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Mapping barriers to healthcare access for people experiencing homelessness in Cambridge

Research presentation:
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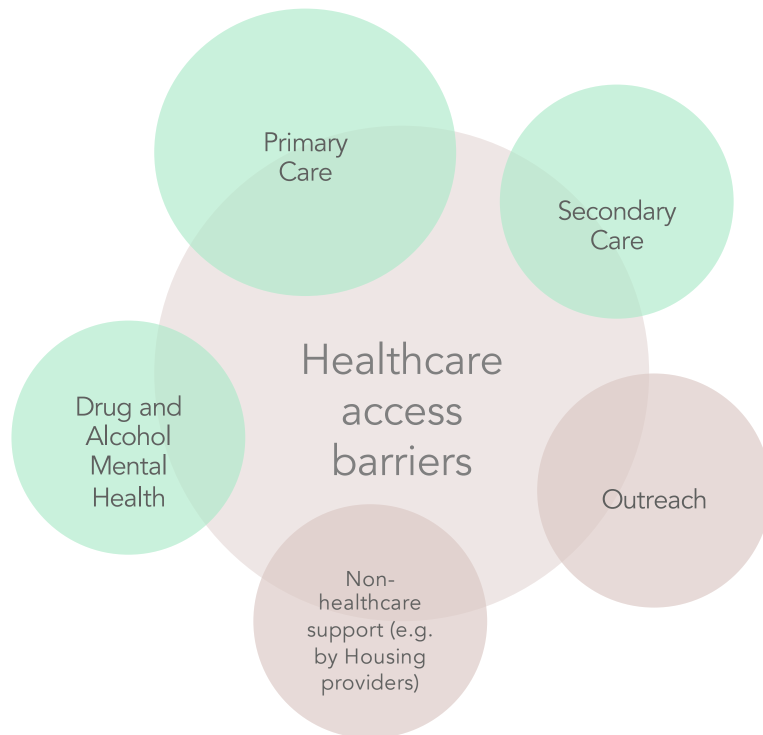
Picture: Streetsmart.

Study design: Comprehensive qualitative mapping – with clear limitations



Team: Dr Johannes Lenhard (PI), Dr Gemma Burgess (Co-PI), Meg Margetts (Research Lead), Jack Lund (Researcher), Amie Varney (Researcher)

Key Collaborator: Damita Abayaratne (CAS)

Methods:

- Rapid Ethnographic Assessment
- Qualitative, unstructured interviews (~#60)
- Shadowing (~2 weeks across 4 services)

Research question: Where do people experiencing homelessness in Cambridge encounter barriers to access healthcare?

Limitations

- **Limited time** and broad scope leading to gaps (e.g. sub groups)
- **Focus on barriers** rather than suggestions for improvement.
- **Excluded in this presentation** (but not in report): Dentistry, Palliative care, Outreach and Housing providers.

Where	*When*	*Funding*	*Ethics Approval*
Cambridge	June 2022 – March 2023	NIHR PPIE; Summer research intern (King's College); Cambridge University Impact Grant	Cambridge University Social Anthropology (2022) Cambridge University Land Economy (2023)

Context: Health and healthcare for people experiencing homelessness in devastating state

47 / 43

Life expectancy for person experiencing homelessness in the UK (male / female)

Very low life expectancy

50-70%

People with diagnoses from all 3 categories (physical & mental health, substance use)

'Co-morbidities'

50-60%

50% regularly use drugs or alcohol; 60% of people who sleep rough

Substance use crisis

82%

With mental health diagnoses in 2018/21 Homeless Needs Audit

Mental health crisis

Homeless and Inclusion Health Standards: "adequate services are rare despite clear guidance [...] and in addition, austerity measures are having a devastating impact."

Overall access to healthcare found to be inadequate in the UK:

- Lack of flexible treatment and support across healthcare providers
- Stigma and discrimination widespread in the healthcare system
- Negative experiences with healthcare services reinforce exclusion
- Exclusion especially strong for people with dual diagnosis

Cambridge: a strong ecosystem?

- Ecosystem overall in good shape: from primary and secondary care to community support, the Cambridge ecosystem should technically be able to provide support for almost all common healthcare needs locally
- Coordination much improved: the Streets to Home project, uniting the core housing / outreach provider in Cambridge, as well as initiatives such as Making Every Adult Matter (MEAM) have improved working together across the system

2018 Cambridgeshire Commissioning Review: high level of complex needs persists (including different healthcare needs). 58% of the over 1100 respondents to the survey reported three or more support needs and 18% reported five support needs (the maximum number that could be recorded) → **system approach needed to meet needs**

Research question: Where do people experiencing homelessness in Cambridge encounter barriers to access healthcare?

CAS and DDSP as strong first line of defense in primary care in Cambridge

Cambridge Access Surgery (CAS) as main hub for homeless health in Cambridge

- Flexibility of appointments and approach
- Continuity of care, beyond CAS
- Going where people are and going with them

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

Dual Diagnosis Street Project (DDSP) delivering fantastic work but underfunded

- Often working with **most excluded** and worst off people
- **Holistic**, informal and longitudinal approach highly beneficial
- Providing exactly the kind of support the **person demands**

Question marks around full inclusivity of all primary care and over-reliance on CAS

- Primary health care **not always inclusive to everyone** (incl.drop-ins for women) – barriers for certain sub-groups?
- **Other GPs** outside CAS with some exceptions not adequately equipped to support people experiencing homelessness
- **Mental health** inadequately addressed (lack of funding)
- Unclear pathway of **'leaving CAS'** – detach from stigma?

Key takeaways:

- Both CAS and DDSP providing **first-class primary healthcare support** with few exceptions
- **Funding cuts** especially for DDSP make services too hard to access for many people in need
- **Over-reliance** on CAS?

Under-pressure A&E posing significant barriers to people experiencing homelessness – lack of trauma-informed environment throughout

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

A&E struggling with enabling access and adequate treatment throughout

- Long **wait times** are a major barrier to treatment, especially for people who are in withdrawal

- **Internal processes** can reproduce stigma and discrimination:
  1. *Medical notes:* biased and often documenting negative past experiences
  2. *Consultations:* time limited, notes-based, (e.g. 'drug seeking' label leading to inadequate pain management)
  3. *Lack of coordination and communication*: repeating 'story' = traumatic, lack of internal/external coordination (incl adequate discharge plans from A&E/hospital)

Key takeaways:
- **Lack of trauma-informed environment** throughout processes (access, treatment, discharge)
- **Effects:** no treatment, early (self) discharge → 'cycle of distrust' in the community
- **Role** of high general pressure on NHS and lack of adequate (medical) training for staff?

The landscape for drug and alcohol support is improving, but there are still significant barriers to accessing care

In-patient drug and alcohol services are engaged but struggling to overcome systemic barriers

- **Regular opportunistic inpatient detoxes**, strong links to community CGL teams
- Problem with **inadequate coding** – patients' drug and alcohol needs may be missed
- **Lack of** appropriate alcohol and substance-supported **accommodation** to discharge to

"I was sat in ED waiting for ages to be seen. I fell asleep and dreamed that [HEART team] were with me. I woke up and you weren't there and I cried. Feel so supported by you, you're the only people who care. I feel privileged and a bit embarrassed as I feel you dedicate so much time to me."
[person experiencing homelessness]

CGL Heart Team exhibits flexibility – helps to overcome previous barriers

- **CGL 'mainstream' services historically critiqued**: staff shortage / last case loads leading to lack of follow-up, inflexible processes ~ missed appointments
- **HEART team** (from 2021): flexible, (assertive) outreach-based approach with smaller caseloads = positive

- Engagement limited by **systemic barriers** (e.g. people under probation services referred to mainstream team)
- **Detox / rehab with barriers:** funding cuts, no local beds, no access for complex needs

Key takeaways:

- HEART team provides **high quality service that flexibly meets the needs** of people experiencing homelessness – making up for some of the historic issues with 'mainstream CGL'
- **Systemic barriers are limiting** care for some: detoxification, lack of suitable accommodation, probation
- Experimenting with new solutions, e.g. community detox?

Mental health support need is overburdening a stretched system that is not equipped to cater to people experiencing homelessness adequately, esp. dual diagnosis

Mental health as most significant need

- Homelessness Needs (2018-2021): 82% with mental health diagnosis (from 45% 2012/14)
- Contribute to becoming homelessness and affected by homelessness = vicious cycle

"The majority of people will have complex PTSD. So 60-70%. Then a small amount of people will have psychosis on top of that […] maybe about 10%."
[healthcare worker]

Overall circumstances for mental health support are dire

- Progressive funding cuts leave only a fraction of mental health services in place; remaining ones limited resources
- National shortage of mental health beds → system at breaking point.

Access barriers are high and so is the likelihood to encounter traumatic experiences 'inside'

- **Access barriers:**
  1. 'Underdiagnosis issue'
  2. 'Too complex', leaving especially people with dual diagnosis unable to access support
- **Inside system:**
  1. *Inflexible processes* (e.g. phone assessments, wait times)
  2. *Traumatic processes* (e.g. sectioning under 136)
  3. *Lack of post-crisis support*

Key takeaways:
- **System-level problems** (funding cuts, bed shortage) making any mental health support hard to access for anyone and especially for people experiencing homelesnsess
- **Inflexible and at times traumatic processes** leading to lack of adequate support and adverse outcomes

→ Biggest un-addressed need among people experiencing homelessness?

Women’s experiences of homelessness: a tale of intersecting disadvantages and unheard voices

Men and women have different experiences of homelessness

- "Hidden homeless” vs street homeless
- Women likely to have multiple shorter episodes of homelessness
- Caring responsibilities: children
- Women with specific health and support needs: trauma, mental health, physical health needs (gynecological health and STI)

“The double disadvantage” women face gender-specific barriers when accessing services

- **Trauma and mental ill health:** difficulties establishing trust and communicating with healthcare professionals
- Perceived lack of safety and prior negative experiences **reduces engagement** with services (e.g. CAS drop-in, Wintercomfort)
- **Domestic abuse:** limits women’s access to services
- **Caring responsibility** creating added barriers

Women-only spaces vital

- **Specific trauma-informed services** like the Women’s Resource Centre and Freedom Program = highly regarded
- **Gender-specific housing** (e.g. Corona House)
- **Women-only groups:** safe space and much-needed community

Key takeaways:

- Women have fundamentally **different experiences** of homelessness from men that must be considered when prioritizing funding for services
- **Women's only services** are vital and necessary for creating safe communities for women experiencing homelessness

Conclusions:

1. Barriers to access key services especially high

Context: funding cuts and systemic barriers impact availability of services

1) **Mental health support**: Very high need (~80% of people), but lowest level of service availability / accessibility (e.g. wait times, lack of trauma-informed systems)
2) **Drug and alcohol services**: mainstream CGL services with access barriers (e.g. lack of follow up, phone/online) – increasingly made up for by HEART team but limited by external factors (e.g. local rehab center availability)

2. Barriers for most marginalized groups hardest to overcome across system

1) **Dual diagnosis**: big group (>20-70%) often explicitly excluded ('too complex') from services, especially mental health support; specialized service (DDSP) stretched
2) **Substance use:** long wait times (e.g. in A&E), stigma / discrimination (e.g. by overstretched/not adequately trained staff) and poor communication/coordination of services (e.g. for discharge from hospital) hits people with substance use issues hardest

3. Women especially disadvantaged

1) **"The double disadvantage":** women face gender-specific barriers (e.g. domestic abuse, care responsibilities) when accessing services
2) **Women's only** services (e.g. drop-ins, housing) are vital and necessary for creating safe communities for women experiencing homelessness

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Additional research needed:
- **Experiences of sub-groups**, e.g. people who identify as LGBTQ+, ethnic minorities or prison leavers
- How to **overcome barriers** – what works, what are best practices? Involvement of **Pathway**?

Appendix

Picture: Streetsmart.

Non-healthcare services provide key role in guiding people through the system – while more specialized healthcare services struggle

Dentistry in short supply

- Heightened support need (e.g. impact of methadone) not met
- **Lack of accessible appointments** (incl emergency) in Cambridge putting pressure (inadequately) on GPs
- **Result:** losing / removing teeth with negative effects on overall health

Palliative Care with good outcomes but not enough capacity

- **Disconnect** between support need and number of people accessing services
- **(In-home) access made complicated** by personal circumstances (e.g. unsafe home)
- When working jointly with e.g. GP services, **great end-of-life care** delivered

Outreach and housing providers as important glue to system

- **Housing providers** (e.g. Jimmy's, Cyrenians) not only referring and leading people through system but filling in gaps (e.g. in-house mental health)
- **Wintercomfort** as key hub for people to build relationships and begin access healthcare
- **CGL Outreach** often as first point of contact and guidance through the system

Key takeaways:

- **Non-healthcare providers** with key role, also for people trying to accessing healthcare; more coordination?
- **Specialised healthcare areas**, such as dentistry and palliative care (as well as mental health) strongly underfunded – more money needed!