they struggled to recreate it with a new one.

“I know my doctor very well, so they have been absolutely brilliant with me. The service what the NHS provide is brilliant. Same doctor seen me since I were a kid, so I am lucky like that. When the doctor don't know your history and that, it's very hard to get your point to them if you can't explain the symptoms... When I have moved areas, I have had that experience. I have had to register with someone else and I have been to see them and it's been like a total change and they knocked me off my meds. I have ended up in a bit of a mess. Now I am back living where I am and doctor's up the road, everything is fine.”
(Undisclosed accommodation type, Calderdale)

Our findings suggest that the pandemic had a far stronger impact on people's relationships with GPs than on relationships with any other health service. Most participants (85%) had accessed a GP in the previous year, but many told us how COVID restrictions had led to poorer experiences. Only 10% of participants rated their pre-pandemic experiences below 4, but this rose to 26% when participants were asked about more recent encounters. Most commonly, people talked about issues caused by the absence of face-to-face appointments. For those who already had well-established relationships with their doctor, this was surmountable.

“It's just since this pandemic's been really tough times. She put me on right medication at the moment to help with whatever, but she has just been ringing me and reviewing it. Just making it a lot easier... So yeah, they have been pulling their weight and making sure I am stable.”

(Private renting, Calderdale)

Those without such established relationships told us of challenges they had faced speaking to doctors by phone, with COVID restrictions taking “the personal service away from [the] GP practice.” Often, the stresses and practical difficulties of homelessness made these remote relationships with doctors particularly challenging.

“You feel like a pain ringing all the time, know what I mean? Because you are trying to get your point across. But sometimes they say, 'we will ring you back today', and it could be five o'clock when you have rung at 8am and you've had a hell of a day. And you can't get your point across at 5pm because your day's been manic. And you are like, 'oh yeah, I forgot you were ringing back'.”
(Supported housing, Calderdale)

Participants who had moved to another area were more likely to tell us about the negative consequences of the shift to phone appointments; moving often meant registering with a new surgery without meeting doctors face-to-face. Moving to a new area was particularly likely during the pandemic, when people experiencing homelessness were relocated through 'Everyone In'. Accordingly, just **6%** of those who had moved because of COVID had a very positive recent experiences with their GP (giving a rating of at least 9 out of 10) compared to **31%** who had not.

Frequent relocation, however, was a feature of homelessness even before the pandemic. When people are homeless, they may be required to move to wherever accommodation is available, and that often means registering with a new surgery. This may explain why **35%** of people experiencing homelessness for two years or more rated their GP above 5 out of 10, compared to **64%** of those who had been homeless for less than two years.

“Because I moved, they said I was out of the jurisdiction area for them to still care for me. I got used to that doctor... so then I have got to get used to it again. Going to go through the same process, all my life, every time I move. My anxiety goes through the roof.”

(Temporary accommodation, Wakefield)

But, while this issue may have been ongoing and persistent for some, the challenge of establishing a relationship with a new GP does seem to have been heightened by the pandemic. Interactions with a new surgery were sometimes seen as “hit and miss”, and the quality of a consultation might “depend [on] what doctor you get on phone”. Perceptions of different unknown doctors making different interpretations of health conditions, each prescribing different medications “willy-nilly”, made treatment feel haphazard, and this effect was worsened by the necessity to have such conversations by phone. While this may point to a failing in continuity of care and effective communication within surgeries, participants tended to see the problem in terms of whether they had a relationship with an individual doctor. Even when people had been registered with the same surgery for long periods, we heard that this was vital.

“You see that many doctors; you don't see the same one. If I have got a worker, I want a worker that I can trust and talk to. When you go to the doctor, they don't even have you see the same doctor. It's always a different one. So that makes me feel uncomfortable straight away.”

(Rough sleeping, Calderdale)

This idea of having a specific doctor that people could “trust and talk to” was a common theme that linked those with positive experiences of their GP. In both positive and negative accounts, we heard the word “listen” repeatedly.

“I spoke to them, told them about my mental health and my experiences and it was nice to get the doctor to listen to me and take on board what I was telling them.”

(Supported housing, Wakefield)

Positive experiences such as this often centred around how patient-led doctors were perceived to be and how involved participants felt with their own treatment. For people going through the traumatic experience of homelessness – and the challenges leading to and surrounding it – having a doctor who pays attention and provides or enables personalised treatment can make a significant difference.

“I have only met two GPs... who get with my programme, who supported me with having reflexology, aromatherapy, acupuncture, hypnosis. And the first one that sent me for hypnosis was when I got divorced and was going through a DA [domestic abuse] relationship. And I come out of that, and I was almost suicidal. And he sent me for hypnosis and that saved me. It was either that or putting me on Valium or... other alternatives. And I didn't want to get to that point where I would be dependent on that.”

(Social housing, Wakefield)

This feeds into a recurring narrative in our findings that GPs often prescribe medication, for both mental and physical health conditions, without paying due attention to patients' medical history and personal circumstances. A good doctor was seen as one who does this well, especially by gaining understanding through conversation.

“The amount of times I was in pain and they give me a massive box of co-codamol, especially on my record – I have got numerous suicide attempts from the age of 11 – they give me a box that was very capable of making me die within one night. It was like they were saying there you go; go and kill yourself.”

(Supported housing, Calderdale)

Frequently, participants spoke of feeling ignored, not listened to, “like you are not there, like you are transparent.” This relate both to the absence of an enduring relationship with an individual doctor – one who is willing to listen over extended periods – and a lack of consistency in practices' approach to handling and acting on patient information.

Diagnosis and coordinated care

This lack of involvement in – and knowledge about – their own treatment was discussed by several participants in various locations and accommodation situations, not just in relation to their GP but across services. Countless anonymous health professionals having access to participants' medical records was felt impersonal and disempowering.

“They just read notes on computer and they think they know you. It's not about that, is it? It's like reading a book, and I am not a book.”

(Rough sleeping, Calderdale)

Personal medical information – often only accessible to patients via professionals or through digital means – had consequences for long-term understanding of conditions.

“I have got personality disorder, that's what it says on my sick notes... I were in a psychiatric unit when I were 19... and just after six weeks, not even diagnosed with owt, saying you have got learning difficulties and behavioural problems and thrown back out. But this doctor straight away went, oh I can see you have got [personality disorder] – this is when I was 40, not 19, so it's only just appeared on my sick note, this. And I thought this guy was reading it off something, so I have always had it and no one has ever told me. What is personality disorder? ... What does it mean? Do I need tablets for it? Do I need counselling? You probably would do; it sounds a bit like that to me.”

(Supported housing, Calderdale)

This lack of knowledge about diagnoses was not restricted to mental health. Other participants told us about physical health conditions they had been diagnosed with that they did not understand.

“I didn't know what COPD was or owt like that. I found out off other people, off the street and that. They told me I had got COPD, asthma, and I said, 'oh all right'. But they never took me through it or owt.”

(Supported housing, Kirklees)

30% of participants also told us that they had not received results following a test or scan.

“I have had quite a few times where I have had blood tests, things like that and I have never heard from it again ... probably because I was homeless. Whether they have told my local doctors the results, it probably would be on your medical history. But being homeless, not everyone has mobile phones, internet access, to check things out.”

(Private renting, Wakefield)

Community Pharmacies

Relationships between people experiencing homelessness and pharmacy staff were generally reported positively, mirroring findings from #HealthNow research in other areas. Many participants told us about how pharmacy staff had been diligent and successful in meeting their needs during the COVID pandemic.

“I would say they even go out of their way to help me, because I was struggling with some medication I needed because I had a chest infection. And because I didn't have a phone at the time, for them – because it was still on ring-back; because of COVID, you can't see doctor face to face – I actually went up there a week later to pick up my normal medication. And she said I have had a word with the doctor and she actually got me the antibiotics without [me] having to see him and talk to him. So she has gone out of her way to do that. So that was really good.”

(Undisclosed accommodation type, Calderdale)

This service was often informed by a knowledge of the individual needs of participants. Sometimes, this meant help to resolve practical barriers, such as the above participant's lack of a phone, or to remind people of appointments. In other cases, pharmacists provided highly personalised medical advice and assistance.

“Our pharmacist is brilliant, absolutely brilliant... And because he knows me, he understands my medication. And the other week when there was a shortage of something and I had to go to another pharmacy... I went back and I said, 'well I have got this one?' and he went, 'you can't take that'. Because he knows my reaction to it. He said, 'hang on a minute, let me run round to GP practice and let me get it sorted.' And he sorted it in ten minutes for me.”

(Social housing, Wakefield)

“He took a lot of time in explaining the tablets to me... He said to me, 'I don't want you to take these tablets and [not] understand the situation with them,' and they went through everything with me.”

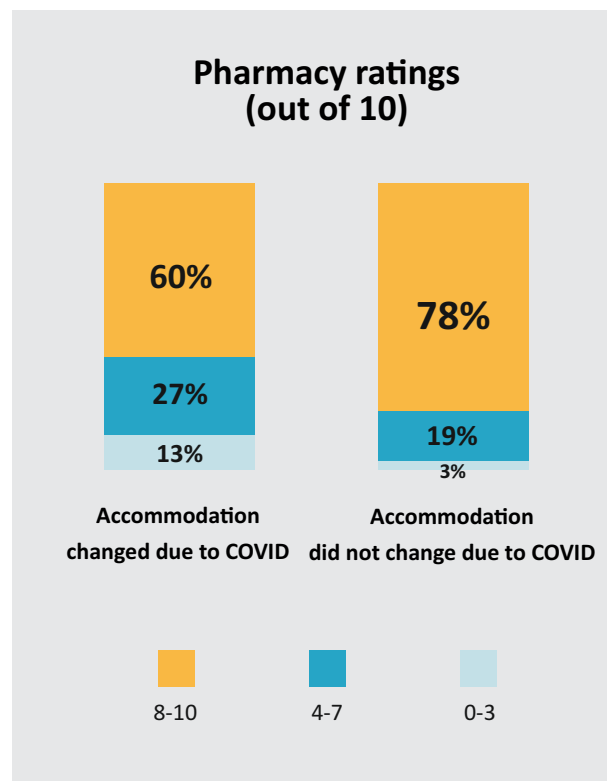
We found that the pandemic had a much less negative impact on relationships with pharmacy staff than it did on relationships with GPs. Ratings out of 10 of experiences before and during the pandemic were near-identical. At least in part, this was likely because pharmacies were still open for face-to-face advice. In some cases, the pandemic actually meant an improvement in the service people received. When pharmacies restricted the number of customers allowed inside, participants found that services were fast and efficient and that were given more attention by staff. This provided a marked contrast with the reduced service that people described receiving from their GP. Several people even told us that they valued the personalised advice of pharmacists more than their doctor. Again, “listening” was very important.

“They actually listen. They ask questions, rather than assuming and telling you. When you are talking to them, they ask you more questions about the condition, whereas if you go to the doctors they will go, 'right, well, it's this, this and this'. They don't ask that many questions about what's going on with you.”
(Supported housing, Calderdale)

However, we recorded an effect of long-term homelessness on experiences of pharmacies similar to that of GPs. 65% of people who had been homeless for two years or more rated pharmacies at 6 or higher, compared to 91% of those who had been homeless for less than two years. As with GPs, establishing relationships is problematic for people who move frequently between different regions. Similarly, we found that people who moved because of the COVID pandemic had less positive experiences.

One participant who had moved to a new area during the pandemic gave a lower rating for the pharmacy she was currently using than for the one she had previously used, explaining that this was because she no longer had access to the personalised service and support that she was used to.

“They don't talk to you. They just ask your name and tell you to sit down... Usually you get pharmacy what read through it with you. You don't get none of that... I am on



medication for my craving, try to stop my craving. They never talk me through what to do or how many to do. They just put it in the bag and then 'here you go.'”
(Supported housing, Kirklees)

By contrast, people using a pharmacy that they had used before the pandemic benefitted from consistency.

Repeated contact with individual staff members was valued but seeing the same staff team over a long period could have a similar effect. Referring to pharmacy staff, participants were just as likely to say that they “get along with them all” as to pick out single staff members for praise. Established relationships reduce the need to explain situations and repeat stories; “once they have got used to you, you don't have to do the same stuff.” This goes some way to explain the anxiety people experienced when required to switch pharmacy.

“Because I am homeless... they were going to change my chemist that I have been to for so long. They were going to say I had to go up to somewhere [else], because I am barred from in town. I can't go to Sainsburys, Boots or owt like that. They were going to stop my Saturday, Sunday pick-up and have to go every day, even with a broken rib. I said, 'are you mad? You can't do that to me.'”

(Rough sleeping, Calderdale)

Drug and alcohol dependency as a barrier

We did not ask explicitly whether participants had drug and alcohol dependencies, but we did ask whether they had accessed drug and alcohol recovery services in the previous year. 58% of participants had done so. Inability to access these services was rare; only one participant had been unsuccessful and one other would like to have accessed them but had not tried.

For our participants, drug and alcohol dependence was the most common reason for feeling stigmatised by people working in health services. While a few participants talked about how being homeless made them feel “like a rat” or that their clothing and appearance meant that health professionals looked at them “like dirt”, this was relatively uncommon. Much more frequently discussed was the view that relationships with health practitioners – and the resultant quality of healthcare – were negatively affected by professionals' attitudes towards drug and alcohol dependence. This view was expressed in relation to a number of services, and often focused on the trail that accessing recovery services left on medical records. A participant talks here about her experiences in an A&E unit:

“It will come up on computer: drink and drugs. And because they might look at it, they might think 'we will just put her in there and wait for a bit, see to her when we have got a bit of free time'.”

(Supported housing, Kirklees)

While 90% of those not accessing drug and alcohol services rated their experiences of A&E at 7 or more out of 10, only 46% of those who were accessing drug and alcohol services did so. Nothing else we looked at, including accommodation type or the length of time people had been homeless, made a difference to how A&E services were rated.

This perception that being an “addict” influenced treatment by urgent and emergency healthcare staff made participants feel unwelcome. On rare occasions, this effect was such that they left a hospital before getting their health needs addressed.

“The paramedic that come said it was an emergency, they needed to get me there as soon as possible and get me seen by a doctor. And then when we got there, the nurse didn't even check my legs. She just obviously saw that I were a drug addict. The paramedic were being a bit condescending, know what I mean? My groin area had

swollen up. Now I don't inject in my groin. I ain't done for about ten or fifteen years, maybe longer. And I explained this to them. But when we got to hospital, he were saying to the nurse 'oh his groin area is a bit swollen, inflamed. Denied using obviously, don't use in that area.' And I said, 'that's because I don't.' And he went, 'well, like I said, he denies using in that area but it does look like he is.' So he were basically calling me a liar. And when I got there, they weren't really bothered, to be honest. She took my temperature – 'oh your temperature is a bit high.' Didn't even look at my leg, the main problem that were causing the temperature and that. And then they just stuck me in waiting room. I were sat there for three hours in pain. Still hadn't seen the doctor and it said there were a two hour and 56 minute waiting time, so I got up and walked out.”

(Temporary accommodation, Wakefield)

Experiences of discrimination at pharmacies

Despite the largely positive experience of pharmacies outlined previously, there were some examples of participants feeling stigmatised when they collected medication to treat drug dependencies. One person talked about how people using a particular pharmacist for methadone and similar medications were given a unique service that made them feel discriminated against:

“Well, for the script I am on, for drug use – its er, different than your average person going into the pharmacy because we have got our own entrance, so we are treated differently. Like if walked in, even now, if I asked in chemist in the front one, like everyone, they would come round the back and very angrily shoo you. We are treated a lot differently. We have to go round the back where the bins are... We have to use a little entrance at the back, it's like an alley. And this alley is all the restaurant bins. And you are like literally – it's disgusting.”

(Social housing, Kirklees)

But this issue is not straightforward. Other participants requiring treatment for drug dependency had the opposite concerns. They discussed the problems that arise when they have to mix with other customers.

“I hate the whole atmosphere of going in. Security guy just assumed I was a robber when I walked in and I was like hoping he wouldn't talk to me. Having to stand over at that counter thing. It makes you look dodgy anyway. Whereas they should have locked up or at least walk in separate door. You are doing it in front of other customers that are going to the counter and buying things. And I just think its degrading.”

(Private renting, Calderdale)

The ideal middle ground might be for those requiring drug treatment medication to be talked to like any other customer but to be given some additional privacy. The variance between different pharmacies' physical layouts, however, meant participants' experiences differed a great deal.

“Well, some of them, they have like booths, don't they? You know like where you can go in, but a lot of them, even town centre ones, don't have it, you know. It's just there and you might get a member of your family walking past, you know, or people who you know, you know – you stood at a methadone counter, or Subutex. It's not got the words 'methadone counter', but everyone knows why you're stood in the corner.”

(Supported housing, Calderdale)

As noted previously, the COVID pandemic often made for better experiences of pharmacies, and some people found privacy easier to come by. At the time of the interviews, many pharmacies were still admitting only one customer at a time, allowing people to talk to staff unseen by other customers. While pharmacies might provide “a little private room if you want it”, this was often unnecessary during the pandemic. The negative experiences outlined above were relatively exceptional, and many people with drug and alcohol dependency issues spoke favourably about pharmacies. Ratings out of 10 for pharmacies were generally high, regardless of whether participants accessed drug and alcohol treatment services. Unlike with other health services, pharmacy staff might not know about customers' engagement with this treatment, which might go some way to explaining this. However, participants whose needs required pharmacy staff to have knowledge of dependencies often spoke of their non-discriminatory attitudes.

“They are absolutely excellent. They are polite, know what I mean? Just talk to us. They don't see us as drug addict. If you are alright with them, they are alright with

you. That's how it should be. They don't discriminate. They don't put us to back of queue when other people come in.”

(Temporary accommodation, Wakefield)

“The pharmacist – I have used this chemist on and off for a long time. When I lived in Netherton that was my local chemist. And from the age of four onwards I used that doctor's surgery and that chemist and never had a problem. She knows about my history. She doesn't discriminate whether you are a drug addict or not.”

(Temporary accommodation, Wakefield)

Kirklees: negative experiences of pharmacies

Participants in Kirklees tended to have more negative experiences than most with pharmacies. Around a third of participants in Huddersfield rated their experience of using their pharmacy as below 5. Participants who used their pharmacy for medication to treat drug dependency or who did not pay for their own prescriptions said that they felt uncomfortable in the pharmacy they used regularly:

“If I were to buy the prescription... that would be different... it's how they look at you and how they treat you.”

This echoes the experiences we often heard about in relation to stigma faced by those with drug dependencies when engaging with other healthcare services. We were also more likely to hear stories about being “left to your own devices” in Kirklees than the accounts of a “personal service” that we heard in other towns. Some felt that there was little advice or help, especially when medication was out of stock.

As in the above quote, the non-discriminatory attitudes of pharmacy staff were often seen as the product of the well-established relationships outlined in the previous section. Several participants believed that, when pharmacy staff got to know them better, they were treated “as a person”, not just as a drug addict.

Mental health access for people with drug and alcohol dependency issues

Of those accessing or wanting to access drug and alcohol treatment services, 95% reported challenges to their mental health. This compares to 57% of those who did not consider drug and alcohol dependence a support need.

The association between mental health and drug and alcohol dependency was often explored by participants. Many challenged received assumptions that poor mental health was caused by habitual drug-use.

“I've had depression for years. But then I'm thinking, is that all to do with fucking drugs? Obviously, it didn't help, you know, but when I were growing up, I was depressed a lot because of my family.”
(Supported housing, Calderdale)

Some participants were bemused over why this understanding was not shared by professionals. Drug and alcohol recovery services refused talking therapies to clients on methadone prescriptions, but “what they should do is give you access to both at the same time, because the talking therapies would help you come off the script quicker because you are dealing with your problems.” Treating addiction and mental health issues as separate problems could lead to a seemingly endless cycle.

“Sometimes, at some points, your life is so bad that you want to access or kind of [get] help to stop or change your situation. But then what happens is you get some help, you get clean and sober and you can then like – unless you do other work or unless you are actually ready – them thoughts start coming back in your head and you've got no real defence against them. So that is why people are in and out and in and out, stop, start, stop, start.”
(Hostel, Kirklees)

Despite [NICE guidelines](#) stipulating that people with coexisting substance misuse and mental illness should not be excluded from services to treat either condition, recent use of drug and alcohol services was the single biggest influence we identified on whether mental health services were successfully accessed. Prolonged experiences of homelessness, for instance, made no difference to successful access. Excluding people who told us that they were staying in private or social rented

housing (a group likely either to have lower overall support needs or to have less access to support), 100% of participants attempting to access mental health services who were not engaging with drug and alcohol treatment had been successful. Only 63% of those who were accessing drug and alcohol support succeeded.

“They wouldn't see me for another six months because it were down to my drug use ... They had a 45-minute conversation with me, but they says they can't do owt, because your past, you know, you're a drug user, or you was a drug user. And I was like, I've been clean three months.”

(Supported housing, Calderdale)

Sometimes mental health challenges were felt to have been dismissed as being little more than symptoms of drink and drugs. As a result, no further support had been offered.

“I got sectioned as well just after I had my baby. Post-natal depression. They said there was nothing wrong with me. I was on no medication, no nothing. They said, 'Just don't drink; There is nothing wrong with you at all. Just do not drink.' So mental health, there is nowt wrong with me, except it's my own fault.”

(Supported housing, Calderdale)

This participant's use of the phrase “my own fault” was not uncommon in interviews with people with coexisting mental health and drug dependency challenges. Taking personal responsibility was seen as important by those who were successfully recovering from addiction, but participants who had made less progress with their recovery were also likely to accept blame, telling us, for example, “if I got myself sorted out, my health needs wouldn't be there”. How helpful this belief is – and how much of it stems from interactions with health professionals – is difficult to understand, but our evidence did suggest that health workers overlooking the link between mental health and addiction could reinforce stigma.

Drug and alcohol dependency and GPs

The struggle with convincing health professionals to consider mental health before or alongside drug dependency was very common in talk about relationships with GPs. As with experiences of A&E – and contrasting with experiences of pharmacies – people who used drug and alcohol services were far less likely to report positive interactions with their GP. Only 37% of those using drug and alcohol services rated their GP at 6 or above out of 10, compared to 65% who were not. Efforts on the part of GPs to see beyond drug and alcohol dependencies were warmly received.

“[They] just absolutely weren't judging, just always kind. Because the thing is some of that time I was relapsing, so I wasn't always in a very good mental or physical state, but they never made me feel shit about it. They were always kind and took their time, and just always lovely there.”

(Hostel, Kirklees)

However, this sort of experience was not widely shared among participants. Many spoke of feeling like they were seen as an “addict” first and a patient second, and this created barriers. Sometimes, the help that people felt they needed was medication that doctors were unwilling to prescribe because of dependency issues.

“I need Diazepam to get off drink and they won't give me nowt, so if I don't have a drink, I go into fits. I proper go into anxiety attacks and go right suicidal. They are not bothered, so that winds me up even more because, now if I haven't got money, I am having to pinch or beg, know what I mean? They say, 'stop drinking'.”

(Rough sleeping, Wakefield)

This participant felt abandoned to deal with his anxiety when he no longer had legitimate access to the medication he had previously been prescribed. Some participants, however, were careful to explain that being prescribed drugs was far from the most important expectation they had from their GP.

“Because I've had problems in the past with drug addiction, the minute I go to a GP and ask for help with my mental health, they just assume I am wanting drugs. But I am not, because my drug addiction started as a result of my mental health issue. I started taking drugs to self-medicate for my PTSD when I came out the forces. All they see is drug addiction; that's it. They don't want

owt to do with you. It takes a lot of work. My mental health issue started in 1997 and it's taken until now to really try and get somewhere with the systems.”

(Temporary accommodation, Wakefield)

This participant, like several others, talks here of feeling stigmatised, that he is treated differently because of a history of drug use. Often, this perceived stigma meant that drug and alcohol dependencies were seen as a barrier to the establishment of a mutual trust with GPs that might help begin a fruitful journey into meaningful mental health support.

“Unfortunately, I have got substance misuse and due to that they look down their nose at me and they just think it's down to that. But they don't realise that my substance misuse is because I have had trauma in my life. I have never had a doctor actually sit and talk to me in a manner where I can look at him and respect him and feel safe with them.”

(Supported housing, Calderdale)

Stigma – or feelings of being stigmatised – by GPs because of drug and alcohol use was certainly not universal, but it was prevalent. Resultant outcomes varied greatly between participants. When drug and alcohol issues had represented a barrier to accessing medication or other mental health treatments, some participants told us that they had seen no option but to increase their use of street drugs. Those who had managed to overcome their drug dependencies, however, were sometimes later able to improve their relationships with GPs, who became “more willing to help”.

Unmet mental health needs and the consequences

Of participants who attempted to access mental health services, 60% were successful. A further 25% had tried to access them but had been unsuccessful. The remaining 15% said that they would like to access them but had not tried. These figures may be slightly misleading, however, because of differences between participants' interpretations of what the term 'mental health services' might include. Some people accessed mental health services in prison, for instance, or were unclear about whether the support they received was statutory or non-statutory.

The perceived role of GPs and consequences on physical health

Seeing a GP was commonly seen by participants as the first step towards accessing mental health support. The quality of relationships with GPs, as explored in previous sections, strongly influenced – and was influenced by – experiences of accessing mental health services. Those unable to access mental health services were far more likely to give their GP the lowest ratings out of 10, with 61% of them rating their GP below 5, compared to only 22% of those who had been successful. While the reasons for this may be complex, it is worth noting that ratings for other services, such as pharmacies, were relatively stable regardless of mental health issues. Some participants were explicit in holding their GP responsible for failings in referral or signposting.

“A lot of times people don't know what to ask for but I feel like I was definitely failed through something general like a GP, especially for me and probably for a lot of people, because that's mostly people's first port of call: the GP.”

(Temporary accommodation, Wakefield)

GPs' role in non-prescription-based mental health treatment is often to signpost for self-referral, rather than to make referrals themselves. Some people expected more from their GP and felt let down by this approach.

“They give you a little handout saying here is some numbers you can ring... Because it were just like routine. Know what I mean? Oh, you have got depression, here's some tablets, go deal with it.”

(Hostel, Kirklees)

Having found it difficult to ask for help through her GP, this participant struggled to summon the energy to repeat the process by self-referring, and eventually gave up trying to access mental health support. In other cases, when people had followed up on GPs' signposting, they had still felt stranded and confused by the system.

“The places where I were trying to get counselling were using it as an excuse, saying you need to see your doctor and go from your doctor. And then I got told, no you don't need to see your doctor. They just kept saying – making excuses, saying this and that.”

(Supported housing, Calderdale)

Several participants talked about how their experience of attempting to access mental health support had negatively affected their overall attitude to health services. The consequences of this are particularly clear when GPs were perceived to be fault. 77% of people who successfully accessed mental health services said that, when they were feeling unwell or had health issues, they sought information from their GP. Only 17% of those who had made unsuccessful attempts to access mental health services said the same. Instead, they were more likely to look for information online, from friends and family, or not at all. Perceptions of GPs' inability or unwillingness to take mental health concerns seriously often had further consequences.

“I very rarely go to the GP. I don't trust them. Because of how they dealt with my mental health, I have no trust in the NHS whatsoever. I have had issues with my leg for a while, and I have been told by a number of people to go and get it scanned because they think it might be a blood clot, but I won't. If it kills me, it kills me; fair enough. But I can't be arsed going to a GP and just being told the same shit over and over again and getting nowhere ... I don't bother [to look for information about health]. I just have the opinion if I wake up the following day, then it's a bonus. If I don't then who cares?”

(Temporary accommodation, Wakefield)

“The amount of times I went to the doctors and asked for help over in Huddersfield. They just tried to put me on anti-depressants. Now my depression is not down to a lack of chemicals in my brain; my depression is down to live situations. So I stopped dealing with the doctors. And again, when I came over here, they put me on antidepressants, and I did end up walking out my grandmother's and I was going to kill myself.”

(Supported housing, Calderdale)

Several of the participants who had been unsuccessful in accessing mental health services, and who had negative attitudes towards their GPs, told us they have begun to take their health problems into their own hands.

“If get a lot of pain I will self-medicate. If I get an abscess and I can't get antibiotics I will find them off someone. So, I tend to deal it with it myself rather than go chasing after GPs.”

(Temporary accommodation, Wakefield)

In some cases, the lack of engagement with health services by this group of participants led to escalating physical health problems that were only addressed when people outside of the NHS intervened.

“I got to the [day centre] and I had been there a few days and one of the staff said, 'look, we've phoned an ambulance.' And I said, 'why?' Now I were poorly but I just thought I was withdrawing off the drugs. And the pain were horrendous. I was in so much pain I could hardly walk, but I was still trying to push through it. Anyway, it were a good job because when I went to hospital they kept me in for six weeks. I had to have a blood transfusion I was so run down.”

(Supported housing, Calderdale)

Mental health challenges were the single largest influence we found on the use of urgent and emergency care services. 51% of people who told us of challenges with their mental health had made use of A&E in the previous year. By comparison, only one participant who told us that they had not had mental health challenges had done so.

Unmet mental health needs leading to homelessness

We asked participants whether they felt their homelessness could have been prevented if their health needs had been better met beforehand. 47% answered yes, 44% answered no and the remaining 9% were unsure. There was a clear gender divide in answers to this question. Only 31% of men answered yes, compared to 59% of women. The one participant who identified as “other gender” also answered yes.

When people of any gender were asked for their reasons for answering yes, they overwhelmingly spoke about mental rather than physical health. One woman spoke about how her difficulties in accessing mental health support after losing her children had led to her homelessness:

“I think when I first lost the kids and that... because I went down, I think if I had the doctors there, I wouldn't have gone off the rails like I did and not paid no rent. If there was someone there when I asked then, when I needed something and when I first started and I asked them for help, if they had helped me then... no, I wouldn't have lost my house like that. I would have paid my rent and then I would have moved. Yeah, four years ago because I started using drugs and I asked them for help.”

(Temporary accommodation, Wakefield)

Women tended to answer in terms of how their mental health effected their relationships, and how better addressing it might have resulted in more positive outcomes that had not led to housing crises.

“The reason why I was always like having trouble with my parents was because of my mental health, so maybe if I had got help with that and got a bit about how to cope with things. Because my mum and my dad like never understood my mental health. So it's quite like – its part [mental health services'] fault, part bad luck. They could have worked a little bit more like personally and specifically with me and like telling me what I could do. At least advising what I can do to deal with things better.”

(Temporary accommodation, Wakefield)

“Had I got therapy, I probably would have been mentally stronger to stay in my home and fight the perpetrator. Mentally I think therapy would have gone a long way and I wouldn't have been sitting here in a refuge. I would have been in my house and fighting for what was mine.”
(Women's refuge)

There is a danger in placing the responsibility of preventing domestic abuse on victims and not perpetrators, but the second participant's feelings here nevertheless deserve consideration. She had been unsuccessful in seeking the help she felt she needed to manage a relationship and felt that that help might have made the difference. It is this seeking of support at an early stage that was common to many of the women we spoke to; they had either been unsuccessful in obtaining support or, as in the first participant here, they felt that the support they received was inadequate. Men, on the other hand, generally told us that they had not asked for help with their mental health until they had reached crisis point.

“It weren't until I hit proper rock bottom and nearly died, that's when I seeked help... because I turned forty and my life was unmanageable.”
(Supported housing, Calderdale)

This attitude sometimes meant that men saw themselves to blame for their own health and homelessness, telling us for instance, “If I got myself sorted out, my health needs wouldn't be there.” Others were more specific about why they had not sought help for their mental health. A few times, “pride” was mentioned as a reason, and this came up in a few different ways. We spoke to a Polish man who told us he thought that cultural differences in help-seeking might have prevented him from asking for support at an earlier stage.

“The polish mentality is different like British mentality. The Polish people from experience, I can say they don't like talking about own weakness. The British have no problem. You love it!”
(Rough sleeping, Wakefield)

He suggested that being expected to talk about mental health problems in the same way as a British person might do was unrealistic. He mentioned another man from Poland who had been more comfortable speaking to a Polish Doctor, “because he can be understand. That's a barrier I think many times mostly.”

Beyond nationality and culture, participants spoke of other differences that they felt presented disadvantages for navigating the health system and which may have led to homelessness. One person felt his experiences of being in the care system had had a considerable impact.

“From being a young child, yeah, all the way along – it stems from being young. This health service has been failing me all my life, so how can they say that it stems from other sources, other reasons? It's not just down to that is it? Come on, let's be a bit more open-minded now. I come from the care system ... I left with nothing.”
(Temporary accommodation, Wakefield)

This participant said that failure to get his mental health needs addressed at an early age had led to a lack of faith that the NHS was working in his interests, and that this had ultimately led to eviction and homelessness. The “other sources, other reasons” he spoke of were the drug and alcohol dependencies that he saw as rational responses to his situation.

The common thread running through many of these stories is that inadequate mental health support can lead to the worsening of physical health and, in some cases, homelessness itself. Barriers to accessing that support include a lack of information about where to look for it – including unrealistic expectations about what GPs can provide – and repeated encounters with health professionals who give the impression of seeing addiction as a cause rather than an effect of poor mental health and homelessness.

What works: overcoming barriers

Much of what had been explored above has focused on poor experiences and outcomes. It is clearly important to understand what has prevented people who are homeless from receiving adequate healthcare and how existing systems have not been working for them. But we also heard many positive stories and examples of good practice. Some of our questions were designed to find out what had worked for participants. We asked whether healthcare services have adapted to meet specific needs and whether anyone outside of the NHS had provided health support, advice, treatment, or help to access NHS services.

Some of the answers to these – and similar – questions further revealed where gaps were and where participants felt that they needed further help to engage with health professionals. The following participants described struggles with visiting their GP and identified a need for more support to do so. The first is speaking about his difficulty holding a conversation with his GP.

“[I] clam up. I can't get my words out then, so nobody can engage with me. I can't engage with people... Having a support worker there at side of me [would help]. When I clam up, they can butt in and go well this is what he is trying to say but he can't look at you... I end up with stomach cramps and need to go, need to get out of that situation.”

(Temporary accommodation, Wakefield)

The second was asked what could have helped him to attend an appointment with a specialist.

"Maybe someone saying like come on I will take you. Yeah, if I had someone to come with me, I probably would have gone. But when I am suffering like that, I just want to be on my own in bed or whatever."

(Hostel, Kirklees)

But other participants had received this kind of support and advocacy in a number of different ways, and this final section explores what has made them successful.

Support from accommodation providers

Several participants who were living in supported accommodation told us about the difference support workers made to enabling effective engagement with health services. Sometimes, they had received practical help, perhaps a lift to an appointment, but support workers were sometimes able to provide much more. Some participants who had been accommodated in hotels under 'Everyone In' noticed a lack of support in accessing health services, but support in hostels was frequently regarded positively. One participant told us about how the hostel she was staying in provided something close to a therapeutic environment, which had positively affected her mental health.

“I suffer from PTSD as well, from things I have been through when I were younger, and I could possibly have bipolar as well ... When I lived with my parents, they never noticed – my triggers or me being up and down. Me obviously having support here, they notice when I am like that. They will come up to me, they will talk to me, and they will even ring the doctors for me if needs be ... [At the hostel] it's so open, they talk to you like it's just normal. When I moved here, I was so scared and so sad about it, but I feel more supported here than I ever had.”

(Hostel)

The same participant went on to explain how having a support worker can help to mediate between a patient and a mental health service.

“I didn't get listened to until I were here. So now that I have got a support worker, saying [name] is suffering with her mental health and she is not just saying it. They listen now. So if you are already involved with these kind of people, got a support worker or got someone to vouch for you, you will get listened to more. But if not, it's just word of mouth.”

This experience was not exclusive to people living in hostels. One participant staying in temporary accommodation told us that his support worker provided advocacy around his mental health treatment in a similar way.

“I was asking for help with my mental health for a long time and got nowhere. And my housing officer wrote them an email saying if you don't help him, he is going to kill himself. So then they decided to prescribe me antidepressants.”

(Temporary accommodation, Wakefield)

This kind of support was not confined to mental health problems. Participants were able to rely on housing support workers for advocacy for their physical health problems too, often when they felt unable to communicate effectively themselves.

“I have been waiting for a wrist appointment for over a year. Soon as I moved here, got one straight away. It is good but it's bad. I am scared to move out now. The support, honestly, I can't even explain it – it's mad like. And the job that they are doing is just literally supporting. But because they have got a different number and they have got the name badge or whatever they ring up and say, 'I am ringing on behalf of [name] for her wrist. She really needs it checking; this is taking bit now.' They will listen to them. If I say that I am aggressive, know what I mean?”

(Hostel, Kirklees)

This participant talks about becoming over-reliant on support workers to get her health needs met. She suggests that professionals' higher status means that they have more power when talking to health workers and can therefore be more assertive and effective in seeking treatment.

Specialist homeless health support

Speaking to regular visitors to day centres in Huddersfield and Halifax, we learned about the often-vital role that such places play in offering support to access health services. Those who were sleeping rough, for example, were able to use a phone to make appointments or to use the internet. We heard that such places “help you more than more-or-less anybody”. Daycentres can also act as a hub, connecting people with specialist health services, such as inclusion GP practices, when they have been unable to access mainstream services.

“I had no fixed address. I stayed in different towns, sleeping rough. There was no base for GP, so I didn't have any until I came here.”

(Temporary accommodation, Kirklees)

Very few participants had used an inclusion health practice for long, so it was not possible for us to find out how they were experienced, but we did often hear that the opportunity to register with one was welcome.

Several participants gave favourable views on how one day centre in Halifax had recently been hosting district nurses to provide medical care onsite. This service has been providing treatment for those who had struggled to use other health services.

“I needed better access to healthcare because I am in a bit of a predicament really because I couldn't get house visits because I was homeless, and I needed these dressings each week – twice, sometimes three a week for chronic leg ulcers, because they're specialised bandages. And obviously they are not going to come out on the street and do them. So, before this pop in clinic was set up at the [day centre], which it hasn't been going that long, and before that there was nothing ... And I didn't have a phone to get in touch where they could phone me.”

(Supported housing, Calderdale)

As well as providing treatment and advice, these nurses can act as a go-between with GPs and other health services.

“I have got a new GP [name of surgery] and oh my god they are shit. I – literally yesterday – and its only because I went and seen a district nurse yesterday about my leg – it was her that chased it up and managed to get doctor to ring me up and make me an appointment for this Thursday ... [She] has been trying for weeks to try to get the doctor to make me appointment to see him. This is why we end up having to go past him and go straight to a district nurse, tell her about my symptoms and that and then get her to chase my appointment up. She done it straight away. She has got more clout obviously.”

(Supported housing, Calderdale)

The comment about the nurse having “more clout” when talking to doctors echoes the points made by participants about housing support workers using their professional status to talk to health workers. Feelings around lacking the skills and confidence to get the advice and treatment they are entitled to, and needing others to advocate for them, were common.

Peer support

Participants in various accommodation situations recognised a need for advice and advocacy, but when support was given it exposed power inequalities. The participant who was “scared to move out” of the supportive hostel environment doubted her ability to access mental health treatment independently because she lacked her support worker's assumed authority. This feeling of helplessness and disempowerment is perhaps why “more clout”, at least in terms of professional status, was not always helpful. Some participants who had lost trust in NHS services had begun to value support from people whose own experiences matched their own, perhaps making relationships feel more equal.

“I always tried to contact my GP, but I don't think that would be first point of call now. So, if I do have any health issues, I would probably – through the pandemic, instead I would probably seek out groups and people that are actually going through similar things. Because I realised that the way the world is now, you need the support of others even more, whether that is physical or mental help.”

(Temporary accommodation, Wakefield)

“I have got a new worker. I have had this worker for probably six months, and I have accomplished more in six months that I have in the years previous... This worker is an ex-user and he understands... When it's someone who has been in your situation they tend to listen more and they understand more. And you know that they understand because they have been there. It's the old thing: walking a mile in a man's shoes so you know how he feels. People that learn it from a book – they don't really understand it. It's just words that they have read”

(Temporary accommodation, Wakefield)

Lived experience was held in particularly high regard by those struggling with drug and alcohol dependency. Considering the issues explored previously about participants' feelings of being stigmatised by health services because of their addictions, this is perhaps unsurprising; talking to somebody who has been through similar experiences may help to redress the power balance.

“I have stopped smoking and everything now, going onto a E-Cig but that is down to [Recovery Project]. It's not to do with my doctor; it's not through NHS; it's not through any professionals who have gone to university. It's due to addicts helping addicts. I can actually walk away and think I can do this.”

(Supported housing, Calderdale)

Other participants reflected on what made these experiences with recovery services positive and what lessons might be applied to other health services.

“Whether they were an alcoholic, drug addict, on the street, you can relate to them, and they can relate to you. When you go in [to a mental health service], I can't relate to some young lad that is at uni doing a degree, never been anywhere close to that.”

(Social housing, Kirklees)

“Perhaps keyworkers can be like addicts and that not book-wise, streetwise. I don't know why, because I listen to them somebody else who had been here and I don't know, more trust like.”

(Rough sleeping, Wakefield)

Professionals with experience of homelessness or addiction were thought to have a more empathetic attitude. They listen. The idea that health professionals gain all their understanding from books and computer screens, rather than from paying attention to patients, is one we heard expressed often, and the disempowerment stemming from this disconnect was seen as a barrier. But not all professionals were regarded this way. When they were seen to engage on a personal level and to show genuine interest, experiences tended to be much more positive.

“They actually listened and actually [had] a bedside manner that was ... client orientated rather than ... looking in a medical book. Because I have sat there with quite a few and they have sat with British medical thingy and gone 'right, okay', and wrote prescriptions out before they have even listened.”

(Social housing, Wakefield)

Kirklees and Calderdale: drug and alcohol peer support

Participants in Kirklees and Calderdale were about twice as likely to report positive experiences with drug and alcohol services (ratings of at least 6 out of 10) as those in Wakefield. Several participants in Kirklees and Calderdale were interviewed at Basement Recovery Project sites. The Basement Project has a peer-led approach to support, and encourages involvement in the running of the service from people in recovery from addiction.

“My main thing I drank for is anxiety and feeling isolated, so overcoming your anxiety and getting a bit more confident, getting proper support and advice, and just somewhere you can come each day. So it's been a real godsend.”

Participants who used this service spoke about how being actively involved in a community and helping others increased their confidence. This social, participatory element helped to create shared understandings about the connection between mental health and drug and alcohol dependence. While the participants we spoke to at the Basement Project all told us that they had mental health challenges, they also said that being part of this community was helping to resolve them.



Next steps

This research provides empirical evidence that illustrates the key issues people experiencing homelessness face when accessing healthcare services and maintaining their own health and wellbeing in West Yorkshire. Findings will be used to inform a local homeless health action plan.

These local insights will also be utilised to influence national decision-making through our #HealthNow campaign, which carried out similar research in 2020 in Newcastle, Birmingham and Greater Manchester.



020 7725 2851



Canterbury Court (CC3.44)
1-3 Brixton Road
London
SW9 6DE



Info@groundswell.org.uk



www.groundswell.org.uk



[@ItsGroundswell](https://twitter.com/ItsGroundswell)

Groundswell
Out of homelessness