healthwatch Lambeth

Homeless But Not Voiceless

Improving Access to Care for People Experiencing Homelessness and Dual Diagnosis

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About Healthwatch Lambeth

We are the independent champion for people who use health and social care in Lambeth. We have the power to make sure NHS leaders and other decision makers listen to local feedback and improve standards of care.

Our purpose is to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf. We focus on ensuring that people's worries and concerns about current services are addressed and work to get services right for the future.

- We listen to people, especially the most vulnerable, to understand their experiences and what matters most to them.
- We gather service users' experiences through surveys, focus groups and face-to-face discussions.
- We act by carrying out Enter and View visits to talk to patients, service users, carers, and staff.
- We empower and inform people to get the most from their health and social care services and encourage other organisations to do the same.
- We influence those who have the power to change services so that they better meet people's needs, now and into the future.

Acknowledgments

We are grateful to all the organisations and services that have enabled us to engage with people experiencing homelessness with a dual diagnosis. A special thank you goes to all individual participants who have given their time to share their experience. Their feedback is key in helping improve the care they receive.

Executive Summary

This report highlights the engagement with 14 people experiencing homelessness with a dual diagnosis (mental health and/or substance misuse) in Lambeth and the challenges they face when trying to access healthcare.

Healthwatch also worked in collaboration with local organisations supporting people experiencing homelessness, speaking to 14 clinical and non-clinical staff.

Key Findings

What worked well

- Support from key workers and nurses helped individuals experiencing homelessness to book and attend appointments and chase prescriptions.
- On-site services, such as regular GP or psychiatric visits provided in temporary accommodation, made care easier to access and more consistent.
- Some addiction support services were praised for actively re-engaging clients and not requiring them to start over if they missed an appointment.
- Many individuals expressed hope for the future, including getting housing, returning to work, building skills, or volunteering to live more independently.

Areas for improvement

- Barriers to GP registration persist, despite NHS guidelines.
- Digital exclusion and lack of digital technology meant that many individuals experiencing homelessness struggled to make appointments.
- Individuals reported feeling judged, dismissed or not taken seriously by some healthcare professionals.
- Short appointments and a lack of continuity lead individuals experiencing homelessness to feel frustrated and lacking in trust.
- Mental health and addiction services often operate separately, leaving individuals without adequate support for both.

Key Recommendations

We recognise the hard work healthcare professionals and community support staff do to provide care and support to individuals experiencing homelessness with complex health needs. Whilst our findings highlight several positives and good practice examples, our findings also show some room for improvement. Key recommendations are summarised below, with more detail on each provided at the end of the report.

1. Flexible access to primary care – Which includes piloting drop-in appointments in practices or supported housing, offering longer appointments for people experiencing homelessness. Additionally, provide digital support at GP practices or homeless centres.
2. Improve knowledge on patient registration rights and understanding of homelessness and dual diagnosis – Staff within GP surgeries to be reminded about patient registration rights for homeless individuals in line with NICE guidance. Training and information to be provided to staff to ensure they understand the life challenges and needs of people experiencing homelessness with a dual diagnosis, to achieve a more equitable access to care.
3. Integrated support – Consider piloting a new dual diagnosis care pathway co-designed with individuals experiencing homelessness and support staff that combines mental health and addiction support, local GP practices and or supported accommodation.
4. Life skills training – Organisations providing supported accommodation should consider offering life skills training to help residents manage health and daily life more independently.

Background

Homelessness is legally defined as the state of not having a home available and reasonable to occupy. It does not just refer to people who are sleeping rough, and includes those who are in temporary, insecure or inadequate housing.[1] In 2023-24, 324,900 households were owed a prevention or relief duty following a homelessness application to an English local authority, an increase of 8% from the previous year.[2]

Ill health can be both a cause and a consequence of homelessness, and the health and wellbeing of people who experience homelessness tends to be much worse than that of the general population.[1] The life expectancy for a person experiencing homelessness in the UK is far below the national average: 47 years for men and 43 years for women. 50-70% of homeless people have diagnoses from all 3 categories (physical health, mental health, and substance abuse). 50% of homeless people regularly use drugs or alcohol, rising to 60% for rough sleepers.[3] Projects, such as the Dual Diagnosis Street Project, work with the most excluded and worst-off people to provide holistic, informal, and longitudinal support.[3]

Homelessness and Access to Care

People experiencing homelessness generally use more acute hospital services and emergency care than the general population. Barriers to access and engagement with primary and social care services mean that problems remain untreated until they become severe and complex.[4] The flexible nature of emergency services compared with primary care, i.e. no appointment times or registration required, means that these services are often more compatible with the complex and often chaotic lives of those experiencing homelessness.[5]

A review of factors that influence individuals experiencing homelessness' access to care found six key themes:

- Staff education
- Flexibility of systems, including the possibility for longer time slots
- Service co-ordination
- Patient preparedness
- Complex health needs (both a barrier to access and a result of poor access)
- Lack of holistic, person-centred care.[6]

Many people experiencing homelessness face stigma from healthcare professionals due to their living circumstances, immigration status, and health issues.[7] This can be further exacerbated by difficulties in maintaining medication compliance, and an unwillingness from people experiencing homelessness to engage with services due to a lack of trust in healthcare professionals.[8]

Although you do not need a fixed address to register with a GP, many people experiencing homelessness find this a barrier to accessing primary care.[7] Approximately 98% of the English population are registered with a GP, compared to 83.3% of homeless people in accommodation, 89% of hidden homeless people and 65.5% of rough sleepers.[9] As other health and social care services are accessed through the GP, the homeless population is more likely to struggle to access other services if GP access is impeded.[10] Furthermore, the lack of flexibility of GP services with regard to appointment slots and short windows for consultations can present a barrier for access to care for those experiencing homelessness due to their complex health and social needs.[5] Lack of continuity of care is a problem for all, but is exacerbated by the complex physical, social and mental needs that those who are experiencing homelessness may have.[7]

Homelessness with Dual Diagnosis and Access to Care

Dual diagnosis refers to the diagnosis of both a mental illness alongside substance abuse issues.[11] People experiencing homelessness can face additional stigma when living with mental illness. This is exacerbated when the individuals have a dual diagnosis of substance abuse issues and mental illness. Dual diagnosis can act as a major obstacle to registering with a GP practice, and experiencing stigma from healthcare professionals inhibits trust and discourages further engagement with primary care. Health issues may be explained as related to drug issues by primary care practitioners, and underlying issues may therefore go unaddressed.[12] This can result in people experiencing homelessness disengaging with services due to their health needs going unmet.

Substance misuse can be a catalyst for mental ill health, and vice versa. Frequently, access to mental health support is restricted until an individual can demonstrate a period of stability and sobriety.[5] However, once people reach stability, they often have to wait for funding to be put in place for the therapeutic intervention, resulting in people returning to addiction while waiting for support.[5] Mental health issues can be interpreted as the result of drug use and, therefore, not the concern of mental health services, leaving individuals caught between health services and drug services and receiving treatment from neither.[13] Some individuals experiencing homelessness expressed that their health needed to deteriorate to a crisis point for them to access mental health support.[14]

Project Rationale and Objectives

In response to initial insights gathered from our information and outreach services concerning the challenges faced by some individuals in accessing care, Healthwatch Lambeth aimed to gain a deeper understanding of the difficulties encountered by people experiencing homelessness with a dual diagnosis (addiction and mental health) when seeking access to primary care services and receiving treatment for their health needs. To achieve this, we conducted a more thorough engagement to explore these issues. Our objectives were to:

- Listen to people with a dual diagnosis and hear what their experience has been like when trying to get health care.
- Speak with support organisations to better understand the challenges people face in getting care.

Methodology

Recruiting Participants

Healthwatch Lambeth worked with local organisations in Lambeth that support people who are homeless and have both mental health and addiction problems.

These included:

- Ace of Clubs – a Day Centre for the homeless and vulnerable in Clapham, offering hot meals, clothing, showers, and other assistance.
- Groundswell – a charity that helps people move out of homelessness through advocacy, practical support, and information.
- St Mungo's – a charity that provides emergency accommodation, hostels, and other services to help people rebuild their lives.
- Glassdoor Homeless Charity – offering shelter and support to people affected by homelessness.
- Thames Reach – a charity that helps people in London who are experiencing homelessness or are vulnerable to becoming homeless. They offer a range of services, including accommodation, outreach, employment, and education programmes.

These organisations helped us promote the project by giving out flyers to their clients. Support workers from these organisations also gave us useful insight into the barriers their clients face when trying to access care.

Interviews

The project adopted an exploratory qualitative design using individual semi-structured interviews with individuals experiencing homelessness to explore lived experiences.

To conduct interviews, we met people at times that worked best for them, in convenient, safe, and familiar spaces within the organisations. This helped participants feel relaxed and more willing to share their experience. We respected their boundaries if they were not ready to answer all our questions, and we made them aware that they could stop the interview at any time. Everyone got a shopping voucher as a thank-you for their time.

All participants were asked simple open-ended questions about their experience on the following and were prompted for more detail where relevant:

- The care they needed and how easy it was to access it
- What would make accessing care less difficult
- What else would make their life better

Data Analysis

Verbatim notes were taken during interviews. Two staff members independently read interview notes and analysed anonymised data. Inductive thematic analysis was used to identify themes, which were refined through several meetings to ensure consistency and accuracy of interpretation.

Strengths and limitations

Strengths

- Using an exploratory qualitative design, which gave individuals experiencing homelessness the space to share experiences in their own words in spaces that were safe, familiar, and comfortable
- Using sensitive interview techniques, respecting personal boundaries, and using a trauma-informed approach, where individuals were able to lead the pace and length of the interviews and what insight they wanted to provide.
- Collaboration with frontline services already supporting this group, which gave access to individuals seldom heard.
- Obtaining multi-perspective insights by speaking to front-line services to provide a broader view of the issues affecting access to care for individuals experiencing homelessness and possible solutions.

Limitations

- The number of participants was small (14 in total), which makes it difficult to generalise across the wider homeless population with dual diagnosis.
- We could not capture in-depth demographic information.

Participation

Individuals experiencing homelessness

All participating individuals were of working age, reflecting a younger adult demographic. In total, 9 men and 5 women participated. Individuals identified as White, Black African, or Black, although some clients chose not to disclose more details about their ethnicity. They all had a dual diagnosis which included substance misuse, and mental health issues (e.g. Depression, anxiety, personality disorder) alongside physical conditions, for example, Asthma, Rheumatism, or chronic pain. Several individuals we spoke to were struggling with long waiting times for treatment of their physical and/or mental ill-health and talked about how delays in hospital appointments and cancellations exacerbated their conditions.

In terms of accommodation, our participants were engaged through three organisations: Ace of Clubs, St Mungo's, and Thames Reach. All individuals from Ace of Clubs were sleeping rough, while those we recruited through St Mungo's and Thames Reach were staying in temporary accommodation or hostels provided by those organisations. This range in living situations highlights the varied nature of homelessness and housing instability among those with complex needs.

Support staff and healthcare professionals

We also heard the views of 14 healthcare professionals and support staff, including:

- A Consultant Psychiatrist and Occupational Therapist based at Homeless Outreach START at SLAM (a multi-disciplinary assessment team assessing street homeless people with a severe mental health problem and referring them to local mainstream services. The team covers Lambeth, Southwark, and Croydon.
- Nurses from the Homeless and high intensity users (HIU) service at Guy's and St Thomas' NHS Trust supporting individuals experiencing homelessness who also frequently access emergency department (A&E) services. They provide tailored support in connecting them with social services and appropriate community support alongside medical care.
- The Co-occurring Conditions Project Officer at the Transformation Partners in Health and Care (TPHC) supporting programmes and projects, working with a range of partners from integrated care systems, local councils, and NHS organisations.
- Key workers at Groundswell, St Mungo's and Glassdoor charity providing individuals with various support, such as information, advocacy, and shelter

Findings

This section shares what we found after speaking with individuals experiencing homelessness and the support staff who help them. It shows what's working well and what still needs to improve. The findings cover experiences of accessing primary care services, mental health care, and addiction support services.

This section also highlights perspectives in relation to coordinated services. Common themes emerging from interviews with both individuals experiencing homelessness and support staff are presented together to avoid duplication.

Health as a priority

Because of their difficult life situations, some individuals experiencing homelessness often do not see looking after their health as important, unless they become seriously ill. Support staff described how regular check-ups can be missed because surviving day-to-day takes up all their energy. Individuals may only access healthcare when they feel extremely unwell. It can also be hard for them to explain what kind of care they need. This shows how important it is to have services that understand their needs and help them feel supported and listened to.

"Given their life circumstances, looking after their health is not perceived as a priority, so having a check-up may be overlooked."

"They may wait until they feel unwell with a chest infection or liver problems and then present to hospital instead."

"They may not be able to explain in full the care they need, so if they feel unwell, they need someone to go with them."

Access to and experience of GP and pharmacy services

We had mixed responses from participants experiencing homelessness on accessing primary care.

The value of holistic and compassionate support

Many individuals experiencing homelessness reported that having a key worker or a district nurse was central to navigating healthcare. Support staff often helped with booking appointments, chasing prescriptions that led to more consistent engagement.

"I have support from Groundswell for GP appointments, and the district nurse takes my blood pressure every fortnight, also makes appointments for me and chases medication."

"My key worker helps me with doctor's appointments. If I were on my own on the road, I wouldn't get any help."

One person valued having mental health professionals at their GP practice. This allowed for more tailored support and continuity of care.

"The district nurse helped me get one GP as I was seen by different ones. My Practice also has a mental health nurse, which is good. The GP initially refers patients to the mental health nurse, but for following appointment, you book directly with the nurse. She offers me suggestions on coping mechanisms which help with my mental health."

Having health professionals embedded within supported accommodation was also seen as making care more accessible.

"The GP and Psychiatrist come here (at Martha Jones House, Thames Reach) once a week. It's easy to get care if I need because staff can arrange it for me."

Digital exclusion

The reliance on digital tools, for example, the NHS App, created challenges for those without consistent access to mobile phones or who were not digitally confident.

"Technology can be stressful for those who can't cope with it. Not everybody has kept updated with technology."

"I can use NHS App to make appointments, but it's not easy because sometimes I can't remember the password, or the system is down. I don't understand why you have to go through the app when you could make a call, and I would prefer it."

"The NHS App is useful for people who are confident with their phone, but for older people is still good to have the choice of booking appointments through the phone."

Support staff highlighted how text messages and calls often go answered due to a lack of device signal or confidence to use technology.

"If they [individuals experiencing homelessness] don't have a mobile phone, they don't call a GP to make an appointment, so need to be supported."

Appointment systems were seen as inflexible and not suited to the real lives of individuals experiencing homelessness.

"Clients are not able to attend GP or dental appointments because of the lack of flexibility of timings." (Support staff)

Staff interactions

The Triage process conducted by receptionists was perceived as intrusive and obstructive.

"GP Practice receptionists' attitude can be off-putting as they ask why I want to see the doctor. It's the job of the nurse or GP to triage, not the receptionist."

It was also difficult to get a GP appointment, unless it was an urgent matter. There was also frustration with rushed interactions, with some individuals feeling that doctors were not interested in talking in depth about needs.

"You have to make your health issue sound worse than it is to get an appointment! After 5 minutes, GPs rush you out. So, if you have more than one issue, you don't have the time to talk."

"The appointment is for 10 minutes, so I never have a proper examination."

A perceived lack of continuity of care contributed to these feelings and a poor understanding of needs.

"I can't see the same GP. I see different doctors, so nobody knows you well."

"You see different doctors who tell you different things and don't even look at your notes. I want the same doctor, so they know you and you can build a relationship."

Prejudice and dismissal

Experiences of feeling dismissed were common in homeless individuals' narratives. Some individuals mentioned their doctors' poor communication and lack of empathy during their interactions. In this context, they often described not feeling listened to and a lack of eye contact when discussing their needs, which contributed to feelings of not being taken seriously.

"Do they listen to me? Doctors look at their computer screen; they don't summarise what you say. If you have an emotional problem, they signpost you, but if it's a physical health e.g. like a cough, they ask you to go to the pharmacy and buy a cough mixture."

"I have a GP but tend not to go to them because they don't take you seriously. They say things like…the pain will go."

"You don't want to be judged as less than others."

Support staff noted the damaging impact of stigma and negative assumptions by healthcare professionals.

"Clients have reported feeling judged by receptionists. When clients turn up, it's as if staff expect trouble."

"Homeless people are often disrespected, not treated with empathy or compassion."

"GPs have a poor understanding of homelessness and poverty, and the chaotic life and challenges homeless people face."

Additionally, a lack of understanding of circumstances led to disengagement from care. One example shared with support staff was a patient with schizophrenia who misinterpreted a long wait time as deliberate neglect.

"I accompanied a client with schizophrenia to get his depo injection. He was made to wait 50 minutes without explanation. He thought the nurse didn't want to see him, so he refused to go again."

Systemic issues – GP registration

Support workers highlighted how systemic issues, such as challenges with registering patients without proof of address, continue to be a persistent barrier despite NHS guidelines.

The quote below highlights the ongoing difficulty of registering people who are homeless with a GP, despite NHS guidance clearly stating they have the right to register without proof of address or ID. Case workers often face resistance from reception staff, who sometimes ignore official guidance and make the process harder than it needs to be. Online registration forms frequently require a mandatory address field, creating further barriers. While using a Groundswell card or NHS entitlement card sometimes helps, the process is still frustrating, emotionally draining for the guest, and time-consuming for staff. Registering with a GP should be straightforward, but in practice, it often is not.

"I'm a senior case worker at Glass Door (Homeless Charity) and found it difficult to register a client with a GP surgery. I called the GP surgery and talked to the receptionist (the Practice manager never came to the phone). She kept on arguing, and I was asked to raise the case via email. I attached the link to the NHS guidance. Eventually, the client was registered. I have experienced the same problem for the last 10 years. When I register guests online, almost all the time, the proof of address is a mandatory field, and I upload a scanned copy of a Groundswell card, which states people's right to register with a GP. Most of the time it works. But sometimes the GP keeps insisting on providing proof of address. Some GPs online registration forms still have the mandatory field where you need to input your address. When I upload the NHS card that gives entitlements, the client is finally registered. The whole experience is emotionally draining for the guest and time-consuming for the worker. Registration should be a simple process."

Support staff also told us that some undocumented migrants do not register with a GP because they are concerned about their immigration status, language barriers or are not aware of their rights.

"Some clients are often worried about being tagged or just don't trust official channels for fear of their immigration status. Or they don't know they are entitled to primary care."

"There is a lack of trust in the health system (or anything 'official') because of fear of their immigration status."

Delays in receiving medication

Some interviewees shared their frustration about the delays in receiving their prescriptions, which exacerbated their health conditions. This was because the pharmacist could not get through to their doctor or because the request for medication was sent to the incorrect chemist.

"The pharmacists have problems in getting through the doctor. They said that are waiting to talk to the doctor to receive the prescription. I have been on the same medication for some time, so don't know what the problem is."

"Last time, the GP sent the medication to another chemist. When the district nurse chased the medication, was told that we had to wait to correct the mistake of sending the medication to the incorrect chemist. So, I missed 3 days of my medication and got high blood pressure and problems with my thyroid because I need to take medication daily."

Access and experiences of dentistry

Some interviewees also shared their experience of accessing dental care. We had mixed feedback. Those who had continuity of care with long-term relationships with dental practitioners had positive views.

"My dentist is good. I have been with the same dentist for a long time and get checked every six months."

However, cost and lack of transparency in pricing deterred access.

"Have contacted a dentist but was not told that the initial assessment cost money. They didn't tell me before I got there. The fee was only discussed at the end. I can't pay £70, so this stopped me from getting help."

Services for drug/alcohol dependence

Some individuals using drugs and alcohol praised the accessibility and continuity of support they received at Lorraine Hewitt House, part of the Lambeth Drug and Alcohol Treatment Consortium. Their approach of actively re-engaging individuals who miss appointments was particularly valued.

"I feel I get good help with drugs at Lorraine Hewitt House. The service is good there. They text you to remind you of the appointment, but you must keep them. What is also good is that if you miss an appointment, you don't have to start all over again through the GP. They call you and give you the chance of being seen again."

Although the staff were friendly, one individual highlighted the challenges of alcohol dependence and how difficult it was to control the drinking habit. The complex interplay of addiction and trauma was seen as making it difficult to engage and recovery more difficult.

"I've been to Lorraine Hewitt House. They are friendly enough, but I'm not engaging because I've got so much going on with so many thoughts. If I'm really upset, I drink and black out every bad thing. I've been to rehab, detox hospital, but I seem to slip up again. If I have one drink, I feel I have to carry on drinking."

Access to mental health care

Some interviewees mentioned the need to access talking therapies to better manage their mental health. However, the waiting times were seen as long, the number of therapy sessions was insufficient, and the service was affected by a high staff turnover.

"Lorraine Hewitt House only gives you six CBT sessions, and I need longer support, but the therapist told me to see how I would cope for two months, and then I may get more help. Six CBT sessions didn't go deeply in the reasons of my depression. It was like cramming your own entire life in one hour for six sessions."

"I need more mental health care, but I'm on 3rd key worker and 2nd therapist, so staff change!"

One individual shared a painful experience of being treated badly by mental health staff at the Maudsley Hospital. They felt mocked, not believed, and spoken to with contempt, which made them feel worthless and powerless. Instead of getting proper help, they were sent back to their GP and had no care coordinator to support them. They also described waiting 18 months to join a support group, showing how slow and broken the system can be. When they were in crisis, they were isolated with no one to call, resulting in police intervention. There were no hospital beds, so they were compelled to go home, sleep rough, or ride buses. Their narrative highlights their need to speak to others like them, further

illustrating how lonely and unsupported they feel, and how much better the system could be if it were kinder, faster, and more joined-up.

"I've been to the Maudsley hospital, and staff are horrible. They laugh and joke about me, they mock me…there's a lot of contempt. They tell me that I'm a liar. The consultant has referred me back to my GP. I need a healthcare worker at the other end of the phone if you have a crisis. I don't have a care coordinator. The Police picks me up, but there are no beds at the hospital, so they ask you to go back home or sleep in the street or go on a bus. I fell asleep on the bus once because of the medication. You are in bed all day…you can't go to the toilet…you are banged up. I stopped drinking 8 years ago because had a heart attack. At the Maudsley, there is a service users' group of people like me but have been on the waiting list for 18 months. I haven't heard yet. Why can't I get a place to chat to other people like me?"

What Could Be Improved

Better access and support in GP services

Individuals experiencing homelessness talked about how important it is to see a GP quickly and easily. Many liked the idea of drop-in appointments and having more time during visits to talk about their health. They also expressed that they did not like being asked questions by receptionists and felt it was not their job to triage them.

"It's not their job to decide how urgent my problem is."

Some said they preferred to book appointments by phone because they were not confident using apps or the internet.

"I just want to phone up – I don't use apps or the internet."

Some individuals wanted to be referred to hospitals more quickly and to get clearer information about surgery. One person said:

"When they write a letter, they're not always specific about what happens before and after surgery – I want to ask questions."

Having kind and understanding mental health workers or nurses based at GP surgeries was seen as helpful, and people also wanted more information about services for those with both mental health and drug or alcohol problems, especially in places like GP surgeries, food banks and supported housing.

The need for integrated services

A critical issue identified in the narratives of professionals who provided feedback was the lack of integrated services for individuals dealing with both mental health and substance misuse issues. Clients with these issues were perceived as being passed between siloed services.

"Psychological services often ask homeless people with a dual diagnosis to recover from addiction before getting psychological support!"

"A person with dual diagnosis needs to go through their addiction rehab, go back to their GP, who will then refer them to mental health services. Why can't talking therapies be offered to those who are acceptably sober? Why can't mental health services offered to people who have a well-maintained addiction?"

"Services don't work jointly. When clients with substance misuse and poor mental health may experience a crisis, we make a referral to the mental health team. A mental health assessment needs to be done when a client is not using substances, and often the response is that it's the substance misuse that creates the issue, so the client should work with drug and alcohol services. The client has to stop using the substances before having an MH assessment. In fact, it could be the clients' mental illness that leads to use substances to self-medicate. Services don't wrap around the client. MH services are dinosaurs!"

Support workers also highlighted the fragmented nature of recording and communication systems with the NHS, which often made navigating the system more challenging.

"A client had a prescription from Lorraine Hewitt House, but the GP was not aware of it, so the person ends up with different prescriptions. Why can't we all have one recording system? There could be a separate space for private notes for clients who would rather not share certain information. Otherwise, all health professionals and support workers could have access to the same 'real time' information, which would then help deliver better services to those we support."

Longer-term solutions – Holistic support

Having a better life meant different things to different people. Individuals experiencing homelessness expressed a strong desire for independence, housing, and either working or volunteering.

"A better life? It's about stop drinking, have my own place away from people who take drugs and volunteering or working."

"Having my own flat and going back to work. I used to work in construction but need to have my foot operation first and get well, as they have strict rules."

Support from peers and staff was also seen as key to boosting self-esteem.

"I volunteer at Ace of Clubs to keep emotionally well and feel valued. Here, they know you as a name and not a number."

Achieving an independent life, which included developing key skills such as budgeting, being able to afford and cook healthy food, so that complex health issues could be better managed.

"Need more help from my key worker to get out, do things, and achieve a more independent life, e.g. help with budgeting, cook, use a washing machine, shopping for healthy options. If you have underlying issues like diabetes, you need to eat healthily. This way, when you go back into the community, you can cope on your own."

Some of them would prefer to live in supported accommodation where they could be looked after or take time to re-learn to be independent.

I would like to have time to settle into the accommodation, where you can get back on your feet. You may have forgotten how to bathe or sleep on a bed. You need to re-learn some basic skills.

"I wish I could go into supported accommodation for over 50s because I can't cope in a flat on my own because of loneliness, and people can prey on lonely people. Most of my family are abroad."

Not being judged or discriminated against played a big part in having a better life. One person also shared the support he received from other rough sleepers and the sense of solidarity he felt within the homeless community.

"You don't want to be judged as less than others. Other homeless people helped me more than anyone else with not taking my life, sharing food, and kindness."

Some interviewees living in supported accommodation told us they needed more support in building their confidence and reintegrating into the community. To that end, they suggested arranging training sessions within the premises.

"If you are in supported accommodation, need to have organisations coming to running sessions here. Rather than expecting people who have severe anxiety to attend courses externally. This could be done in stages to improve people's confidence."

Discussion and Conclusions

Our findings highlight the intricate challenges faced by individuals experiencing homelessness with a dual diagnosis in accessing healthcare in Lambeth, while also uncovering areas of promise and opportunity for improvement.

The findings reinforce existing national evidence that demonstrates how homelessness, mental illness, and substance misuse are closely linked and often result in people experiencing difficulty in accessing essential services.

As highlighted in previous research,[1, 4] individuals with multiple complex needs often experience poorer health outcomes, increased stigma, and reduced access to care compared with the general population.

Our Lambeth findings echo and are consistent with national evidence, which highlights challenges such as disconnected services, limited digital access, rigid systems and occasional negative experiences within primary care,[6, 7] However, they also underscore more localised issues such as poor implementation of GP registration guidance, the continued insistence on proof of address (despite the guidelines)[15] which demonstrates a persistent institutional barrier, adding stress to people who are already struggling.

Encouragingly, the involvement of trusted homeless organisations plays a key role in providing support with positive impacts.

Having a trustworthy, empathic key worker or a professional embedded in a local homeless organisation or primary care leads to more positive experiences. These good examples show that it is possible to make services more accessible and suited to homeless individuals' needs.

A central issue drawn out from the findings is that services for mental health and addiction do not work well together. Individuals experiencing homelessness are often told to fix one issue before getting help for the other. This means they can be passed between services and so get no support at all. These challenges reflect other research while adding local voices and insights.[13-14]

Whilst acknowledging ongoing efforts by the Lambeth Together Care Partnership Board to address these issues, our findings suggest that further steps can be taken. For example, GPs might consider offering more flexible access options such as drop-in appointments in line with NICE guidance for Primary care and homelessness.[15] Similarly, substance misuse and mental health services could benefit from a greater connection to ensure more holistic and continuous care for individuals with dual diagnosis.

Our findings support the aims outlined in Lambeth's Homelessness and Rough Sleeping Strategy, which calls for more integrated health and support services for people experiencing multiple disadvantages.[16] These goals could be supported through enhanced training and awareness raising among both clinical and non-clinical staff to better understand homelessness, the impact of dual diagnosis on the health needs of individuals experiencing homelessness and through improved communication.

Recommendations

Primary care recommendations

1. Improve GP access and reduce digital exclusion

- Pilot drop-in GP clinics for individuals experiencing homelessness in GP practices and/or supported accommodation
- Consider reminding patients and carers that double appointments can be booked by/for people with multiple health issues/conditions.
- Provide a choice of telephone appointment booking for individuals without access to or less confident with digital technology.
- Provide digital access sessions with support staff or peer mentors offering support on using the NHS app and other health-related digital tools.

2. Ensure full compliance with NHS registration guidance.

- Staff within GP practices should be reminded about NHS registration rights for people without a fixed address or ID.
- GP practice staff should work with patients experiencing homelessness to agree on the most reliable method of contact for follow-up appointments. This could include telephone calls or using a trusted contact address (for example, the address of a carer or key worker), provided appropriate consent is obtained. These preferences should be recorded to support continuity of care.
- While data on Integrated Health Network clients (INH) show encouraging registration rates and engagement with healthcare services, rough sleepers, especially those not residing in hostels or attending day centres, may continue to experience barriers to registration. Further steps are needed to replicate the success seen in supported housing across the wider rough sleeping population in Lambeth.17

3. Improve understanding of homelessness and dual diagnosis

- Train and support primary care staff in understanding the life circumstances and complex needs of people experiencing homelessness with a dual diagnosis. Training could focus on reducing stigma and unconscious bias to promote equitable access to care. Training could also include:
    - Where resources allow, new staff should have the opportunity to shadow key workers in hostels or outreach teams as part of their induction. This will enhance knowledge of the daily challenges of being homeless and the kinds of support that are most effective

    - Staff could also be trained in trauma-informed approaches to better understand and respond to challenging behaviours that stem from trauma, missed appointments or not responding to letters. The training could help reduce the risk of unnecessary de-registrations and improve patient engagement.

- GPs should consider ways of improving their collaboration with key workers within homeless organisations to better support people experiencing homelessness with a dual diagnosis.

4. Continuity of care

- Consideration should be given to improving continuity of care to enable patients to establish trust and a good relationship with GPs and social prescribers.

5. Embed mental health support within practices.

- As integrated Neighbour Health Services are delivered, consider the inclusion of mental health workers who can signpost to emotional support/community support/additional mental health support.

6. Better information

- In case of a hospital referral for an operation, patients should be given the contact details of the hospital surgical team that can be contacted for queries before a procedure.
- More leaflets and posters about homeless organisations and services could be placed in venues such as GP Practices, food banks and supported accommodation.

Broad service recommendations

1. Integrate mental health and substance misuse services

- Consider piloting a new dual diagnosis care pathway within neighbourhood health services, co-designed with service users, patients, and homeless support organisations. This approach could be tested in select local practices to ensure tailored and effective implementation.

2. Provide life skills training

- Organisations providing supported accommodation should consider setting up life skills training (including budgeting, cooking, how to use a washing machine, shopping for healthy options and employment support) to support the return of clients to an independent life.

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