# Women, Homelessness and Health: A Peer Research Project

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Groundswell

Out of homelessness


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## About Groundswell

Groundswell works with people who have been homeless to create solutions to homelessness. We believe that the experience of homelessness brings insight that can help tackle the issues of homelessness; that's why all our volunteers and over two-thirds of our staff have been homeless. Participation of people who have been homeless is crucial in making decisions that affect their lives – this may be in policies, designing or commissioning services.

Groundswell is a unique charity that focusses on the health of people experiencing homelessness, which is, relative to the general population, extremely poor. We know that good health creates a foundation for moving out of homelessness. Through Groundswell's award-winning Homeless Health Peer Advocacy (HHPA) service, we support those experiencing homelessness to use services and improve their health. Through HHPA, people become more motivated to address their health issues and ultimately manage their health independently. Everyone delivering HHPA has been homeless themselves, they act as role models showing others that, with the right support, moving out of homelessness is possible. In the financial year 2018-2019, we delivered nearly 4,000 one-to-one engagements and almost 700 Health Promotion sessions with people experiencing homelessness.

The Insight and Action team delivers a range of innovative research and consultations through peer research methodology. Staff and volunteers with experience of homelessness are trained to gather real stories, insights and experiences 'from the ground'. The empathy of the researchers, who have been homeless themselves, means they can build a level of trust a 'professional' may not be able to. The Insight and Action approach focusses on creating deep understandings of the challenges faced by people experiencing homelessness and developing achievable solutions.

## Acknowledgements

This research would not be possible without funding from the Greater London Authority (GLA). Thank you for supporting this vitally important piece of research and for your commitment to supporting women experiencing homelessness. We would also like to say a huge thank you to the following services who warmly welcomed us and enabled us to complete this research. These include the Ace of Clubs, Look Ahead, Connections St Martins, Crisis, Glass Door, The Green Room, Manna Society, Magpie Project, Marsha Phoenix, New Horizons and Passage Day Centre. Thank you for all the amazing work you do to support women experiencing homelessness. We would also like to thank all the guests at the research launch event who contributed to these recommendations.

A huge round of applause to our volunteer researchers whose enthusiasm, love and commitment know no bounds. We have loved every minute of doing this research with you. Lastly, we would like to thank the women who took time to participate in this research; thank you for sharing your stories and warmth with us at a difficult time in your lives. The strength you have shown gives us the hope and drive to keep on fighting for change.

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## Executive Summary

This research was conducted by Groundswell and was funded by the Greater London Authority. This research is aimed at understanding more about the health conditions women are facing and how their housing issues affect their health. The second aim was to understand more about women's experiences of accessing health services when homeless.

This was a mix method study, including 77 survey-based interviews and 3 focus groups reaching a combined total of 104 participants. Data collection was carried out between February and September 2019 in support services working with people who are homeless. Researchers who have experience of homelessness were involved in all stages of the research process, and their contribution was a crucial factor in the success of the project.

This research supports literature regarding the high health needs of women experiencing homelessness. The research shows that not only is poor health caused by homelessness, but that health is a common cause of and a factor that perpetuates homelessness for women.

### Summary of findings

#### Factors causing homelessness. Participants had long histories of homelessness in which physical and mental health were contributing factors to their situation.

- Participants often had long and complex histories of homelessness; 65% had been homeless for more than a year, and 42% had been homeless at least once before.
- The 3 main reasons participants cited for becoming homeless included relationship breakdown and/or family breakdown, physical health issues and domestic violence.
- 59% either agreed or strongly agreed that their health had contributed to them becoming homeless.
- Reasons participants became homeless were often a result of gender inequality; 39% had experienced domestic violence at some point in their lives, and 25% had experienced sexual abuse.

#### Physical health issues. Most participants were living with several health conditions that were aggravated by living conditions and the stresses of being homeless.

- 74% had a current physical health issue.
- The most commonly diagnosed physical health issues were joints, bones and muscles (40%), blood conditions (26%), problems with feet (21%) and stomach issues (19%). The conditions which showed the biggest increase upon homelessness were issues with joints, bones and muscles, blood conditions, heart conditions and problems with feet.
- Participants frequently talked about how their living situation affected their health and exacerbated their existing health issues.
- Participants spoke of how they were affected by allergies, skin conditions, bed bugs, difficulty breathing and back pain from their accommodation.
- The stress of their situation resulted in headaches, losing hair, stomach pain, irritation in their eyes, rapid heartbeat, panic attacks, chest pain and early menopause.

Mental health. Issues with mental health were common among participants and in many cases, caused self-harm and/or addiction.

- 64% expressed that they were experiencing mental health issues compared to 20.7% of the general population of women.
- The most commonly diagnosed issues include depression (45%), anxiety/phobia (29%) and post-traumatic stress disorder (PTSD) (18%).
- Some mental health issues existed before homelessness; however, many developed new mental health issues because of their housing situation.
- Self-harm and attempted suicide were not uncommon; of those who had required an ambulance, 27% needed one because of self-harm and/or attempted suicide.
- 24% felt an addiction affected their day-to-day life, and homelessness was often a trigger for addiction.

Homelessness was causing significant damage to the physical and mental wellbeing of participants. Participants had issues with sleeping, finding enough food, keeping clean and were affected by addiction and on-going sexual and/or domestic abuse.

- 45% rarely, or never, get enough sleep. Many had anxiety which made it difficult to sleep; some participants spoke of how, regardless of how much sleep they got, they were still tired.
- 35% were eating either no meals or one meal a day; 46% of participants ate less than one portion of fruit and vegetables a day.
- Eating patterns were often erratic, and participants spoke of not knowing when they would get something to eat again. For some, this resulted in periods of overeating and hunger.
- While some felt they were able to keep clean, many did not. Busy day centres often meant there were queues for the shower and laundry, and opening times did not always fit for those who were working.
- Generally, participants felt they could easily access tampons and contraceptives.
- 35% felt that domestic and/or sexual abuse was currently affecting their day to day life.

Healthcare usage. Participants were reliant on the support provided by healthcare services and not-for-profits but highlighted a need for additional specialised support.

- The main healthcare services participants used included GP surgeries (both general and specialised), A & E, hospital admittance, counselling and support from health professionals in charities. Healthcare services in homelessness services were highly beneficial.
- The main reasons participants used an ambulance were physical health issues (53%), mental health problems (33%) and self-harm/attempted suicide (27%).
- 81% were registered with a GP, and 40% were signed up with a dentist. The research found that 17% of participants had been refused registration by a GP.
- 65% of participants felt that they struggled to find the motivation and confidence to deal with their health issues. A combination of exhaustion, poor health, stress and a lack of self-worth were barriers to engaging with healthcare services.
- There were structural and practical barriers to accessing healthcare, for example, not having money to get to appointments, inflexible appointments, being refused registration and a lack of support to get to appointments.
- 45% either strongly agreed or agreed with this statement *"healthcare services understand the issues I face as a homeless woman*" and most participants (73%) felt that they could be honest with staff in healthcare services.
- There were catch-22s related to accessing mental health services, primarily centred around housing and addiction issues.

# Women, Health and Homelessness

> You are under stress constantly! It means you are very vulnerable...in terms of illnesses and everything.

We spoke to 104 women experiencing homelessness and they said....

**74%** were experiencing physical health issues

**64%** were experiencing mental health issues compared to 21% of the general population

**42%** had been homeless more than once

**35%** were eating either no meals or one meal a day

**39%** had experienced domestic violence and 25% experienced sexual abuse at some point in their lives

> *My physical and/or mental health issues contributed to me becoming homeless*

**59%** Strongly agreed or agreed

> *I struggle to find the motivation and confidence to deal with my health issues when I am homeless*

**65%** Strongly agreed or agreed

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This research was funded by the Greater London Authority.
Groundswell is a charity that involves homeless people in creating solutions to homelessness. We specialise in supporting people with health issues.

## Recommendations

These recommendations were created based on the findings of the research and with the input from women with experience of homelessness and people working to support them[1]. The findings suggest that:

### There is a need for a deeper understanding of health issue women experience when they are homeless

- **Further research.** Further research is needed to better understand the health needs of women experiencing homelessness on a national level. This research identified the need for further research particularly on past and current experiences of violence and the mental health implications of the experience and risk of 'losing children'.
- **Sharing existing knowledge.** Research should be shared between funders, academics, NHS staff and representatives from local authorities, Government departments and women and homelessness services. Where possible organisations should collaborate to create standardised research and monitoring tools.
- **Increasing knowledge of NHS staff.** NHS staff need to have further training to develop their understanding of homelessness and housing issues with a focus on gender.
- **National standards and accreditation.** Services supporting the health of women who are homeless including health providers, housing and homelessness support providers and organisations in the women's sector should work towards shared standards. These should be developed with the full input of women who have been homeless themselves.

### There is a need for flexible, considered and participatory commissioning

- **Creating dedicated services.** Services should work together to ensure that there are spaces for women who are experiencing homelessness to go at different times of the day – 24-hour services should be highly beneficial to women.
- **Participation in commissioning.** Women with experience of homelessness should be involved in designing commissioning tenders, assessing proposals and on interview panels.
- **Fund early intervention.** Increased funding and resources for domestic and sexual violence service are important as violence remains a common cause of homelessness and significantly affects mental health.
- **Flexible funding.** Commissioning should encourage organisations to work together and to bridge the gap between women's and homelessness sectors. Flexible funding arrangements are especially important in the context of pressure on local budgets and limited resources.
- **Homeless Health Peer Advocates**. One-to-one advocacy support from people with a shared experience of homelessness is an effective tool to support women with complex health needs.

[1] On the 31st January 2020 Groundswell organised an event that shared the findings of the research and collaboratively developed the recommendations. Guests included funders, academics, journalists, NHS staff and representatives from local authorities, Government departments and charities. The researchers and some participants from the study also attended.

### There is a need for flexible, compassionate and consistent support centred around individual need within homelessness services and housing provision

- **Develop a women's strategy.** Providers of support should develop and implement a women's strategy with users of the service. It should clearly set out steps to respond to women's health and wellbeing.
- **Co-produced services.** Asking women who experience homelessness to design services and inform practice leads to services that better meet the needs of individuals. This participation needs to be meaningful and not a tokenistic gesture.
- **Women only spaces.** Services should create women only drop-in times to engage women who face challenges in mixed gender groups.
- **Training on the frontline.** Staff and volunteers working in support services need training on gender and trauma informed approaches to better support women's health and wellbeing.
- **Gender informed leads/champions.** Designated staff to promote and embed gender informed approaches within services is an effective way to drive change/.
- **Peer-led support.** There is a need to develop support systems for women led by women with experience of homelessness.
- **Ringfenced roles for women with experience of homelessness**. Creating roles across organisations that make use of the skills and experiences of people who use services is a powerful catalyst for change for both individuals and services. These must not be restricted to 'Peer roles' but are across the functions of the organization. E.g. Human resources, administrative roles.
- **Support listening.** Women in this research appreciated being listened to especially by someone with experience of homelessness. It is suggested that support services create more staff and volunteer roles dedicated to active listening and talking. Training should also be given to help staff and volunteers respond appropriately to what people tell them.

### There is a need for a focused approach within NHS services on the health of women who experience homelessness

- **Ask questions on accommodation status.** As this research found physical and mental health were two of the main reasons for homelessness. Given this, it is likely that NHS staff are treating patients before they become homeless, and therefore have an important role in prevention. However, stakeholders at the event felt that NHS staff are often not aware that patients are homeless[2]. All statutory services have a duty to refer when someone presents as homeless, but this needs to go one step further by staff asking patients directly about their accommodation. This is important as women may not be forthcoming about their housing issues.
- **In-reach services and co-location of services.** Having multidisciplinary teams 'under one roof' has a positive impact on women's health. Where possible NHS services should have drop in's in hostels and homeless charities.
- **Mobile health units.** Mobile units specifically supporting the health needs of homeless women[3]can help to engage Women particularly when they do not feel safe going to services that are predominantly used by men.

[2] This is also further evidenced by other research conducted by Groundswell and something Groundswell HHPA advocates experience.
[3] See for example Groundswell find and treat van *https://groundswell.org.uk/2009/tb-peer-educator-hi-vis/*

- **Specialist support.** Support from Navigators[4] and midwives who specialize in working with homeless women in hospitals and community settings can lead to better quality and safer care that is tailored to the needs of women.[5]
- **A safeguarding concern.** Homelessness and risk of homelessness should be listed as a safeguarding concern within women's organisations, housing providers, the NHS and other statutory services.
- **Mental health Catch 22.** Remove the barriers to accessing mental health connected with housing and addiction (see report). In addition to this, there should be support for mental health before people reach crisis point.

### There is a need for joined up working between services and sectors who support women experiencing homelessness

- **Mapping of homelessness, health and women's services.** Mapping of services and good practice would be a helpful tool for services supporting women who are homeless and the bodies that fund them.
- **Increased opportunities for joint working.** Women's and homelessness sectors and other statutory services should identify where their expertise lies and if there is a gap in their knowledge, capacity or resources to partner with complementary services. One way of achieving this is through staff and/or volunteer exchanges between women's and homelessness sectors.
- **Increasing joint referrals between women's and homelessness services.** This will allow women to have more tailored support and for sectors to continue to learn from each other.

[4] See examples of Groundswell *https://groundswell.org.uk/care-navigation/* and Pathways https://www.uclhcharity.org.uk/news/story/pathway-care-navigators

[5] Royal College Midwives have published guidance on supporting women who are pregnancy and who are housing issues or at risk of housing issues. There are also midwives dedicated to supporting vulnerable and marginalised women – this should be extended to homeless women.

## Contents

## Introduction

This following research explores the health of women[6] who are currently or who had recently experienced homelessness. As this report will show, there is an existing evidence base on women and homelessness, and this report builds on this. However, how it differs from existing research is that it has an explicit focus on health and the experiences of accessing services and that it is peer-led, focusing on the voices and experiences of women who have experienced homelessness.

This peer research employed both qualitative and quantitative methods, including focus groups with participatory activities and survey-based interviews. This research was conducted by volunteer peer researchers[7] with experience of homelessness and by Sarah Hough and Suzy Solley from Groundswell staff research team. Sarah was a previous volunteer and is now a staff member with lived experience of homelessness. As in all research projects, the process is as important as the results, but this is particularly true with peer research. We encourage the reader not to jump to the research findings section, but to take time to read our methodology and the magic our volunteer researchers have created.

### Overview of women and homelessness

Identifying accurate statistics on the scale and scope of women facing homelessness is a complex and multifaceted issue. Figures show that female street homelessness in England is rising more quickly than the overall rough sleeping population; the proportion of women rough sleeping in England rose from 12% in 2016 to 14% in 2017[i]. While the number of women rough sleeping is lower than men, women are much less likely to be counted in rough sleeping counts and are more likely to sleep in more 'hidden' places[ii] [iii] Much of the challenge of measuring women's homelessness is centred around two issues; one being how homelessness is defined and the second being how it is counted. As Reeve (2018: 169) importantly stresses: "They (women) do sleep rough, but we do not see them, and as long as rough sleeping is defined and measured as the visible face of homelessness, they will remain invisible".

Women can miss being counted or seen rough sleeping. For example, for safety, many women prefer to sleep on public transport, walk the streets at night, sleep in public places such as stations or to sleep during the day. They may also change their appearance to look male or as Reeve argues (2018: 168)[iv], to 'blend in' and hide the fact they are sleeping rough and try to look like everyone else. In other cases, women can sleep in hidden places such as sheds, at their workplace, hidden doorways where they will not be seen at all.

Women tend to be in more temporary and hidden places where they will not be seen as being homeless. For example, women may be living temporarily with friends or family, in squats or selling sex to survive[v]. Furthermore, women tend to use all friends and family options before rough sleeping

[6] Anyone who self-identified as a woman could participate in this research this includes trans-women.

[7] The volunteer peer researchers all have experience of homelessness; however, recent discussions with volunteer researchers have indicated that they would generally prefer to refer to themselves as volunteer researchers rather than peer volunteer researchers. So, for the rest of the report, when we refer to Groundswell volunteers, we will use the term volunteer researcher. When we refer to the research team, this includes volunteers and paid staff.

and accessing homelessness services (Reeve, 2011)[vi] (Mayock and Sheridan)[vii]. If women do not access services, it is nearly impossible to know they are homeless.

Another reason for not being counted is because of narrow definitions of homelessness. Rough sleeping is often seen as the sharp end of homelessness and is the one that is given the most attention, while others are overlooked[viii]. However, there are other types of unsafe and inadequate places in which women are forced to sleep which should also be considered as 'extreme' in understanding homelessness, and there should not be a hierarchy of different types of extremity.

Temporary accommodation, for example, that arranged by the council, is often not included or not thoroughly counted in homelessness data[ix]. Many women have children and are therefore entitled to varying types of temporary accommodation if they present as being homeless. Despite the temporary and often inadequate and unsafe nature of this accommodation, it is not often considered as 'homeless' accommodation. Furthermore, those who have approached local authorities because of domestic, sexual or other violence might not be recorded as both homeless[x] and as fleeing violence.

The type of support available can also deter women from seeking support and be counted as being homeless. Those experienced domestic and/or sexual violence may not want to seek support from services that are dominated by men[xi]. In other situations, increasing pressure on services means they often lack the space and resources to provide the type of support women need[xii]. This means women may not go to services and therefore, be identified as homeless.

This suggests the need for a broad and 'gender-sensitive' definition and counting to better understand the scale and scope of women's homelessness[xiii]. Given these challenges, the number of homeless women is likely to be higher than the data currently suggests[xiv].

## Causes of homelessness

This leads us to briefly explore the causes of women's homelessness. There are multiple reasons why women become homeless. There is rarely one sole reason, and causes need to be understood in relation to one another. Some of these are issues also shared by men, for example, low paid work, poverty, mental health issues, physical health issues, addiction and historical issues associated with offending, child abuse and leaving care[xv]. It is important to note that physical health and mental health issues[xvi] are often causes or major contributing factors to homelessness that are often overlooked. As Dai and Zhou (2020: 1)[xvii] state: "The feedback effect from health to homelessness is either ignored or downplayed in the existing studies of the health of homeless people".

Very often, the reasons women become homeless are a result of their gender[xviii]. One issue is the fact that women are more likely to be in low-paid, part-time work or carers in a family with little economic security[xix]. As Reeve (2018) importantly argues "financially independent women with savings, property, well-paid employment and affordable childcare can avoid or escape homelessness". Furthermore, recent policy changes such as the introduction of Universal Credit have had a disproportionate effect on women; women have found themselves without enough money to cover basic costs like rent and food[xx]. The fact that tenancies can often be in a male partner's name, and women may not have savings, means it is especially difficult for women to flee violence[xxi].

Although there is not extensive evidence on a national scale, it is commonly understood that a major cause of women's homelessness is a relationship breakdown with family or partner[xxii]. A significant part of this breakdown is due to physical, sexual and/or emotional abuse. St Mungo's found that one-third of women clients said that domestic abuse had contributed to their homelessness[xxiii]. This leads us to question an important question asked by Reeve (2018)[xxiv]: "why do women become homeless when they leave a violent partner?" This reframes the conversation around the cause of homelessness as about a *lack of support* for those who have been abused, rather than the *abuse* itself.

In addition to this, where abuse was not a direct cause of homelessness, it still contributed in some way. Research by Crisis (2014), demonstrates that 61% of homeless females and 13% of homeless males had experienced violence and/or abuse from a partner at some point[xxv]. Given the difficulty of disclosing experiences of violence, this figure is likely to be even higher. The impact of historical abuse and violence can lead to significant mental health issues[xxvi]. Without the right support, many women find it difficult to manage their mental health, and this can, in turn, affect their ability to manage other aspects of their life including work and managing expenses[xxvii].

Furthermore, it is important to note that not only is violence a cause of homelessness, but violence on the street, in hostels and other types of temporary accommodation can be a factor in perpetuating homelessness. Crisis has identified that 48% of women sleeping rough nationally have been intimidated or threatened and that, over the course of a year, more than 1 in 20 Crisis clients were victims of sexual assault while they were homeless[xxviii]. As mentioned previously, due to current, recent and/or historic abuse from men, women are often reluctant to go to services that are dominated by men. Unable to get appropriate support can mean women get stuck in the cycle of homelessness. The previous section illustrates that women's pathways to homelessness, and consequently the support they need, differ to men.

### Overview on women, health and homelessness

Given that there is already significant research, referenced above, on the multiple causes and consequences of women's homelessness, our aim was to explore the health issues of women who are homeless, and their experience of accessing services specifically. The following section will examine the existing evidence on the health of women experiencing homelessness.

The Homeless Link Health Needs Audit demonstrates that 44% of women[xxix] who are homeless currently have a long-term physical health condition and 78% have a current issue[xxx]; this compares to 46% for the general population who currently have a long-term health issue[xxxi]. For both men and women facing homelessness, the most commonly occurring physical health complaint was joint aches or problems with bones and muscles, followed by dental problems and chest pain. Conditions often prevalent amongst the older people in the general population are seen amongst much younger people in the homelessness population[xxxii]. The average age of death[8] of a woman experiencing homelessness is 42, compared to 81 years old amongst women generally[xxxiii].

[8] It should be noted that the average age of death is not the same as average life expectancy. These figures compare the average age a woman who is currently homeless dies and that of a woman in the general population. This figure includes women who are rough sleeping or using emergency accommodation at the time of death.

In terms of mental health, 44% of women experiencing homelessness had been diagnosed with a mental health condition and 86% reported a mental health issue[xxxiv]; this compares to 85% of homeless men[xxxv]. This disjunction between the number of self-reported issues and the number diagnosed indicates that either women are not seeking support for their mental health, diagnoses are being missed or there are barriers to getting support and diagnosed. The most common condition was depression (34%), followed by dual diagnosis[xxxvi] (13%) and personality disorder (7%)[xxxvii]. Furthermore, the rates of suicide are 9 times higher than the general population[xxxviii] and Homeless Link mental health guide suggests that 14% of participants in their study self-harm, compared with 4% of the population[xxxix].

### Homelessness and health inequalities

Homelessness not only causes mental and physical health issues, but barriers and inequalities in terms of accessing health care services can perpetuate and exacerbate these health issues and homelessness itself. Research conducted on behalf of Groundswell by The Young Foundation[xl] identified multiple personal, practical and systematic barriers homeless people experience in accessing and receiving healthcare. Personal barriers include issues with negative prior experiences, low confidence, fear of hospital settings and lack of knowledge about the services available[xli]. Practical barriers include having no fixed address, making it difficult to register and attend planned appointments, difficulty getting to appointments because of mobility and/or lack of money, and having multiple competing priorities and stresses such as the need to find somewhere to stay and something to eat[xlii]. The systemic barriers include a lack of understanding among NHS staff, actual and perceived stigma towards homeless people. As a result of this, there can be barriers to effective communication between people experiencing homelessness and NHS staff[xliii]. Further, the healthcare system can be complicated to navigate, and services can be disconnected[xliv]. These issues are compounded by the chaotic lifestyle that homelessness can create and are especially difficult for those with mental health and/or substance misuse issues.

These barriers can affect the access and quality of care for people experiencing homelessness. As a result, homeless people access a disproportionately higher number of secondary and unplanned health services, for example, ambulance and accident and emergency[xlv]. Further to this, there is a high rate of missed outpatient appointments, and people experiencing homelessness do not often access early and preventive healthcare. This is obviously a significant cost to the NHS[xlvi], but more importantly, these health inequalities cost people their lives. Groundswell's Homeless Health Peer Advocacy (HHPA)[9] service was created to address these inequalities and improve the health of people experiencing homelessness[xlvii].

## Methodology

The research employed a peer-led methodology with input from women with lived experience of homelessness throughout the design and delivery of the project. This included 4 volunteer researchers and one Groundswell staff member with lived experience of homelessness.

[9] To find out more about HHPA visit https://groundswell.org.uk/what-we-do/healthandhomelessness/homeless-health-peer-advocacy/

Peer research is commonly understood as a type of participatory research. As Roche, Guta and Flicker (2010: 4)[xlviii] state: *"the definition of peer research and the role of peer researchers shift according to context, community, the nature of the project, the understanding of community-based research, and over time*". However, what is generally agreed is that peer research works with people from a community as co-researchers for the entirety of the research process from research design, data collection, data analysis, and write up. This means, rather than simply being passive research subjects, peer researchers are actively engaged in research[xlix]. The key advantage of taking this approach is that peer researchers can reduce problematic power relationships that may exist when interviewing people who are experiencing social exclusion, often resulting in richer data and being able to recruit more participants or those that services find difficult to talk to[l]. The answers participants give may be more honest and detailed in their responses than if they were talking to a 'professional researcher'[li]. Another key advantage of peer research is that the research questions are more likely to be those that get to the heart of underlying issues and, perhaps, be more sensitively written[lii]. Furthermore, the involvement of professional and volunteer researchers will add credibility to research, especially when it comes to exploring solutions for effective change.

These are a few of the main benefits Groundswell volunteer researchers feel they bring to the research:

- Participants can see people like themselves who have come out of homelessness and can find it inspiring and empowering.
- By researchers sharing their own experience – stigmas around homelessness can be broken down.
- Researchers feel they can use their past negative experience for something positive.
- The places researchers refer participants to and the advice they give comes from lived experience, which can mean advice and referrals are more appropriate.

This peer research approach was instrumental in the success of this research.

### Training, preparation and feeding into the research

6 volunteer researchers participated in the training and delivered the fieldwork. A volunteer recruitment pack was sent round to organisations in Groundswell's network. Prospective volunteers filled in a short application form detailing why they wanted to take part. Potential volunteers were then invited to Groundswell to have an informal interview. The interview was important for the Groundswell team to identify if the role was appropriate for the volunteer, and for potential volunteers to see if Groundswell and the role was a good fit for them.

The selected volunteers took part in a training programme with units including confidentiality, consent and boundaries; the history of peer research; best practices in managing bias and pre-understanding and training on the research methods and techniques. During the training, researchers developed skills through practical and hands-on tasks and exercises where they tested and developed the tools while honing their own existing research skills and experiences.

We then started to explore important themes that could be included in the survey. During this session, we also discussed the possibility of mirroring some of the Homeless Link Health Needs Audit questions[10]. This would mean the research could be a stand-alone piece exploring health issues amongst homeless women in London, but also feed into a wider pool of data at a national level. A focus group conducted with women experiencing homelessness prior to the training also helped to form the survey questions. From the focus group data and the provisional themes we identified as a group, a survey was developed, which was designed to be delivered on an electronic tablet computer. In addition to this, towards the end of the training, the volunteer researchers also designed and refined consent forms and information sheets to be given to research participants.

A key point the group felt strongly about was trying to establish a way to also document women's voices and the nuances of their experiences. While it was felt that statistics are important to gain a snapshot of experiences, open qualitative questions offer an opportunity to gain richer insights into the intricacies of peoples' experiences. We concluded that the best way to capture this was to voice record a short conversation between the researcher and the participant at the end of the survey. At this point, we also offered participants the opportunity to add anything that was particularly important to them and to share their experiences of being a woman and being homeless. However, after the first few initial surveys, we discovered that it was easier to record the whole conversation from the start of the survey. This meant that we could obtain more detail and nuance behind the answers given in the survey. If participants were not comfortable being audio recorded, the researchers took written notes. These audio recordings, subject to participant's consent, were to be used to develop a podcast. However, due to the background noise on many of the recordings, we decided it would be best for our volunteer researchers to read out the quotes from participants.

The volunteer researchers were trained to use the Dictaphones and electronic tablets to capture the data. The researchers then had the opportunity to test and to pilot the survey with Groundswell's volunteer advocates, who also have lived experience of homelessness. From these pilot surveys, we were able to identify mistakes, get a sense of the length of the survey and then make any necessary adjustments.

### Sampling

The study had two criteria for participants; women with current or previous experience of homelessness who were currently accessing support services that support homeless people in London. While some people move into accommodation, they still engage with homeless support services for a manner of different reasons. For example, they may need further support with their mental health, gaining employment, sustaining their tenancy or being able to get their basic needs if money is tight. In other cases, people continue to use services as that is where their friendship groups and support networks are based. Given this and the fact that women often fluctuate in and out of homelessness, we felt it was important also to include women who were using homelessness services but were not currently homeless. Furthermore, given the diversity of experience that women who are homeless face, we adopted a broad definition of homelessness and a participant could include anyone who has had current experience or previous experience of the following accommodation

[10] The Homeless Health Needs Audit tool is created and managed by homeless link. It is used to gather information on the health needs of people experiencing homelessness across England in order to assess what the needs are and to improve healthcare services. To find out more go to: www.homelesslink.org.uk.

situations; rough sleeping, squatting, sleeping on public transport, night shelters, temporary accommodation, hostels, temporarily living with friends, supported housing etc.

A representative sample is a proportion of the population that seeks to reflect the characteristics of the larger group accurately. Since precise figures on the number of homeless women are limited, and therefore, so are demographic characteristics, it would be difficult to develop an accurate representative sample. We wanted to make it as inclusive as possible and not to have too many different criteria. Therefore, we limited the criteria to women who were or who had recently been homeless. We used our judgement and recruited women from a variety of different services across London. Given the demographic information of participants, it appears that we spoke to a relatively diverse group of women.

Furthermore, as mentioned above, we know that a significant number of women are hidden homeless and may not be accessing any services. This report, therefore, cannot represent the challenges of women who are hidden homeless and those who are rough sleeping and are not accessing services. In addition to this, we spoke to 104 women in London, and there are an estimated 170,000 people in the capital experiencing homelessness. We, therefore, cannot say that the participants in the research are representative of all women who are homeless in London. Our findings need to be interpreted with these considerations in mind.

The fieldwork took place in hostels, drop-in and day centres across London, we did not conduct research on the street or in public places. Due to the sensitive topics we felt it was safer and more comfortable for volunteers and participants to talk in a specific service. This was so we had a channel of communication if we needed to raise any concerns we had about participants and so we could send suggestions and/or services that could offer further support to the participant.

### 1 to 1 survey-based interviews

The surveys were quantitatively based, with qualitative follow-up questions to give more depth and insight around experiences on particular issues. All data collection was completed on tablet computers with 77 delivered face-to-face at a range of services in London including The Ace of Clubs, Look Ahead, Connections St Martins, Crisis Skylight, Glass Door, Greenroom Manna Society, Marsha Phoenix and Passage Day Centre. Participants were either given £5 cash or a £5 voucher to thank them for their time. Informed consent was sought and received from all participants who took part. Many of participants who participated were happy to be audio recorded. These recordings were listened to and transcribed by a professional transcriber. Groundswell staff and volunteer researchers also helped with the transcription. The interview transcripts were analysed in Nvivo[11] and the survey responses were analysed in Excel.

### Focus groups

3 focus groups were conducted during this research. The first focus group was conducted in the early stages of the research and helped to inform the survey questions and themes that would be explored. Focus groups were also conducted at the Magpie Project and New Horizons. A total of 27 participants

[11] Nvivo is a software programme used for analysing qualitative data.

took part in focus groups and either Groundswell staff or volunteers with lived experience of homelessness co-facilitated. All focus groups were audio-recorded and professionally transcribed, then coded and using NVivo. Participants were given £10 cash or a £10 voucher to thank them for their time – notably, focus groups take 90 minutes whereas surveys typically take about 30 minutes. Informed consent was sought and received from all participants who took part.

### Analysis of data with volunteer researchers

To ensure the volunteer researchers were involved at all stages of the process, an analysis session was run in September to gain feedback and steer the direction of the second phase of the analysis. The workshop offered an opportunity for the volunteer researchers to reflect, scrutinise and discuss where different variables may have interrelated. The structure of this report, and how data has been presented, is based on discussions in the workshop.

### Support structures for volunteers and staff

The reasons for becoming homeless, and negative impacts of homelessness, can continue well after people become housed in 'stable' accommodation. Homelessness is not an on and off switch and sadly, volunteers and staff at Groundswell, still have on-going problems with housing, immigration, their mental health etc. This type of peer involvement is only successful when there are support structures, both informal and formal, in place. Groundswell has several mechanisms to ensure the well-being of staff and volunteers and also that the experience of being involved supports people to develop and move on from homelessness.

Firstly, staff play a role in providing pastoral support to volunteers offering feedback and guidance on delivering the volunteer role. A key part of this is keeping regular contact through text, calls and emails when people are unable to make it to sessions. In the field conducting the data collection, the team would check-in before to brief on the research visit and after to talk about any difficult conversations or issues arose.

Staff and volunteers also have group reflective practice sessions led by a qualified counsellor. This creates a space to share any type of mental health or emotional concerns that arise during the research process and can help researchers to learn about what they're feeling, why they might be feeling it and how to cope.

Volunteers and staff with lived experience of homelessness also have access to support from Groundswell's Progression Programme[12], if they want it. The progression team help volunteers and staff with anything that can improve their wellbeing and time at Groundswell – this might be support for on-going housing problems, immigration issues, coaching, support writing CVs and finding training. Groundswell volunteers are also invited to various Groundswell events and meetings and are free to use our communal spaces, kitchen, computers and printers during office hours. To enable volunteers to continue being able to volunteer, they are paid for their expenses – lunch and travel.

[12] Find out more about the Progression Programme here https://groundswell.org.uk/what-we-do/progression-programme/

Some of the volunteers were unable to volunteer due to on-going issues with their health and housing. Regardless of this, we kept in touch with them throughout, invited them to events, meetings and celebrations, connected them with a Groundswell progression coach and kept them up-to-date with the research findings. Some have recently returned to participate in the making of the podcast.

## The Golden Nuggets of Peer Research

This section explores the seemingly small but hugely significant nuances of peer research – particularly around the relationships developed between researchers and participants. As with any research project, there are considerations and limitations to consider. Notably, some of the limitations are, paradoxically, also the strengths of this research.

### The length of the survey

One of the first potential limitations was that some surveys could take an hour or more when we had envisioned they would take up to 30 minutes. As a team, we thought the length of time it took was due to several combining factors. For example, the survey itself was detailed and comprehensive, some women had complex health conditions that they needed to discuss, and some women wanted to share their story in detail with us. As a group, we think women may have been more forthcoming with their experiences because they were talking to a volunteer researcher who had gone through similar experiences. We also think that perhaps women don't often get directly asked about their feelings and health issues and, therefore, used the opportunity to talk and share. The way women openly told their stories is also a huge testament to the empathy, and emotional intelligence the research team showed to participants.

### Sensitive questions, listening ears

Related to this, we found although some of the questions could be deemed as sensitive, participants were not shy about sharing these experiences. Again, we are not able to directly say why this was the case, but it was indicated at times that women were happy to share because they were sharing their experience with someone who had also gone through something similar. This suggests that research or any kind of engagement with homeless women should not shy away from sensitive subjects like domestic violence, trauma and sexual health if it is done with care and sensitivity. If women must live with the trauma of these issues daily, we must not be scared to ask them about it. However, such questioning requires prior trust and sensitivity.

This point relates to a wider observation that many of the hostels, day centres and drop ins that we visited were very busy. Staff and volunteers were doing brilliant work to support their clients by serving food, helping with benefit and/or housing applications and sorting out washing/shower facilities etc. We found that a compassionate ear of the volunteer researchers was welcomed by staff and especially by participants. We could see women in a room full of people with no one to talk to. In some cases, these women wanted to be left alone but, in many cases, demonstrated by how much they spoke to researchers, they clearly wanted to talk. This led us to think, with the hustle and bustle of busy services and practical needs that need to be met, is there perhaps a need to have nominated volunteers or staff who use their time to simply listen and ask how their guests are? While listening, talking and connecting might not be an obvious solution to tackling immediate needs, we learnt that

they are vital in supporting the mental health and wellbeing of people experiencing homelessness. Clients in services may particularly benefit from this if it is peer-led.

In addition to this, because the research team directly asked questions about health and wellbeing, we were sometimes able to identify issues that staff in services were not previously aware of. With the participant's consent, we were able to make staff aware of these issues and hopefully, something could be done to support them, or at the very least staff could talk to them about the issue. It is apparent that peer research is a means by which we can directly ask people experiencing homelessness about the challenges they face that may otherwise go unasked. It is also a great way of connecting with people and reducing isolation – something which is highly prevalent with people experiencing homelessness. Peer research can be especially meaningful to the participants because researchers do this on a voluntary basis.

### Peer research as a therapeutic practice

One of the main frustrations that researchers experience is that policy change to improve the lives of people experiencing homelessness can take a very long time; much longer than the course of the research. One thing we agreed as a group was that aside from policy and systemic changes, what we could do is offer women an opportunity to talk to and be heard by someone who cares. In the short term, we felt this is, in fact, perhaps the most valuable thing about the research. It is often thought that research happens and then changes, or actions occur, but we see it differently. If done well, research can be a therapeutic experience for the researcher and the participant; this is especially the case for the volunteer researchers who are still living with their own trauma of homelessness. Our conversations often ended with a hug, a shared cigarette, a cup of tea or some kind words for the future and the researchers. Given their own experience of homelessness and the journey they had been on, the researchers have a wealth of knowledge, strength and hope to share. There were many incidences where participants spoke of feeling inspired by the researchers and that the researchers gave them hope for the future. Although immeasurable, the power of this cannot be underestimated.

### Boundaries and emotional challenges

During training, we spent a lot of time thinking about the boundaries of research, what our role was as researchers, and if or how we could support the participants. We agreed that conversations involving signposting to relevant support should happen at the end of the survey to avoid confusion and the participants thinking it was a case working conversation. When issues came up in the survey that researchers felt they could support participants with, it was sometimes difficult for them to wait until the end of the survey to discuss that issue. On occasion, researchers would ask the advice of Groundswell staff, volunteers or staff in the service before consequently signposting the participants. Where we felt participants needed more support or they disclosed a safeguarding concern, (although ironically homelessness is, of course, a safeguarding issue in itself), we would let the service staff know and if required, follow up with lists of places for them to signpost their clients to. In addition to

this, we gave out Pavement[13] magazines, Right to Healthcare cards[14] and referred participants if they wanted to use our HHPA service[15]. We also sent services anonymised information about the issues that their clients were facing for them to use this as evidence for more or adapted support.

There were instances that caused upset, predominantly to the researchers who were affected by what participants told them; some disclosed truly harrowing experiences. When traumatic experiences and events were disclosed, the researcher comforted the participant, asked if they wanted a break or to carry on. The research team also comforted each other. In all cases, the participants wanted to carry on telling their story. However, we should note that despite the difficult and upsetting experiences discussed, there was significantly more laughter than tears.

## Participant Demographics

This section briefly explores the demographics of the women we spoke to, their age, nationality, ethnicity and sexual orientation. This gives us a snapshot of a group of women who are homelessness. As explained previously, it is not intended to be representative of the wider population.

The average age of the women we spoke to was 43– the youngest was 19, and the oldest was 75 years old. It should be noted that this research only included women over the age of 18 years old. However, we know there are many who become homeless before the age of 18. As evident in the graph below, the majority (45%) of the women we spoke to were UK nationals, 27% were EU/EEA nationals and 24% were non-EU nationals. Also, most (53%) of the participants we spoke to described themselves as white and 29% described themselves as either Black British/African and or Caribbean.

*Figure 1: Graph showing nationality of participants*

[13] The Pavement is a magazine for people experiencing homelessness. The magazine has lists of places to get immediate support and articles, often written by people with experience of homelessness, which are designed to provide inspiration for the future of its readers. https://www.thepavement.org.uk/about

[14] Right to Healthcare cards were developed by Groundswell to help people without a fixed address to register with a GP. Find out more about the cards here https://groundswell.org.uk/what-we-do/healthandhomelessness/my-right-to-healthcare-cards/

[15] Homeless Health Peer Advocacy is a service founded by Groundswell in 2010. The service supports people experiencing homelessness to address physical and mental health issues. We work to improve people's confidence in using health services and increase their ability to access healthcare independently. Find out more here. https://groundswell.org.uk/what-we-do/healthandhomelessness/homeless-health-peer-advocacy/

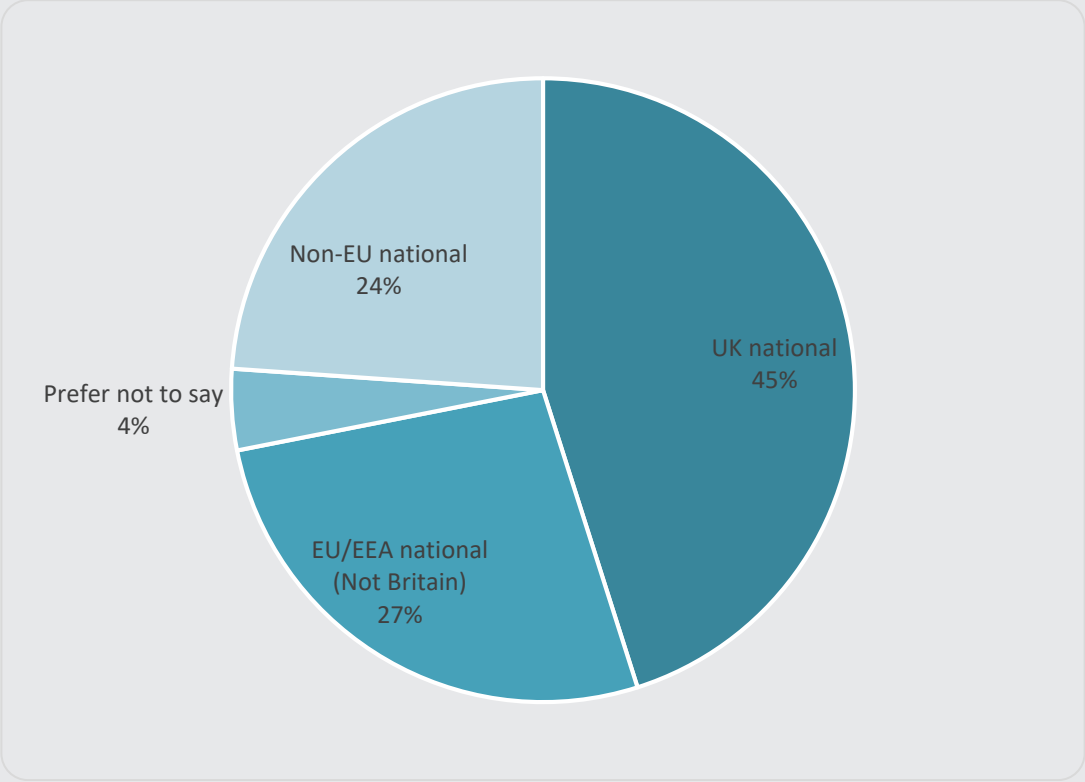
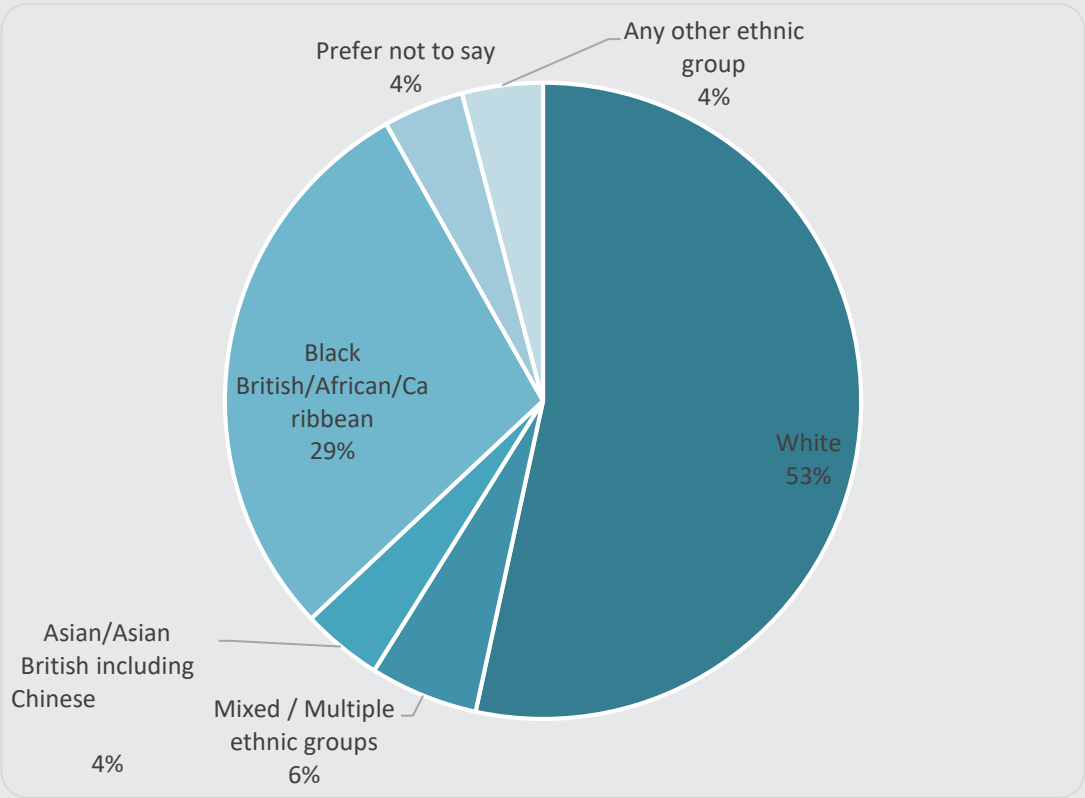



*Figure 2: Graph showing ethnicity of participants*



Most of the participants (81%) who answered this question described themselves as straight/heterosexual, 9% as bisexual, 3% as lesbian and some women spoke of how they would consider themselves asexual. Women often explained that past trauma from domestic or sexual violence meant they became sexually disinterested. Nearly half (47%) of the women we spoke to are mothers, and 22% of those women had children taken into care.

## Research Findings

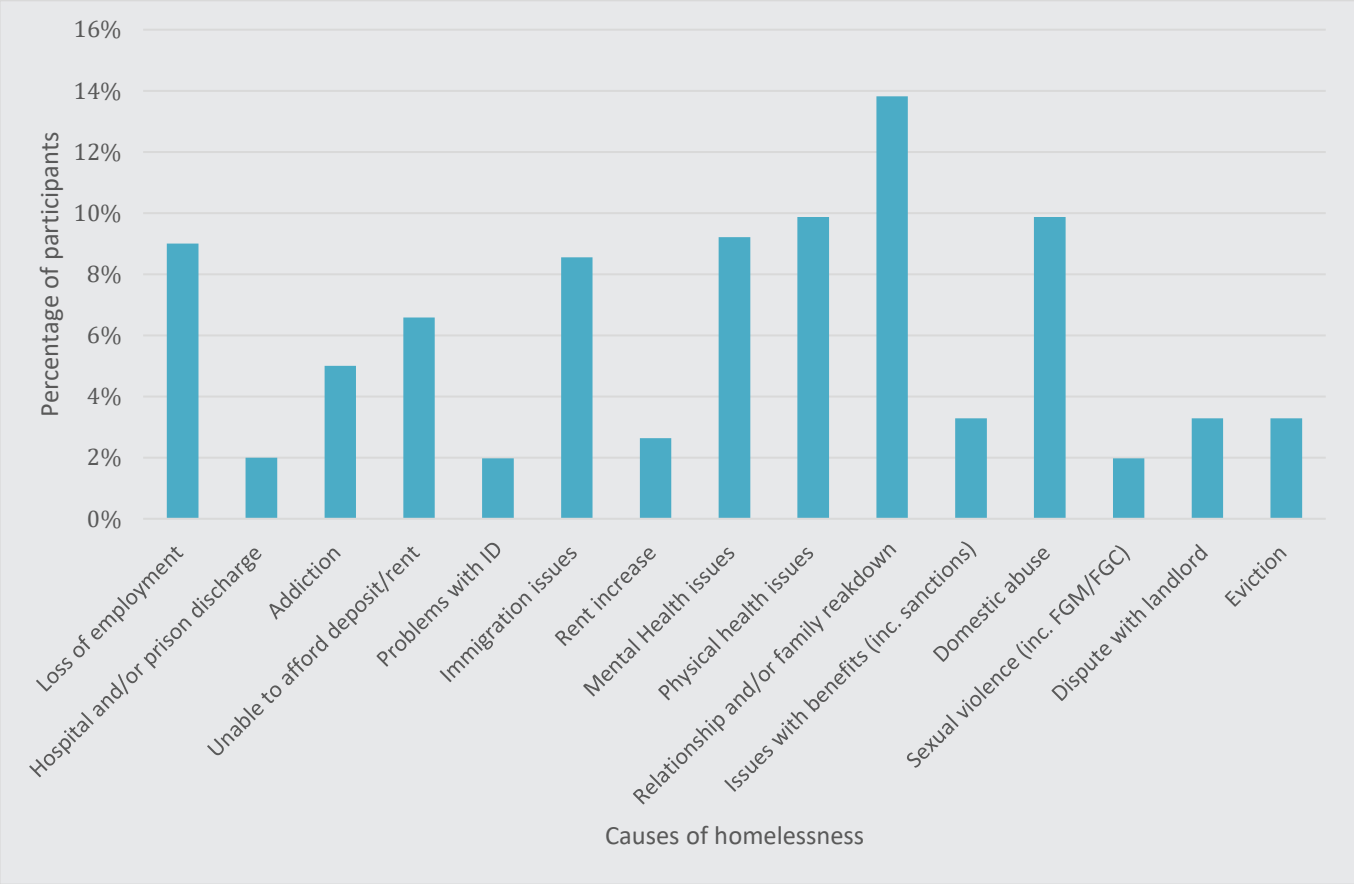
### Becoming homeless

The following section gives a snapshot of the reason's participants gave for becoming homeless. This research was not designed to explore the reasons for women's homelessness in-depth as there is already substantial research on this. However, in order to give some context, it is important to briefly explore the reasons why participants became homeless.


In the survey, we asked what women felt were the main reasons for becoming homeless. We presented a list of possible causes, and they also had an opportunity to add their own and to pick as many as they felt were relevant to them. It was evident there were often multiple intersecting reasons for participants becoming homeless. We also found many of the issues women cited were often compounded by another problem. As illustrated in the graph below the main reasons cited were relationship breakdown, including the breakdown of family relationships, physical health issues, domestic abuse and mental health issues[16]. We found that 39% of participants had experienced domestic abuse, and 25% had experienced sexual abuse at some point in their lives.

[16] Other options not included on the graph include, rent increase, unable to afford deposit/rent and problems with ID, including identity fraud and loss of ID.

*Figure 3: Graph showing main reasons for homelessness amongst participants*




Physical health issues, along with domestic abuse, were the second most common reason cited. As indicated in the literature review above, it is apparent that physical health is still a commonly overlooked cause and consequence of homelessness. Since this research was primarily concerned with the health issues women experience, it was important to ask participants to what extent physical and mental health contributed to their homelessness. We asked women the extent to which they agreed or disagreed with this statement; *"My health (physical and/or mental) issues contributed to me becoming homeless"*. As seen in the graph below, 59% agreed (30% strongly agreed, and 29% agreed).

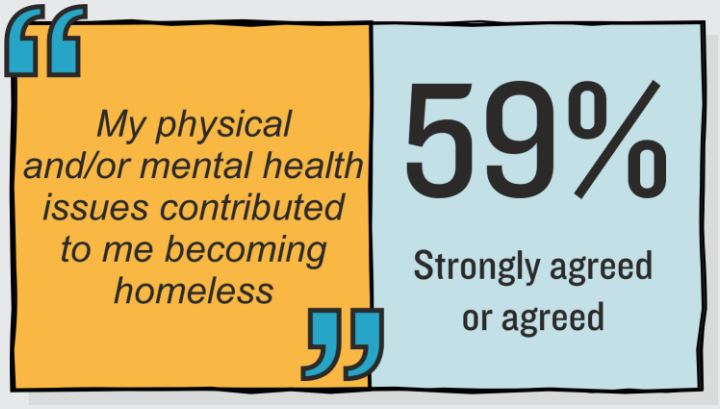
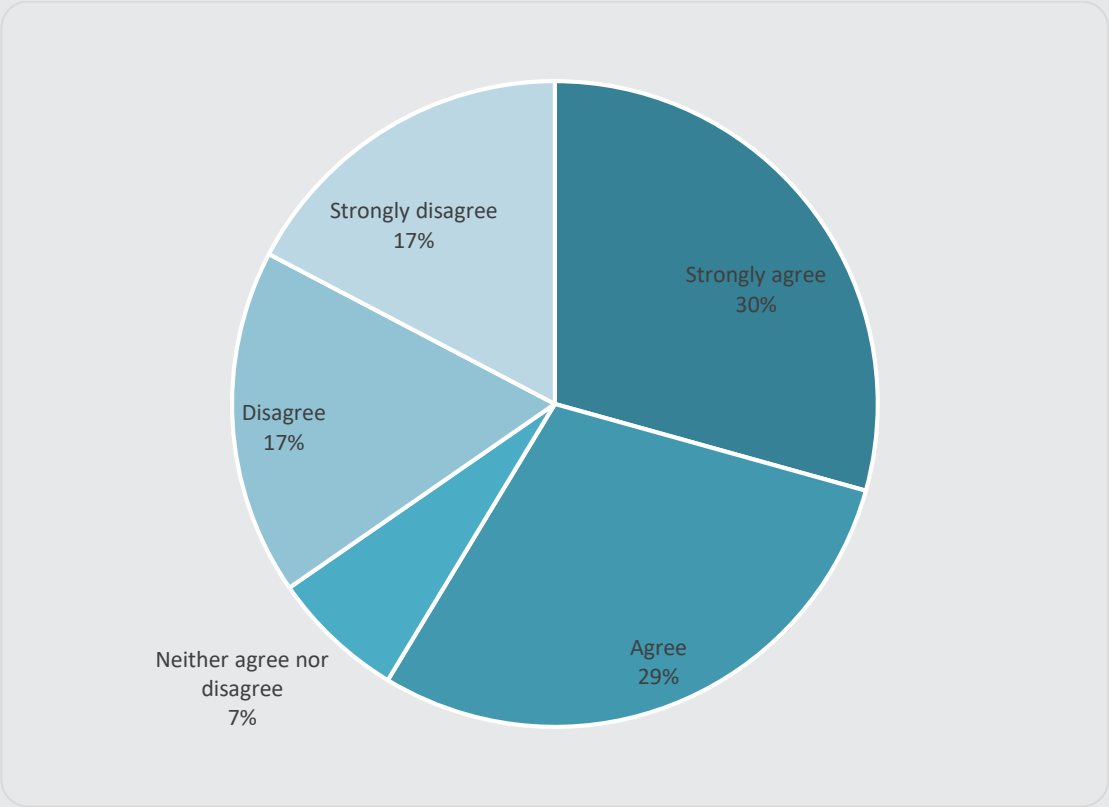


*Figure 4: Graph showing extent to which participants agree with the statement "my health (physical and/or mental) issues contributed to me becoming homeless"*




Participants elaborated on how health contributed to their homelessness. This participant explained how she lost her job as a carer and consequently became homelessness as a result of a physical health problem:

> *"I was working in 2016. And my client (referring to the person she was caring for) broke my thumb when she was falling – she broke my thumb. And I couldn't work because you have got to have two hands. Prior to that I had a client fall down the steps and I twisted my knee."*

Losing jobs because of physical health issues was a common theme in this research. For example, one woman lost her job in a restaurant because of pain and swelling in her hands that meant she had problems moving her hands. Women reported that the types of employment contracts they were on meant that they were not entitled to sick leave.

Undoubtedly, we found that many of the reasons given by participants for becoming homeless were due to gender inequality, for instance, domestic and sexual violence and relationship breakdowns. These issues were often combined with poor mental and physical health, job loss and poverty. One woman described how she had to leave her job due to the inappropriate behaviour of her boss.

*"Because I left my job and it was also because my boss was… er… asking sexual favours. One reason. And then other things. My father passed away, a few things altogether. And then I used to have a problem with drugs as well. But mainly the fact that I had to leave my job because of my boss."*

We found that women can be significantly affected by relationship breakdowns, especially when the tenancy agreement is in their partner's names or if their partner is the main earner. This supports existing evidence that explores gender differences and homelessness[liii].

Many women spoke of the violence they experienced and the subsequent breakdown of their relationship. One woman shared her experience and how the council did not support her as she did not have evidence of her abuse:

*"[I became homeless because of…] a relationship breakdown and being abused for three years after the relationship broke down. I tried to stay for three years, I tried to work with [South London Council] to move, and that's what I was told - has the person put a gun to your face? Has your life been threatened? Unless I was actually, my life was actually in danger. Because I was never admitted to hospital or anything like that, there wasn't anything to say I was in danger".*

Another participant told us of their experience of domestic violence and how being on the street was better for her than facing the violence:

*"Hmm. To take myself away from the domestic violence because … if I didn't, I wouldn't be here today. In a way, I put myself in more danger being on the streets…but street life… is, to be honest…street is the answer."*

It is important to note that some women we spoke to talked about how they came to the UK to flee gender-based violence in their country, for example, rape and Female Genital Mutilation (FGM). These women told us their stories but did not want to be audio recorded.

Women also talked about how pregnancy can contribute to homelessness. Some women spoke about how their relationship broke down with their partner when they became pregnant, and they subsequently became homeless. Other women in a focus group spoke of situations where a partner had got another woman pregnant and left them. These situations, combined with the fact that women were not on the tenancy agreement, left women struggling to pay their rent by themselves and therefore they became homeless. This participant talked of the situation she faced when she was pregnant and how she was subsequently given unsuitable accommodation:

*"I was pregnant, and I couldn't live with my mum and dad. I couldn't live with them. So, when I went to [London] council, they said to me you need a letter of recommendation from your parents that they don't want you living there no more. And then I went to a bed and breakfast in [South London area]. And er… when I went there it was all cockroaches… horrible. And I was there for a couple of months."*

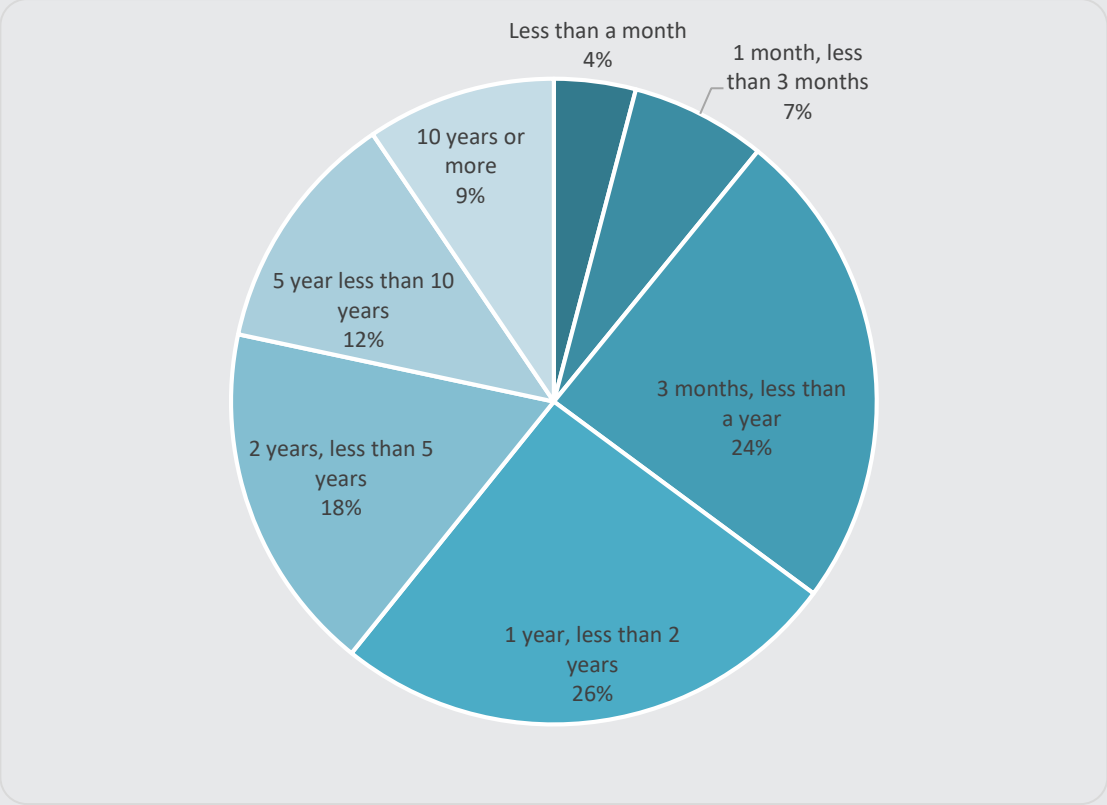
Women also spoke of how their children being taken into care caused addiction and mental health issues which spiraled into homelessness.

This section illustrates that there are multiple reasons participants became homeless, and the examples illustrated show that one reason often compounds another. The data shows that physical health issues were one of the leading causes of homelessness or that it contributed to the situation. These findings also echo evidence in other research studies[liv] that suggest the trajectories to homelessness are different for women and men, and that women's homelessness is often a result of some form of gender inequality.

## Current situation

The graph below shows how long women had been homeless (this time around only, as many had experienced homelessness in the past). The data shows that 35% had been homeless for less than a year, 26% had been homeless between one and two years and 39% had been homeless for 2 years or more. This suggests many women are experiencing long term housing issues.

*Figure 5: Graph illustrating how long participants had been homeless*



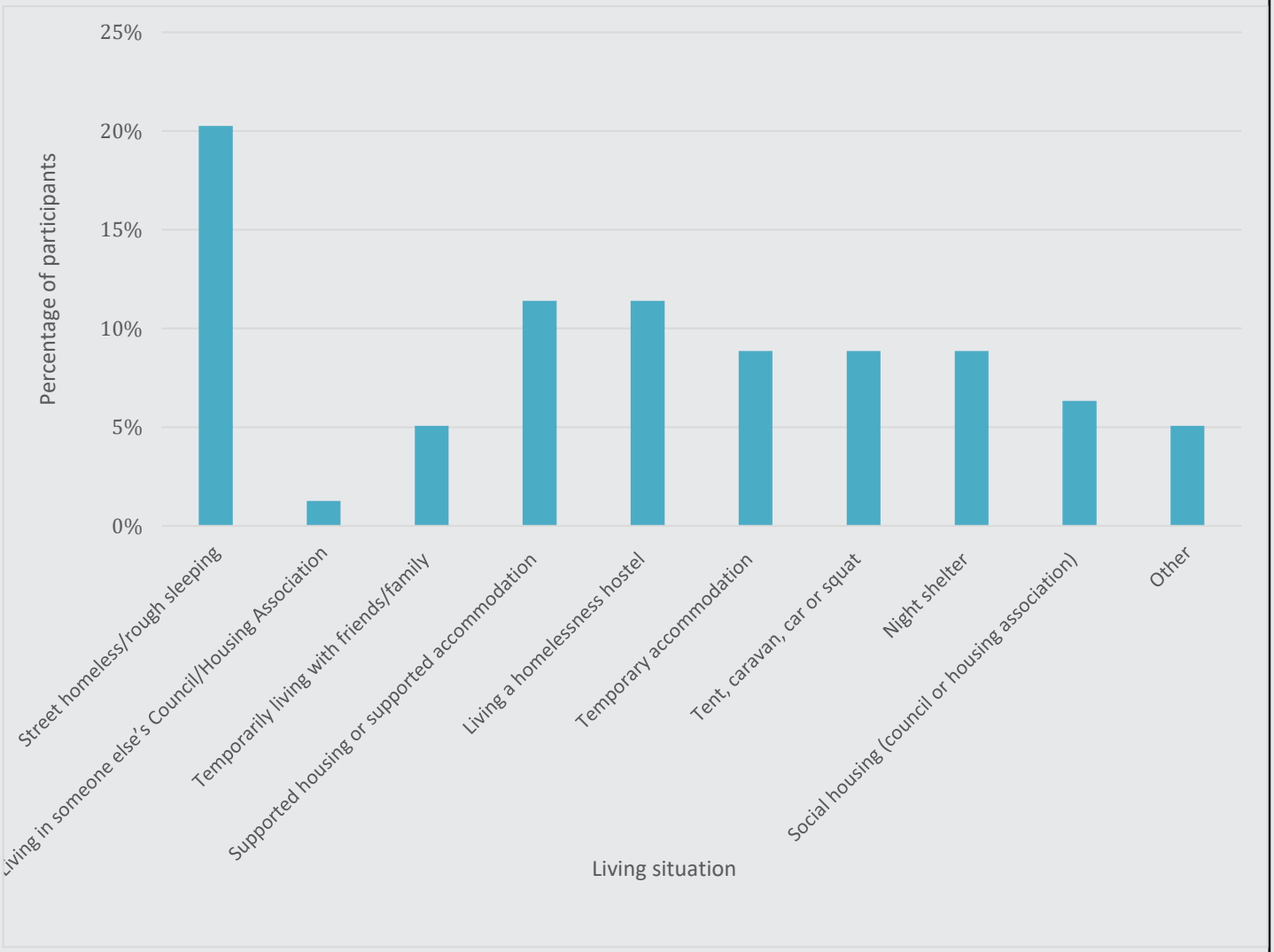
The research found that 42% of participants had been homeless before and that women experience a cycle of repeated homelessness. When asked how long she had been homeless, one woman said, *"I think on and off for nearly 3 years. In and out, out and in, on the street."* Of those who had experienced homelessness before, 31% said the longest time they had been homeless for was 10 years or more. One woman who was in her sixties spoke of how she had been homeless on and off for 30 years of her life. In another case, a woman could not remember how long she had been homeless for.


## Current sleeping situation

The graph below details the current places participants were sleeping. The highest proportion (21%) were sleeping rough, and the other main places include supported accommodation (12%), hostels (12%), temporary accommodation (9%), tents, caravans, cars or squats (10%) and night shelter (10%)[17]. Although only 21% were currently sleeping rough at the time of asking, 70% had slept rough at some point in their lives, and 26% had slept rough in the last week.

[17] Other options not included on the graph include Living in a B and B, Sofa surfing, National Asylum Support Service (NASS) and private rented sector. Other categories include sleeping at work and some did not want to say.

Figure 6: Graph illustrating current living situation of participants




Further conversations with participants about their current living situation revealed some of the challenges they had. This woman explained how she was often allowed to sleep on buses, but when she wasn't allowed to sleep on them, she found it difficult to sleep in more public areas where people were dealing or using drugs:

> *"And they let me stay on the bus when they got to the end. So, I could still sleep and stay warm. And then travel all the way back with them. When I wasn't in the bus, there is, of course, the coach station and railway station… were good. But I didn't approve of… mixing myself with too many… drug addicts at that time. Because that would have been too depressing, and then I had a depression that wasn't… it wasn't able to climb out of."*

Women spoke of how, although they had somewhere to sleep, i.e. in a hostel, night shelter, temporary accommodation, they were worried about what would happen with that accommodation or felt that their accommodation was unstable and unsafe. One participant was worried about where she would sleep after the winter night shelters closed:

*"As I said, our shelter closes in April. So, it means that we need to find somewhere after April for definite because it closes. So, what I mean is… we are already homeless, but you don't want to be on the street. You don't want to go backwards; you want to go forwards."*

Another woman spoke of how the accommodation she was given when she was pregnant did not have a door that locked properly;

*"Then they gave me temporary accommodation and the problem was the front door, so anybody could come in probably murder you or something. And I couldn't sleep at night or nothing."*

Related to this, many other participants, especially those who lived in mixed, temporary accommodation, spoke of how they felt unsafe living there and how this had an impact on their mental health.

## The Health and Wellbeing of Participants

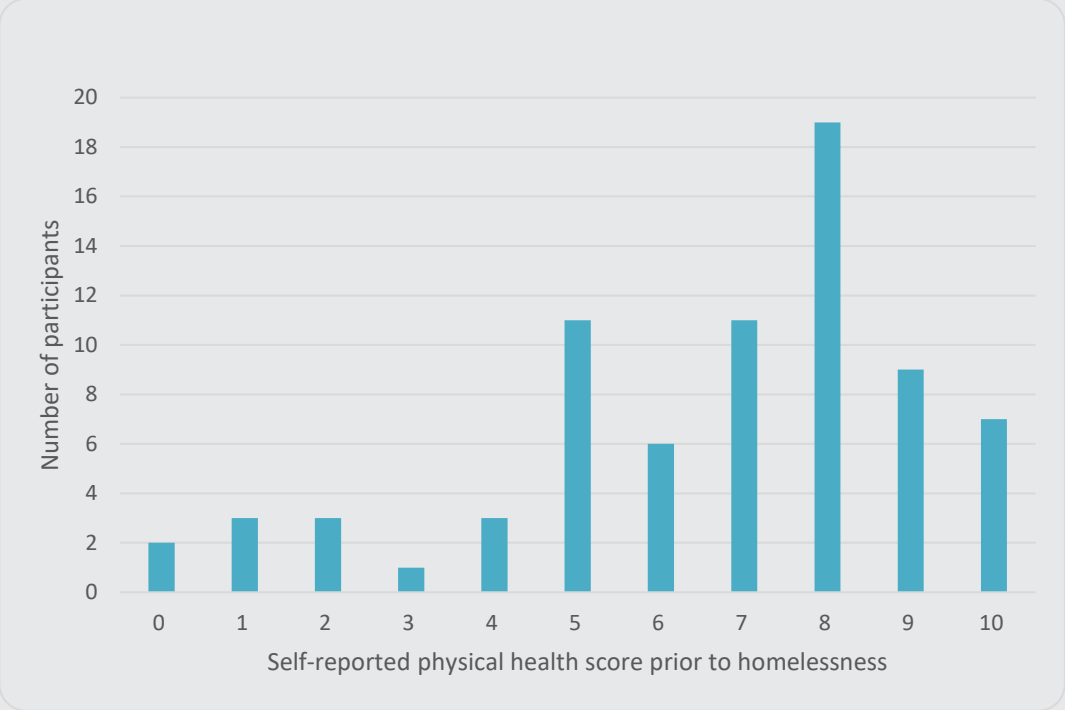
This following section explores the health issues that participants were facing. These are based on self-reported health ratings and health issues. Within our current NHS system, there can still be a tendency to see mental and physical health as separate concerns[lv]. However, we understand that physical and mental health is inextricably interlinked, and the recommendations that develop from this report will acknowledge that.

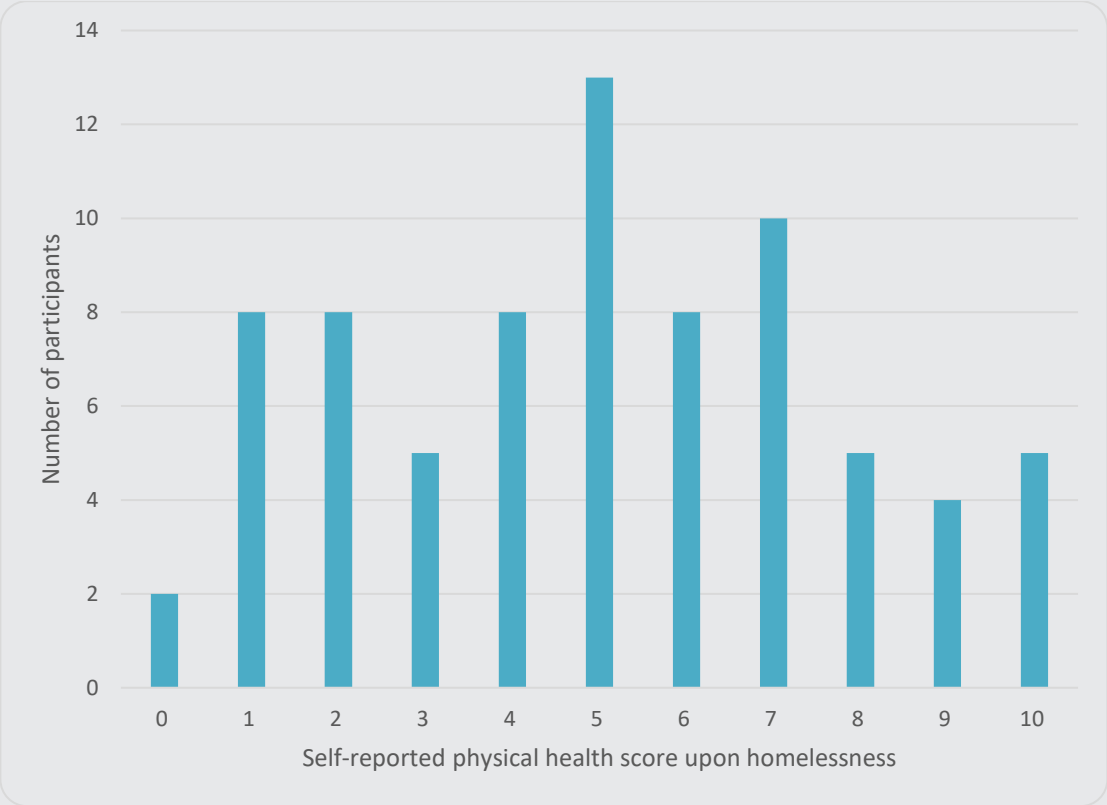
### Physical health issues

Our research found that 74% of participants had a current physical health issue. These findings are broadly reflective of those in the Homeless Link Health Needs Audit (78%)[lvi]. We asked participants to rate their physical health on a scale from zero to ten (zero being terrible health and ten being fantastic physical health) before they became homeless. As a research team, we decided to adopt this simple Numerical Rating Scale which is often used in health research[lvii].


As shown in the graph below, the average physical health rating prior to becoming homeless was 6.5 and distribution is skewed to the right indicating generally good self-reported health. We also asked women to rate their current health on the same scale. As evident from figure seven below, the average rating of current physical health was 5, and the graph is more evenly distributed, indicating a general decline in self-reported health.

*Figure 6 and 7: Self-reported physical health before and after homelessness*




It should be noted that this way of measuring health is not without its limitations. For example, some health conditions can vary considerably on a day-to-day basis, meaning that one day a participant may feel in great health and the next they could feel in poor health. Furthermore, it is important to note that physical health was the second most common reason for becoming homeless, so

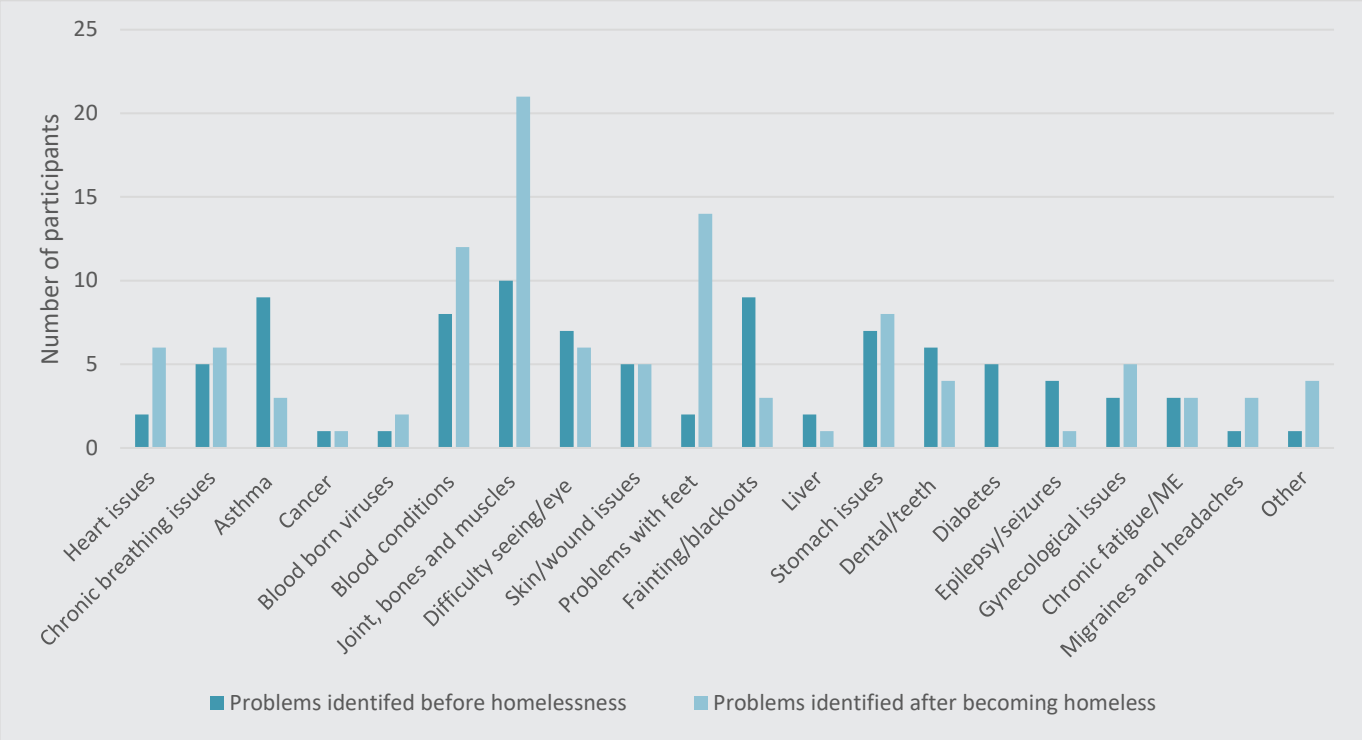
participants may have reported lower physical health before becoming homeless hence why average health rating has not reduced significantly.

The following graph illustrates the currently diagnosed health conditions that the participants had. As mentioned previously, the health options we gave to women were the same structure as those in the Homeless Link Health Needs Audit. If women had a condition that did not fit in those categories, we added it under 'other'. The most common health conditions were those associated with joints, bones and muscles (40%), blood conditions (26%), problems with feet (21%) and stomach issues (19%). Other issues included chronic breathing problems (14%), asthma (16%), fainting and blackouts (16%) and difficulty seeing/issues with eyes (17%).

In addition to exploring the types of health conditions, it is important to identify whether they occurred before or after becoming homeless. The graph below illustrates which conditions started before becoming homeless (indicated in the dark blue columns) and which started to occur after becoming homeless (indicated in light blue columns). As evident from the graph, most of the conditions occurred after becoming homeless. However, it is not possible to ascertain if it was homelessness that directly contributed to these health issues or whether it was either a greater awareness/diagnosis of a health condition or a natural decline in health.

The conditions that had the most significant increase upon homelessness were issues with joints, bones and muscles, blood conditions, heart conditions and problems with feet. These findings echo previous Groundswell research 'Out of Pain' which found that 53% of people currently experiencing homelessness are experiencing chronic pain. Furthermore, given the amount of time women spent outside and walking the streets for hours when they had nowhere to sleep, it is unsurprising that issues with feet were common. Furthermore, some women spoke of how their shoes wore out quickly because of walking and being outside all the time.

*Figure 8: Graph showing physical health issues before homelessness and when homeless*[18]




Conversations we had with participants revealed deeper insight into the physical health challenges that have been created and/or exacerbated by their current homelessness situation. Participants spoke of the health issues that arose as a result of being homeless. As this woman explained:

> *"But my physical health through being out on the street, I have got a now lifetime illness – COPD. It's a killer. Eventually, I would have to use an oxygen mask. Eventually, I will be bed bound because I won't be able to walk or move without being out of breath."*

Another participant told us:

> *"Well, my whole life [unclear] chronic condition, chronic lung problem, because I was sometimes put in places where there were mould and everything. And also the street. And now I am left with the… almost every year with lung and mental health."*

This mirrors findings in a Groundswell research project, 'Room to Breathe', which explores breathing/respiratory issues among people experiencing homelessness[19].

[18] Heart issues include heart attack, angina, murmur or abnormal heart rhythm. Breathing issues include bronchitis, emphysema, obstructive airways disease. Blood born viruses include HIV, Hep C and Hep B. Blood pressure issues include anemia, circulation and clots. Joint, bones and muscles issues include muscular dystrophy, MS, varicose veins and fibromyalgia. Stomach issues include ulcers, issues with intestines, gall bladder, nausea. Gynecological issues include STI's, polycystic ovaries, urinary tract infection, fibroids, FGM/FGC.

[19] Notably, we asked participants if they currently smoke tobacco; 39% currently smoke compared to the 13.3% of women in the general population.

Another woman detailed how she got an infection in her leg when she was sleeping on the streets and how this was made worse by continuously walking on her leg during the day and not being able to elevate it at night:

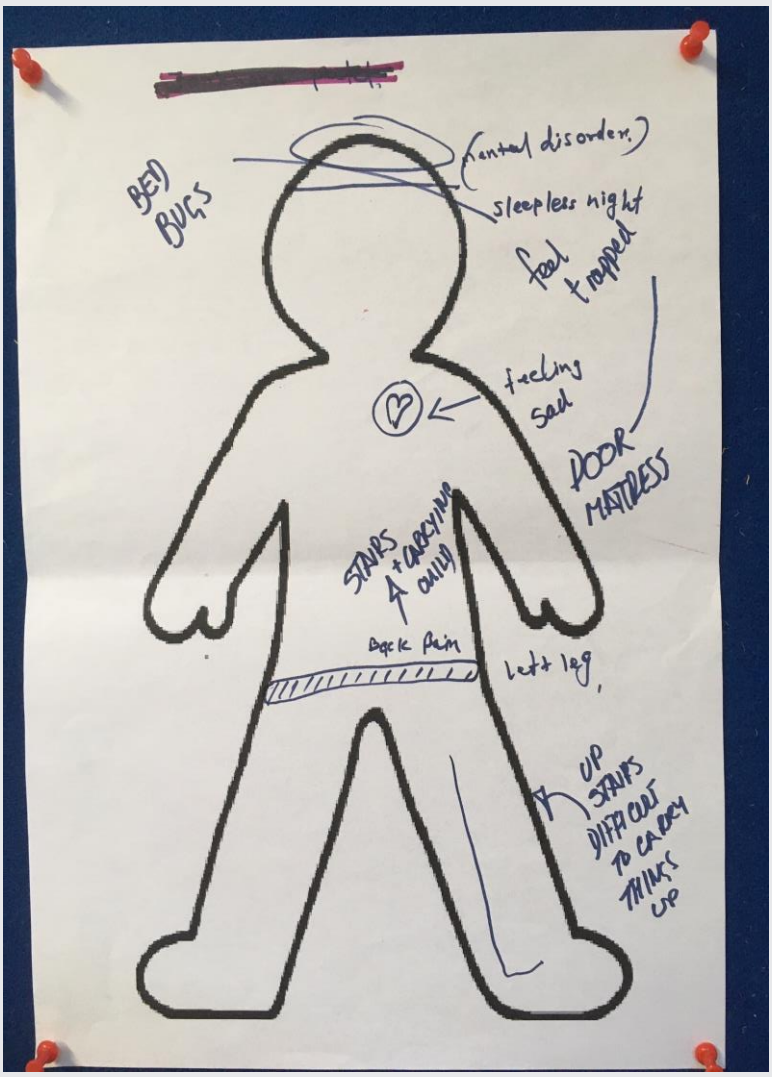
> *"Well, it's probably because during the day I have been wandering around... when I used to go to sleep, I used to raise my leg like this… raised because I wanted to lose the swelling. And that is sometimes a bit hard when you are trying to do it in a sleeping bag."*

Other participants spoke of how it was difficult to prevent infections and keep wounds clean when they were on the streets.:

> *"Because now I was having a hand operation. And I was trying to keep that clean, and you can't do that on the street. And my doctor was horrified to know that I was carrying my clothes around in my bag".*

In focus groups, we asked participants to draw on an outline of a body of how their current living situation impacted on their health (see a selection of images below). Participants frequently talked about being affected by allergies, skin conditions, bed bugs, difficulty breathing and back pain that occurred as a result of their living conditions. Women spoke about the damp and mould in their temporary accommodation and how this created allergies, for example sneezing, skin irritations and consequently, difficulty breathing. Furthermore, it is evident from the pictures that the challenges and stresses of being homeless have an impact on the health and wellbeing. Many women identified their head and how they feel stressed, and many explained how this stress manifested physically. For example, women talked about how their stress resulted in headaches, losing their hair, stomach pain, irritation in their eyes, rapid heartbeat, panic attacks, chest pain and in some cases, caused their periods to stop.

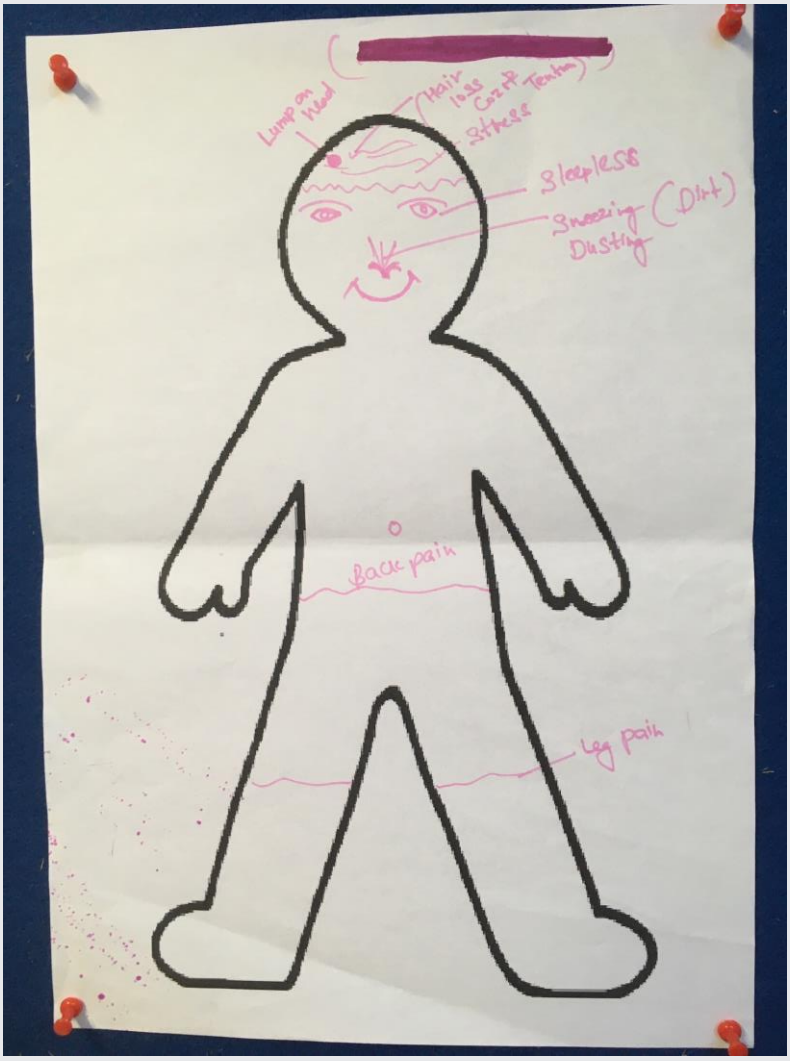
*Figure 9: Photo of image in focus group*[20]




Bed bugs, mental disorder, sleepless nights, feel trapped, feeling sad, back pain from stairs and carrying child, upstairs difficult to carry things up

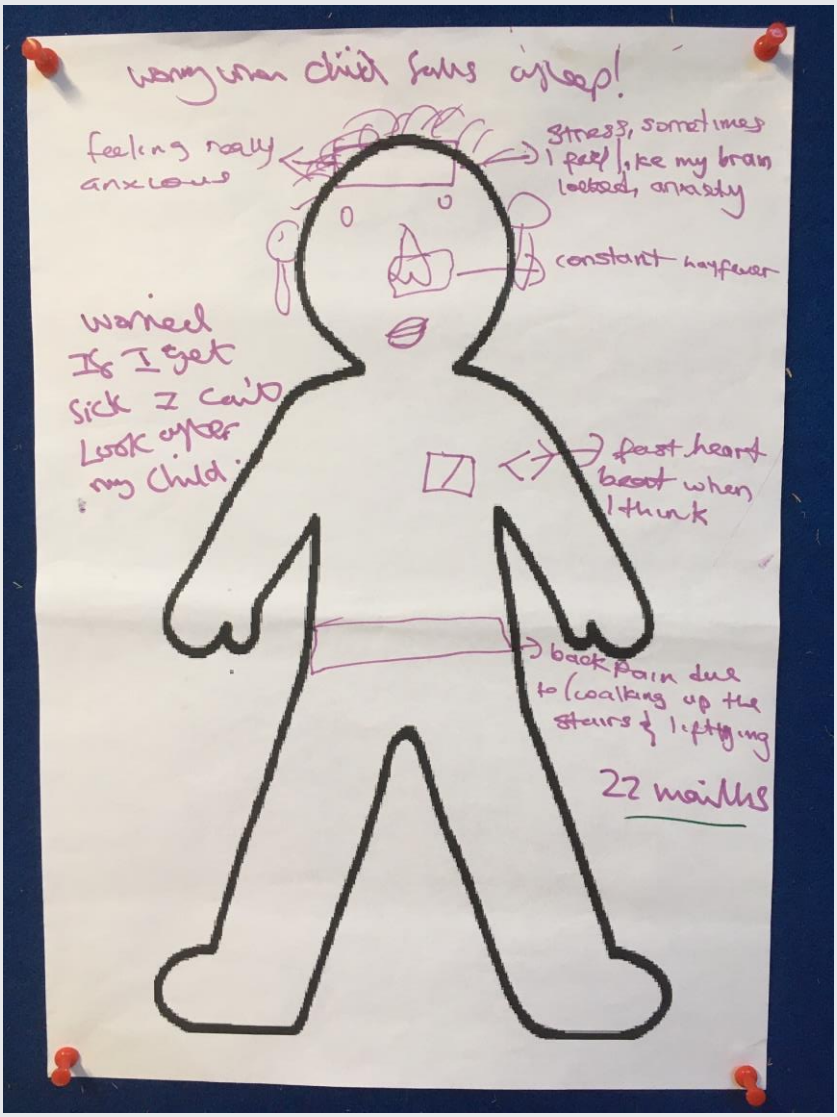
[20] Some of the writing is hard to read so we have also typed what it says below the image

*Figure 10: Photo of image in focus group*




Lump on head, hair loss due to tension, stress, sleepless, sneezing (from dust and dirt), back pain, leg pain

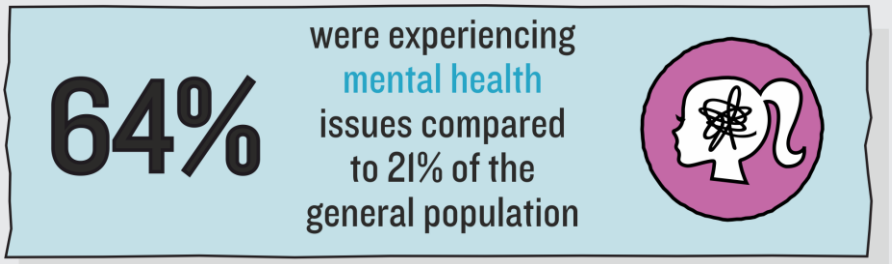
*Figure 11: Photo of image in focus group*




Worry when my child falls asleep, feeling really anxious, constant hay fever, fast heartbeat when I think, worried if I get sick that I can't look after my children, back pain due to climbing up the stairs and lifting

## Mental health

Of the 77 participants we spoke to, 64% expressed mental health issues were currently affecting their day-to-day life; this compares to 20.7% of the general population of women in the UK[lviii]. Our data suggests that mental health problems are significantly higher amongst homeless women than the general population.




Like the question on self-reported physical health, we asked participants to rate their mental health on a scale of 0 to 10 before becoming homeless with 10 representing great mental health. The average rating was 6.9 before becoming homeless, and the current rating was 5.7. It should be noted that mental health ratings before homelessness may be lower as poor mental health is a common reason for homelessness. With the right support, the mental health of women who have experienced domestic and/or sexual violence can improve upon homelessness. Furthermore, it is not possible to ascertain whether a decline in mental health was a direct result of becoming homeless or other factors.

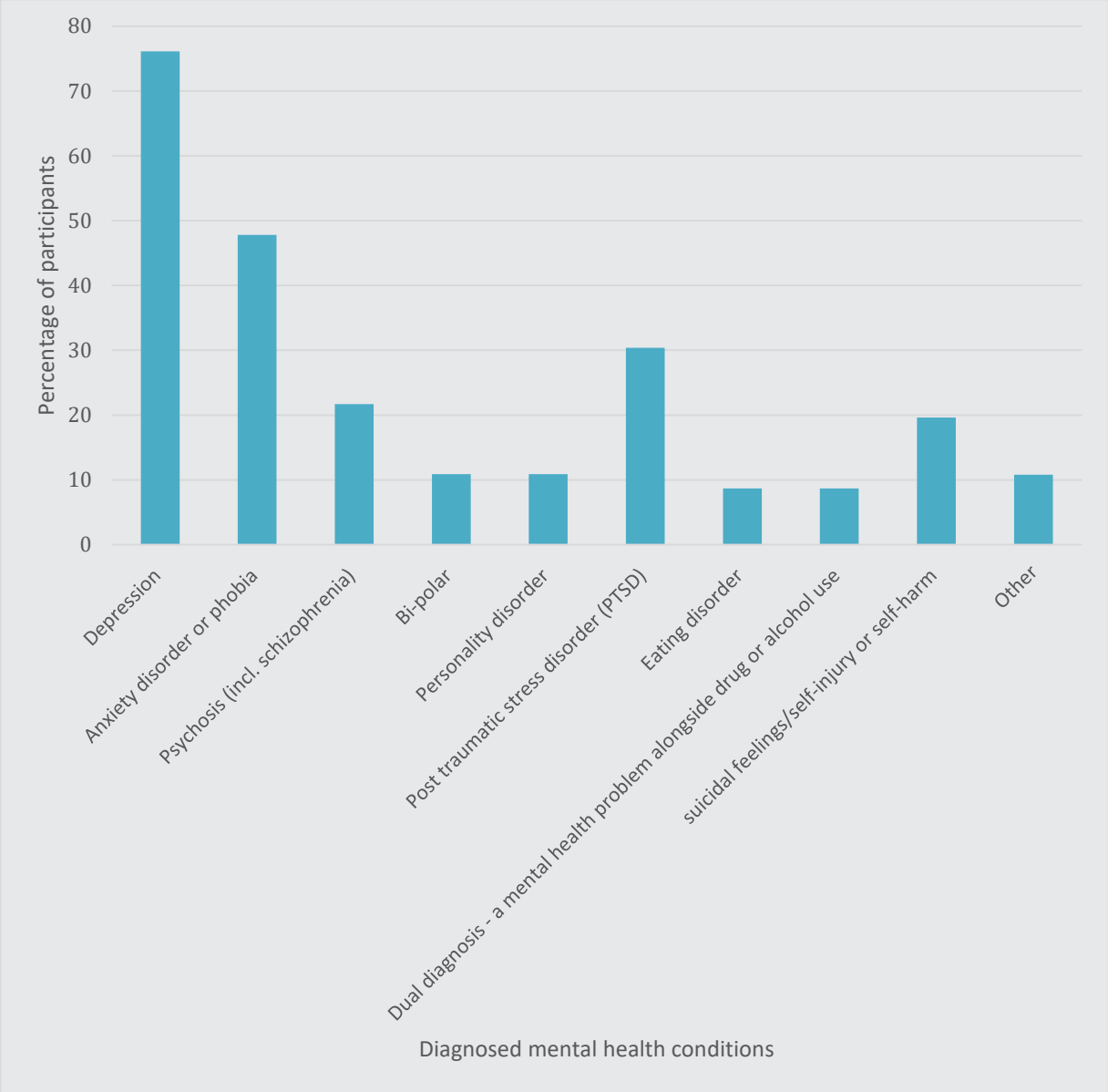
The following graph details the mental health conditions women were diagnosed with. The most common ones include depression, anxiety/phobia and post-traumatic stress disorder (PTSD). While some participants said that their mental health issues existed prior to homelessness, many spoke of how they developed because of their housing situation. One participant developed further mental health conditions when she was homeless:

> *"I am bipolar. Stage 1 bipolar. And I have got split personality disorder. I got that ever since I have been homeless".*

Another woman spoke of how her mental health deteriorated due to the frustrations of trying to get help:

> *"It was serious… I wanted to jump off the bridge or jump in front of a train. It was that serious. You get to a point where every door is slammed in front of you."*

*Figure 12: Graph showing diagnosed mental health issues amongst participants who identified as having a mental health issue*




Another participant, a refugee who had experienced sexual violence, also faced similar challenges with her mental health and accessing support. This participant did not want to be audio recorded, but the volunteer researcher who spoke to her wrote some notes:

> *"During the research, this lady expressed how her mental health has deteriorated since she arrived in the UK and being homeless. She has tried to access mental health services but has had to wait over nine months for her initial appointment with a counsellor/psychiatrist. Although she has access to a GP and has been diagnosed with PTSD, anxiety, depression and insomnia, she feels that the medications she is on are making her paranoid and tired. She feels that talking to someone, i.e. talking therapies, would help her, as she needs to process all the thoughts and feelings she has."*

A common finding in this research was that all the stresses of homelessness meant women felt so unmotivated and, in some cases, lacked the self-esteem to want to do things that would support their health, well-being and escape from homelessness. In some cases, these feelings would lead to thoughts or actions of self-harm or attempted suicide. Of those participants who had required an ambulance since becoming homeless, 27% had needed the ambulance because of self-harm and/or attempted suicide. One woman described her suicidal thoughts after being raped:

> *"My suicidal thoughts, everything like voice, I had those things long before HIV. They just became worse after because I suffered rape, gang rape issues. Sometimes people think you're a survivor. You didn't die. But I'm living with it every day. The smells, the voices, the… anything that makes me remember brings the panic attacks."*

This woman went on to tell us she had repeatedly used emergency services and been admitted to hospital for self-harm and attempted suicide. Another woman told us she feels suicidal:

> *"I was suicidal. I may have damaged my stomach when I was going through rough times cos I didn't have gastric, but I just started self-medicating, so I might have caused it myself…. I'm always thinking of killing myself".*

It is important to note that suicide and self-harm could also have a psychological impact on friends and other guests or residents in homelessness services. This woman spoke of how she had witnessed suicide and lost friends. She explained; *"to experience…to jump off the bloody bridge and commit suicide and taking pills and stuff like that. I have come across all that."* Another participant spoke of how she found it difficult to sleep after she had witnessed a suicide in temporary accommodation.

While diagnosed mental health issues were commonly experienced by participants, the multiple stresses of homelessness were also reported to influence the mood and emotions of women experiencing homelessness. For example, many women did not identify as having a mental health condition but spoke about how they were sad or moody all the time. One participant told us about how her mood or personality had completely changed. Others spoke of how they 'didn't feel themselves'. This participant drew the picture below to illustrate how she felt.

*Figure 13: Photo of image drawn by participant*

## Factors affecting health

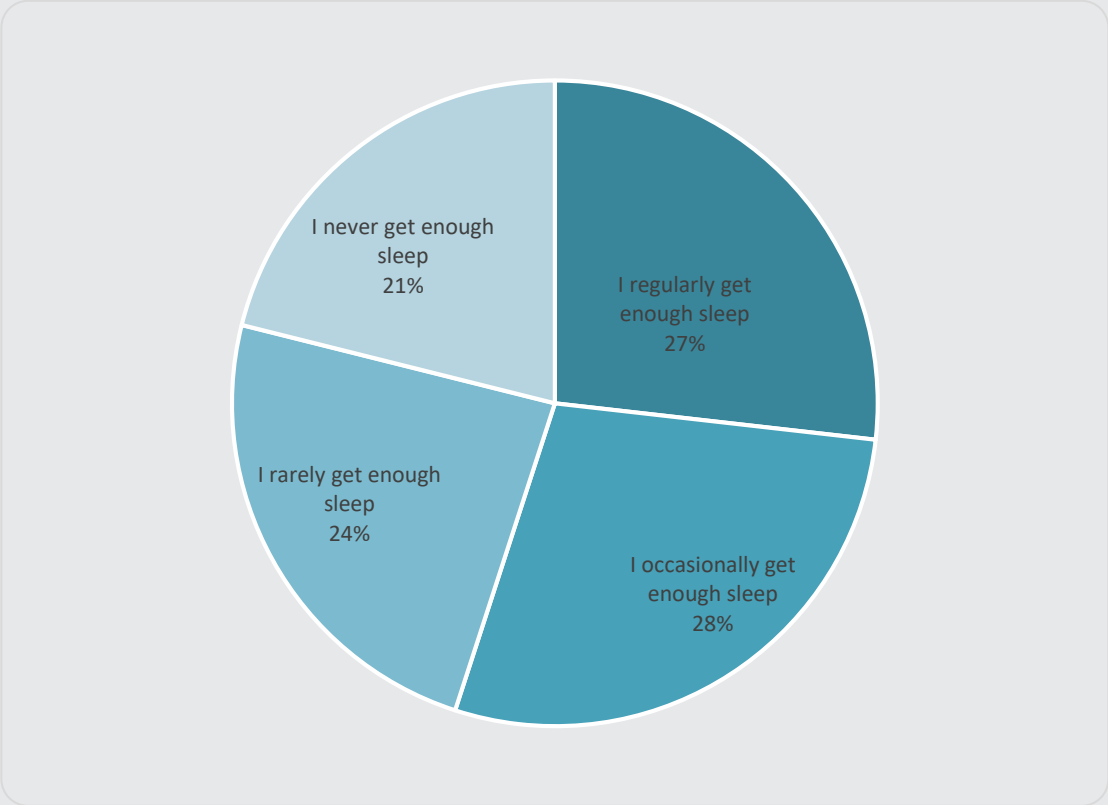
In addition to mental and physical health conditions, we also asked women about other factors that can affect their health, for example, eating habits, consumption of fruit and vegetables, sleep and hygiene. These aspects of health and wellbeing are hugely important in relieving existing health issues and preventing new ones arising.

### Sleep

As evident in the graph below, only 27% of the women regularly get enough sleep and 45% rarely or never get enough sleep. Women spoke about how their sleep was erratic – one night they could have enough sleep, and other night they wouldn't have any. Others spoke of total exhaustion and still being tired after sleeping for long periods of time. One woman who was currently rough sleeping explained:

> *"You are still tired. You have to sleep – you can have 12 hours of sleep, still tired. You still feel tired. It's not the same as being under the roof somewhere, closed place."*

*Figure 14: Graph showing how much sleep participants get*



Related to this, other women spoke of poor-quality sleep and having to keep 'one eye open' if they were sleeping on the street or in other public places. Although participants who were sleeping rough reported worse sleep than those in other types of temporary accommodation, participants in temporary accommodation also reported problems with sleeping. For instance, they often spoke of not being able to sleep due to the noise, their anxiety or not feeling safe. This participant expressed why she finds it difficult to sleep on the streets:

> *"Whenever I wake up I see… Even I sleep in there, many things. They spit on me. And then do like… [hacking sound] oh, sorry. And wee on me, many things. I don't understand, many things… And sometimes people tell me go back to your country. It is not nice when you say that."*

Another participant's anxiety kept her awake:

> *"I have been really anxious lately; I keep waking up at three o'clock in the morning. And because I am waking up anxious, it takes me ages to go back to sleep. I keep having dreams about where they are going to house me."*

Homelessness undoubtedly affects the ability to have a routine and regular sleeping patterns; this was particularly evident for women who were working night shifts and had to try and find somewhere to sleep during the day for a few hours. One participant who was a cleaner in a hotel spoke of how if there were vacant rooms in the hotel, but they would let her sleep there for a few hours. The lack of good quality sleep and ability to keep regular sleeping patterns influenced the mental and physical health of participants. This participant expressed: *"it's been rough, but you can see... as you can see in my eyes that I am just… I have no energy."*

## Food and nutrition

An important factor in maintaining physical and mental health is food and eating habits. The graph below illustrates that 35% of women are eating either no meals or one meal a day. Our research also found that 46% of participants ate less than one portion of fruit and vegetables a day. A woman whom we met who was sleeping on buses and 6 months pregnant, was only able to access one small meal a day; she was obviously concerned for her and her baby's wellbeing.

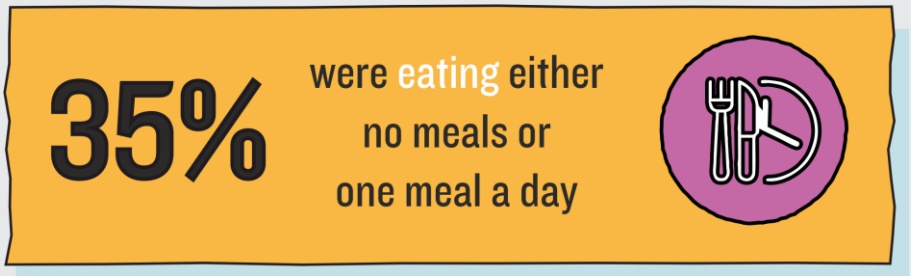
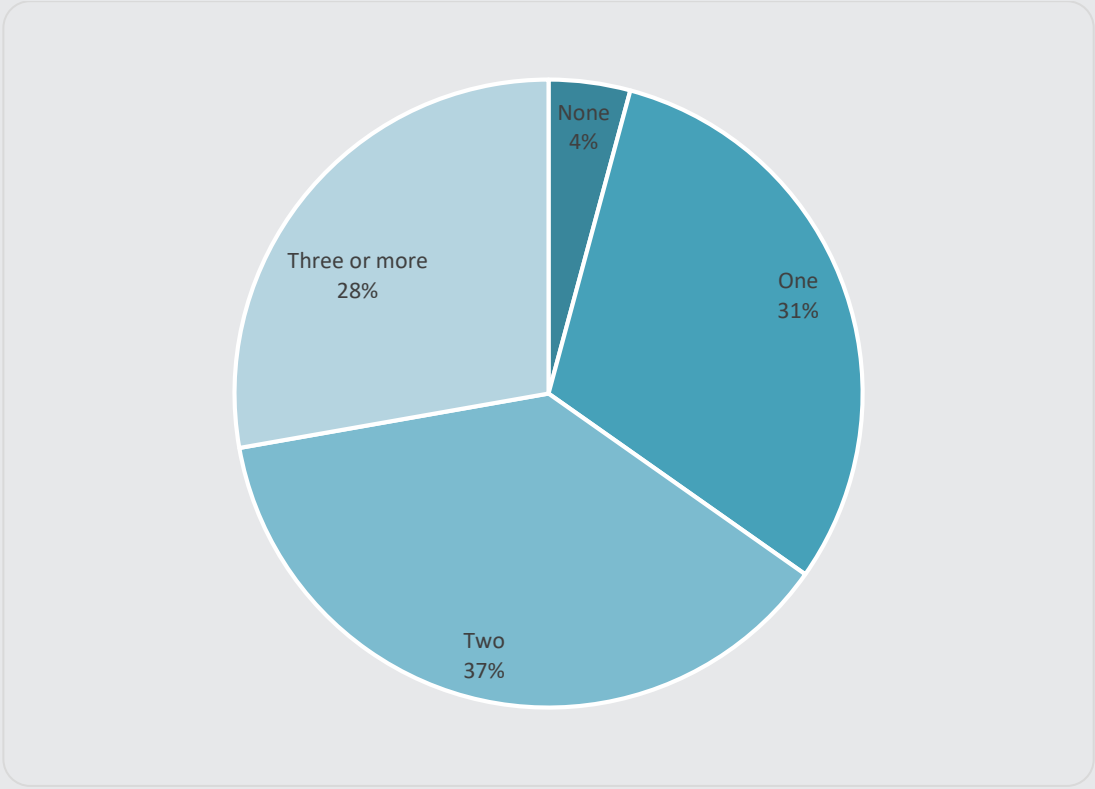
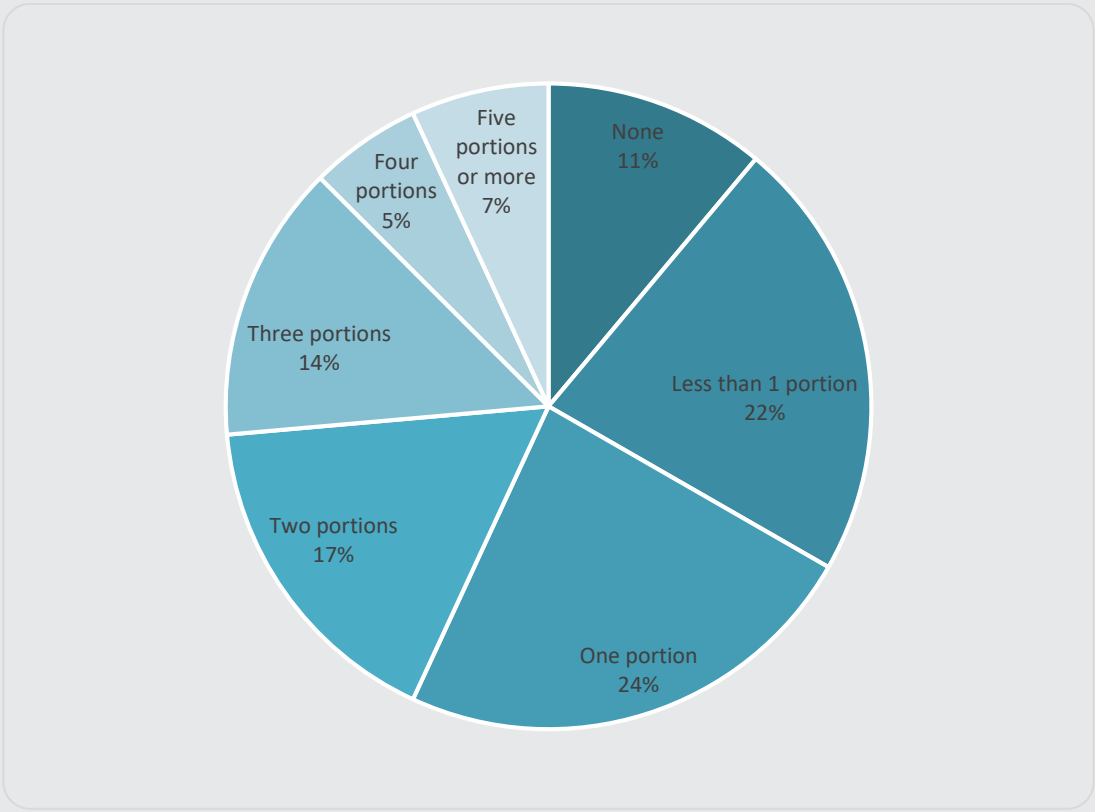


*Figure 15: Graph showing number of meals participants had each day*



During our conversations with participants, it became apparent that not only were women missing meals, but their eating habits were erratic and often opportunistic. One woman told us:

> *"In case I don't get food the next day, so I eat everything. And now I'm carrying that with me till today. For current eating habit, it depends on how I feel. Sometimes it's one meal a day. Some days I can eat five meals. It's never the same".*

Another added:

> *"I do skip meals, but like Thursday I won't eat, Wednesday, Thursday but Friday I'll make a point of eating. But one day like a few weeks, I didn't eat Thursday, Friday, Saturday. I was in a doorway; I couldn't be bothered really, I kept reading really. I was OK, three times I did it, and the fourth, because on Monday I was at a church in Bromley, I was fine. They cooked fresh meals, I was fine. The 4th time it was quite warm, I had nothing, and I was going towards Gregg's, I kept sitting on my bag, I felt really faint, I was scared, I felt to call 999, really faint but I told no one. I sat on my bag, I got there, I did tell then, and somebody offered to buy my tea with tons of sugar, sat in the doorway, felt the breeze, I came around."*

Many women spoke of having to be opportunistic with food often because they did not know when they would get their next meal, so when they did get food, they ate a lot to compensate. Some women were aware of this unpredictably and felt that contributed to them gaining weight. Related to this, women spoke about how they had no control over what they could eat and that the food at homelessness services was filling and calorific but not did necessarily provide all the nutrition that they needed. Some women spoke of how they comfort ate because of their situation or to self-soothe for temporary relief. One woman who had repeatedly experienced sexual violence spoke of 'gaining weight' in order to make herself 'unattractive to men'. She told us how she hated anyone telling her she looked nice. This woman had developed diabetes and was clinically obese. This is a direct example of how sexual violence impacts on the physical and mental health of women.

In other cases, women spoke of how the stresses of homelessness meant they did not want to eat or did not have an appetite. Erratic eating patterns are also linked to a broader feeling among participants of not being in a position to look after themselves well. It is also important to note that these habits picked up during homelessness can continue even after homelessness. A participant expressed how, although now she is in a more settled situation, she still only has one meal a day:

> *"And I still have only one (meal a day). It's very strange how things stay with you, even when you're not homeless. I had only one full day when I was homeless (rough sleeping). And now I have still one meal a day. I cannot bring myself to have lunch or to have a pattern. It lives in your mind".*

### Hygiene

Another factor supporting the health of homeless women is access to showers, toilets and sanitary wear. Women spoke of all the different kinds of practical support with hygiene that they received from day centres, including pads, tampons, toiletries and access to showers that allowed them to have some sense of routine and normality. As one participant explained, being able to access sanitary wear and keep a level of hygiene meant that it *'didn't stop her from being a normal person'*.

However, many participants spoke of the challenges of maintaining personal hygiene when they are homeless. One woman talked about her need to use accessible toilets for her medical condition, she has fibroids, and how hard this is when she is homeless:

> *"I find it extremely hard being homeless as I have many health issues, and am so uncomfortable having to be homeless and using public toilets with my conditions. Also finding accessible clean toilets is very difficult and is a massive challenge for me".*

Being unable to keep clean and wash properly also exacerbates existing health problems. As this woman explained:

> *"Because now I was having a hand operation. And I was trying to keep that clean and you can't do that on the street. And my doctor was horrified to know that I was carrying my clothes around in my bag".*

While many women spoke of how they had access to showers at day centres, those who worked in the morning or during the day struggled to find somewhere they could shower. As this participant told us:

> *"I have got a part-time job in the morning, not being able to access a place where I can shower because most day centres are open in the morning."*

Another participant described the problem of accessing showers when day centres are busy:

> *"Maybe sometimes. I did that sometimes. Because you know when you are on the street – normally if you have a home if you want to wash you just go to wash. But on the street where are you going to wash? You don't have water. You cannot shower every time. Day centres… they close. So sometimes when you go to the day centre, the shower is full, you don't want to wait for one hour."*

Some women who suffered from heavy periods struggled to manage them and keep clean when they were sleeping at shelters, outside or on public transport. When they could not access tampons or pads, they used toilet paper, tissue and/or socks as pads that often-caused leakages. One participant described how she tried to manage her periods when she cannot afford sanitary wear:

> *"When I am on the street, I get a lot of tissue and put when I have period. I did that one. Not that one too much, because when you buy, it costs you too much money. One day it costs about a lot. Oh, no, no. Because you have all day blood, you see. And for three or four days you have that. So, the street is difficult when you need to wash."*

Related to this, the research found that some women's periods had suddenly stopped or they went into early menopause – they spoke about how they thought this was due to the stress and trauma of homelessness or what caused them to be homeless in the first place. One woman told us, *"stress has caused my periods to stop."* Another spoke of her experience of early menopause; "*Yes, very early menopause… because I was so frightened, you know, when I was homeless."*

## Relationships and sexual health

While the research did not ask any direct questions about relationships, most participants did talk about relationships in between our other questions and after the survey was completed. Positive relationships are a key aspect of wellbeing and the need for this does not stop because of the experience of homelessness. The homelessness sector at large is not always well set up to support people who are homeless and, in a relationship,[lix]. As Brighton Women Centre (2018: 4) report states, there is a "lack of action in this area (referring to homeless couples)" and "greater understanding of this issue was long overdue because of the growing incidence of women on the streets, and hence, the related growing incidence of couples." Some participants spoke of how they were in relationships, but many spoke of how it was hard to have a relationship because of being homeless and/or because of past trauma often related to domestic and/or sexual violence. One participant spoke of her sexual frustration because she was unable to form relationships due to previous trauma as a result of being raped multiple times.

Relationships and sexual health are inextricably interlinked. In our research we asked women about their sexual and gynaecological health and whether they had had a sexual health and smear test recently; 28% of participants had never been for a sexual health test, and 21% had never been for cervical screening. This compares to 50% of women in the general population who have never had a sexual health test[lx] and 25% of the general population who had never been for cervical screening[lxi]. So, these findings suggest that the uptake of sexual health tests and cervical screening is higher than the general population. During the analysis session, the research team discussed that the increased uptake of sexual health tests and cervical screening might be because of the pro-active in-reach work often done by professionals in day centres. In addition to this, the research team also thought this might be because some of the participants sold sex for money or for somewhere to stay. Related to this, most women felt they had been able to access contraceptives easily.

Women who had never been for sexual health or cervical screening or had not done so in the past few years gave varied reasons for this. For some their homeless situation meant they had other priorities to deal with, for others an addiction got in the way. Many of the women spoke of how they were not sexually active and therefore, did not feel they needed a test. For some who had experienced sexual abuse, they felt that sexual health and smear tests would again be traumatising: *"if you get sexually abused you are not going to go to a sexual clinic, when they put something up your vagina. You don't want to do that."*

## Violence

Domestic and sexual violence were not only one of the main causes of homelessness, women often shared experiences of violence or harassment at homeless services and on the street. 35% of

participants felt that sexual or domestic abuse was currently affecting their day-to-day life. In some circumstances, women felt that they had to have sex with men in order to get help or somewhere to stay, as this woman explained:

> *"People trying to help me, whatever, but in return, they want to sleep with you, and you keep telling them no. He is saying yes and that. And I was unhappy in that situation, I really was unhappy. I just wanted to have a room and be comfortable. I cry every night and say can't do this."*

This participant spoke of how she was abused in order to stay in the place she was living: "*That's when the sexual abuse started. Cos you find yourself living in a house where you're forced to do things that you don't understand, or you don't want to".* Speaking about the harassment on the streets, this woman shared how she found herself being unable to put up a fight:

> *"Being approached by men too often; being made fun of in the street; some guys take the mickey out of you; guys touching but the tiredness from homelessness makes me let down my guard and get tired of fighting back".*

Another added: *"experienced violence every day on the street, and this affected my mental health. Men urinated on me many times and told me to go back to my own country."* These incidences of violence have a further impact on women's physical and mental wellbeing. Furthermore, it is important that women are not only supported for the trauma caused by historical violence but also current and on-going experiences of violence.

### Substance misuse

For many women, substance misuse, mental health and experience of violence were inextricably interlinked. Research from Agenda (2016)[lxii] highlights how women who have experienced domestic and/or sexual abuse are far more likely to suffer from drug and alcohol dependency. The 2016 Crime Survey for England and Wales revealed that adults aged between 16 and 59 who had taken illicit drugs in the last year were three times more likely to report being a victim of partner abuse than those who had not done so[lxiii]. Similarly, within this research, it was common for women to start drinking or taking drugs to cope with the violence that they experience or because of their mental health issues.

We asked participants about drug and alcohol consumption, and whether their consumption interfered in their day-to-day life. Of the women we spoke to, 24% said that substance dependency was currently affecting their quality of life, and 10% felt that addiction contributed to their homelessness. These statistics suggest that participants acquired addictions as a coping mechanism for their homelessness. For instance, one participant spoke of how they started drinking upon homelessness when they had previously never drunk before. To deal with the stresses of homelessness, boredom, cold weather and not having anywhere to rest meant that many started relying on substances. As this participant explained:

> *"Gotta walk about… having to leave the shelter at seven am is a big problem. Having nowhere to go in the day encourages me to drink, and have nowhere to rest, so I go on the buses/trains, even the library."*

Drinking and taking drugs also helped participants to forget about the situation. This participant told us: *"yeah, being sober because when you are sober, you will remember that something is wrong with you."* Drinking and drug taking exacerbated upon homelessness, especially when participants were mixing with people who drank or took drugs. One researcher wrote this about a participant in their notes: *"she is addicted to crack cocaine, addicted for years, cut down but it's got worse since becoming homeless. She's around other people using, which has made her usage increase."*

Drug and alcohol dependency influenced the health of participants. This participant described how she lost some of her teeth due to drug abuse: *"I am missing a few teeth. That's through drug abuse."* Furthermore, the problems participants had with drug or alcohol dependency often made it difficult for them to get help and escape homelessness. As this woman explained: "*I get in the hostel. And I got thrown out because of my drinking."* Participants with addictions spoke about how they were only concerned about drinking or taking drugs and not other aspects of their wellbeing. This participant stressed: *"when I was rough sleeping, I was only worried about the next drink."* Getting support for mental health issues was particularly challenging for participants when they also had a substance misuse issue and vice versa; this will be explored in more detail in a later section.

### Children

Many participants in this research are mothers, and it is important that this is recognised. Too often, people who present as homeless are viewed as 'single' and without any dependents. We found that 47% of participants in this research had children. Of those who had children, 23% had had their children taken into care. The experience of having their children taken into care was incredibly traumatic for some women. This woman explained how she became alcohol-dependent when her child was taken into care:

> *"Yeah, not only that. As well, the government took my child away for eight years. It was supposed to be eight weeks and I turned to alcohol. I was becoming – not an alcoholic, but alcohol dependency."*

This participant shared her experience of her children being taken into care:

> *"Well, because I had four children and my partner never used to help me. I had to look after them on my own. And the child that was taken away has got severe special needs. He is not walking; he doesn't talk or communicate. And he was five years old, and they took me to court and that. And they said to me we are taking your child away. So, I said, what reason?"*

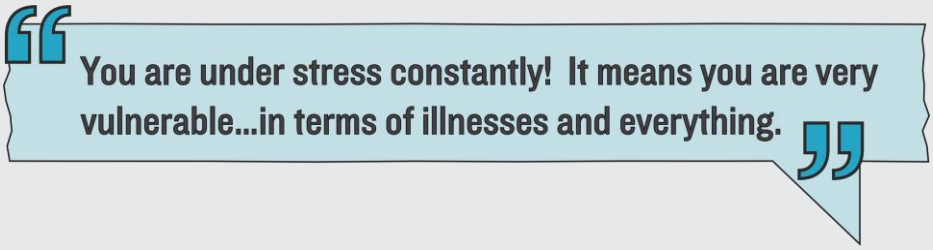
One woman who lost her young daughter told us about how that contributed to her mental health problems and her addiction. This participant told us about the loss of her daughter: *"she was four years old. She lost her life. And then I had to literally watch my baby slip away."* She further

explained, *"I had no chance to say goodbye to her. And that is when I turned back to alcohol again. But two weeks prior to that she got raped by her own dad and one of his friends".*

This quote illustrates that it's not just the sexual abuse of women that can contribute to homelessness, but also the sexual abuse their children and other family members. It is evident that the loss of a child, whether the child is taken into care or the child has died, had a significant impact on the mental and physical health of women that can, in turn, contribute to homelessness.

### Stresses of homelessness

The chaos of homelessness and the stress of not being able to look after oneself can put pressure on physical and mental health. As this participant highlighted: *"you are under stress constantly. It means you are very vulnerable... in terms of illnesses and everything."* Many participants spoke about how the stresses could have a significant impact on their health and wellbeing affecting their ability to self-care, for example, be able to wash, eat and sleep and how a 'normal' routine is difficult to keep. This has a direct impact on the ability, for example, to attend health appointments and take medication as prescribed. As one woman explained; "*my life is never entirely in order, so it's difficult to take medication."*

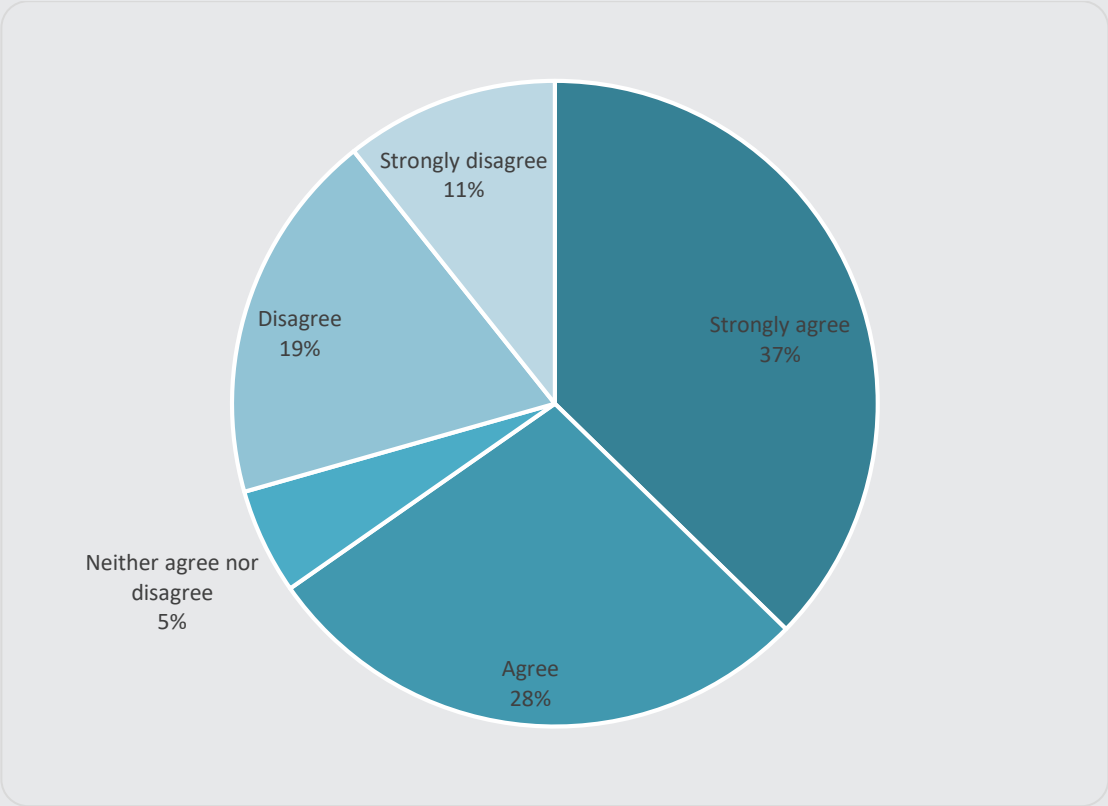



The stresses, exhaustion and practicalities of being homeless make it very difficult for people to prioritise health and get the support they need for their health. One of the researchers wrote this in their notes:

> *"Physical and mental health (of the participant) have deteriorated, and it is near impossible to manage symptoms whilst juggling being homeless. Depression and anxiety causing lack of motivation and hopelessness as there is no stability."*

We asked the participants to what extent they agreed or disagreed with this statement: *"I struggle to find the motivation and confidence to deal with my health issues when I am homeless".* As the graph below indicates, 65% either agreed or strongly agreed. Related to this, this research also found that homeless women's low self-esteem and confidence meant that they often did not value or care about themselves enough to get help. For example, one woman spoke of how she 'avoided support services' because she was 'embarrassed' by her situation. The chronic exhaustion that homelessness brings is also a huge barrier to accessing healthcare. This woman spoke of how she was too tired to look after herself: *"I was working full-time and being homeless, I was too tired to look after myself".*

*Figure 16: Graph showing motivation and confidence to deal with health issues among participants*




Women spoke of having to prioritise more immediate needs such as establishing where they were going to sleep that night, making sure they were able to eat, securing benefits or trying to resolve their homelessness situation, over their health. One woman explained why getting to appointments was difficult: *"I can't make appointments. [I need to] wash first and eat first. Survival comes first. Last thing we have as dignity is to keep clean."* This participant explains how they have no time to sort out their health conditions. She told us: *"no time (to sort health out) usually wait till desperate, death's door"*. Another adds how ignoring her health has had a detrimental impact: *"I didn't deal with health issues as housing was my main priority. I ignored my health, and as a result, paying the price for putting it aside".*

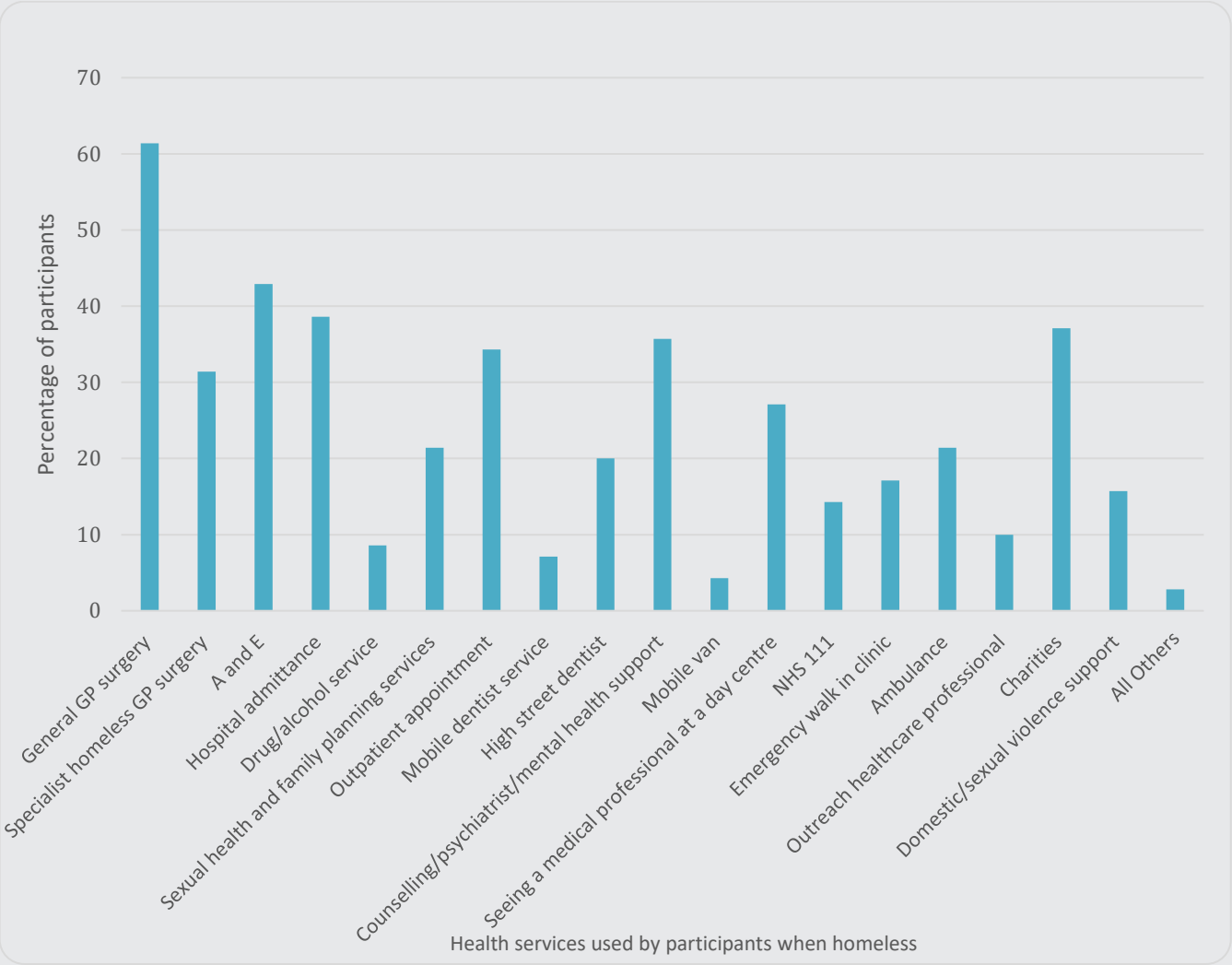
## Healthcare Services

### Healthcare service usage

Considering the severe health issues experienced by participants, there is a real need for access to medical services. Therefore, it is important to explore their access and experience of using services. Participants were asked about which healthcare services they used since becoming homeless. As seen from the graph below, there is a high usage of GP surgeries (61%), A & E (43%), hospital admittance (39%), counselling (36%) and support from health professionals in charities (37%). In

terms of health, women spoke of the significant support they got for their health from homelessness charities. For example, from opticians, dentists, podiatrists and nurses in day centres and other homelessness services. Although the use of A & E and hospital admittance is high, the high usage of GP surgeries indicates that many women are accessing primary care which is contrary to what often happens when people experience homelessness[lxiv]. However, it is important to note the statistics are based on healthcare usage since participants had become homeless. For some, this could be five years and for others a matter of months.

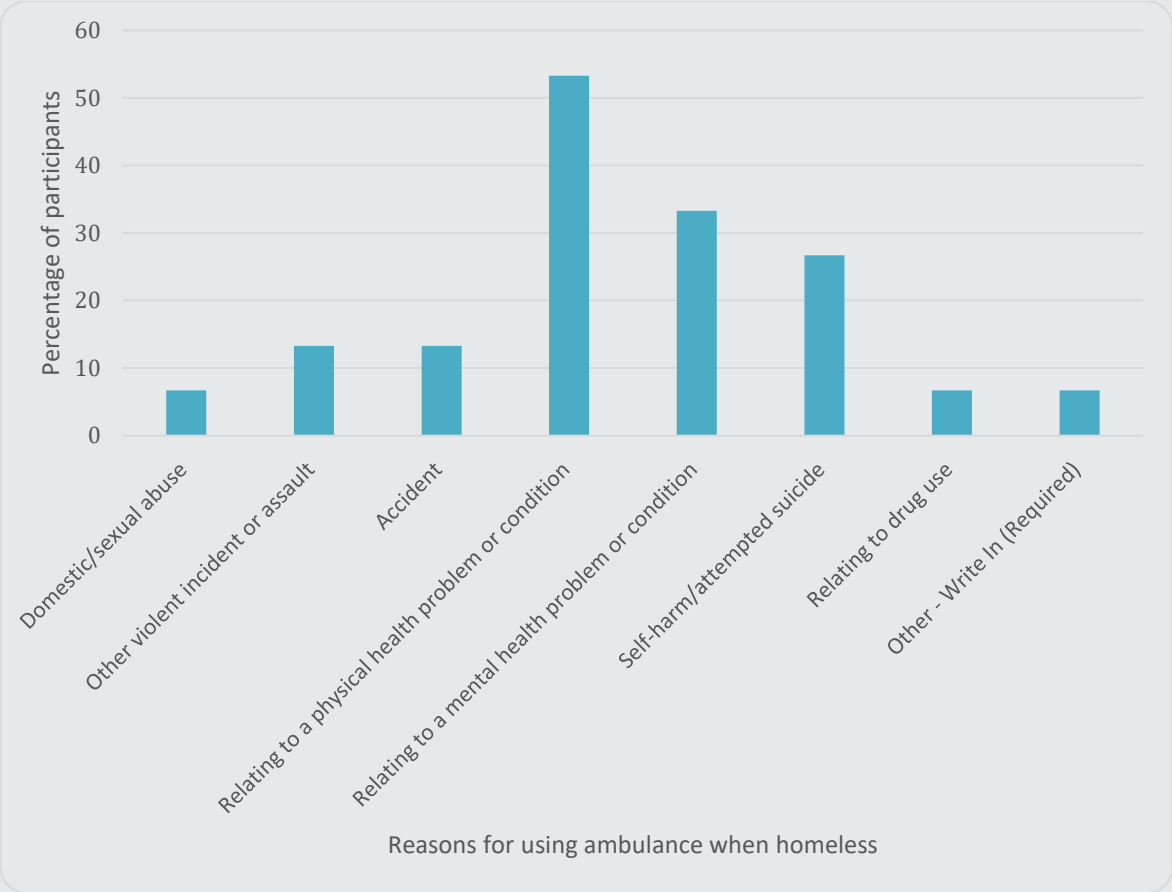
*Figure 17: Graph showing the health services participants used when homeless*




The reasons why women used secondary healthcare services, including ambulance services, A & E and hospital admission were due to domestic/sexual abuse, other violent incidents or assault, accidents, physical and or mental health issues, self-harm/attempted suicide and substance misuse. The graph below shows the reasons why women needed to use an ambulance. It should be noted the reasons for being admitted to hospital, using an ambulance and being admitted to A & E broadly overlap. As evident from the graph, the main reasons for using an ambulance were due to physical

health problems (53%). The second and third most common reasons were relating to mental health problems (33%) and self-harm/attempted suicide (27%). This participant said, *"I have been in hospital for suicide attempts, quite a few times. And I have self-harmed in the past."*

*Figure 18: Reasons for using an ambulance when homeless*




## Experience of healthcare

As discussed in the introduction, not only can people experiencing homelessness suffer from poor mental and physical health, there are also inequalities in terms of accessing healthcare. Many of the common inequalities were highlighted at the beginning of this report. However, it is important to explore the experience of accessing healthcare amongst women specifically.

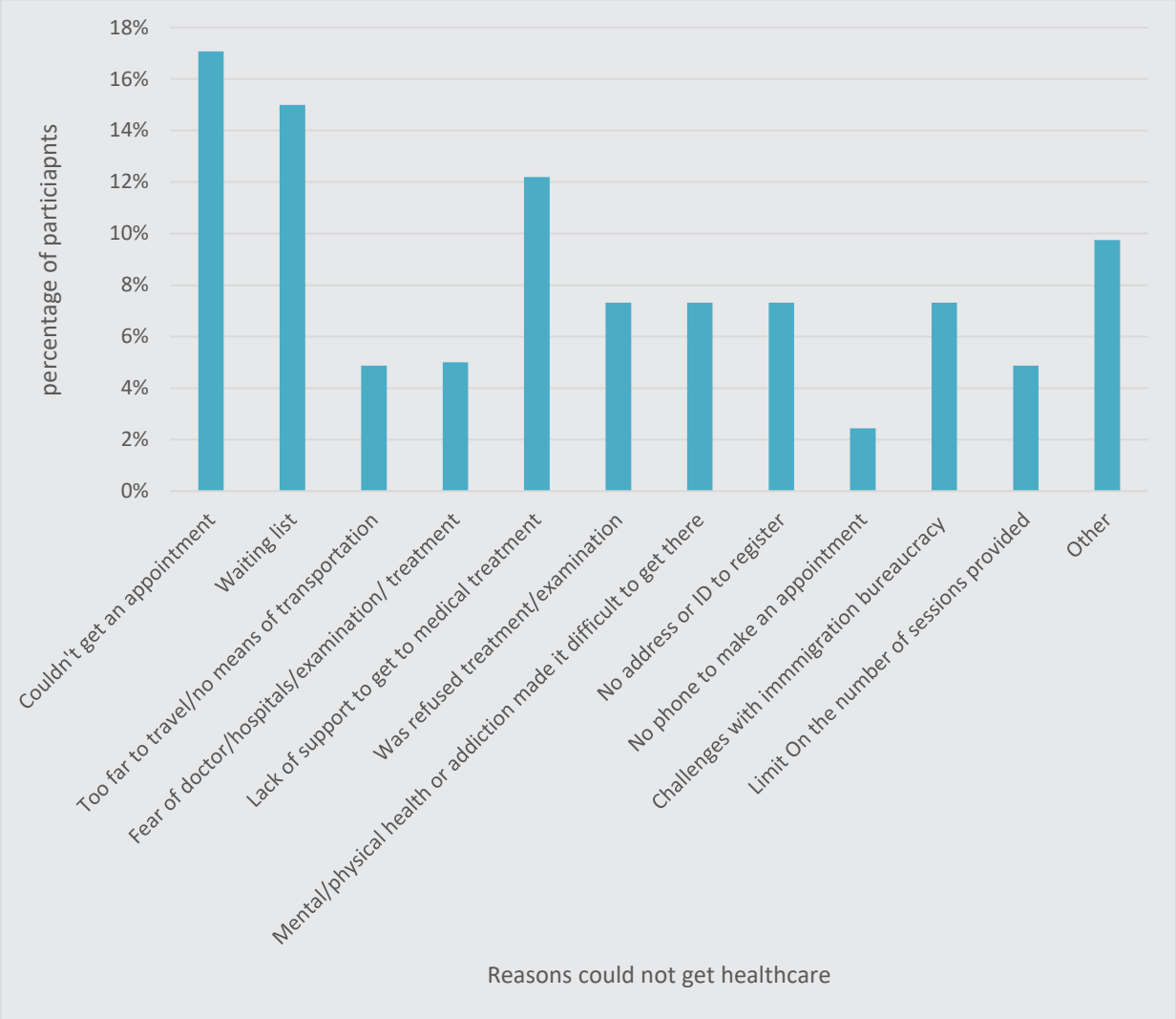
Of the participants in this study, 81% were registered with a GP, 40% were registered with a dentist. We found that 17% of the participants had been refused registration by a GP, which demonstrates that these health inequalities persist. Approximately 40% of the participants said there was a time when they were homeless when they felt that they needed a medical appointment and/or treatment but did not receive one. The graph below illustrates the different reasons why the participants did not receive the treatment and/or appointment. Two of the most common barriers were waiting lists and being unable to get an appointment; some participants also highlighted a lack of support to get to the medical appointment. This participant explained that they did not have the money for travel to get to an appointment:

*"Yeah. Having lost my Oyster… after being on a night bus in another part of London, but trying to get to my surgery in central London. And not being able to get there. Because first I had to find a police station. Nobody knew where the local police station was to tell them that my Oyster had been lost or could have been nicked, I wasn't sure. So that way I could have travel to get either a bus to go there right now. So, if you don't… you never have any extra money for anything."*

Other participants spoke of how it was difficult to access services as they were moved around from place to place. This participant explains the challenges she had with getting to appointments, mainly around being able to afford transport, but that through support from Groundswell she was able to attend them, get diagnosed quicker and avoid using secondary care services:

*"No just being able to have… you as Groundswell has helped me access my surgery a lot easier. Because I was so tempted, one day I was so tempted to bunk, to get on the bus. And I just thought no, if I get on the bus and I get caught, I could get a criminal record if they want to make a… because it is against the law, not to pay a fine [over talking] my future. And means my future would have been worse for me to access employment later. So, having found Groundswell through the centre, actually meant that I will never be tempted to do that, no matter how awful I feel. And I wouldn't have to feel like I need to call an ambulance because going to the doctors and maybe… for her checking my pressure, she could figure out oh, it's just your high blood pressure, blah blah, which is what happened last time. I was feeling dizzy, but I just thought I can't call an ambulance, it can't be this bad, I need to go the surgery. And as it was walking that helped but the time when Groundswell – I met Groundswell and they told me that [unclear] and many other things depending on your condition. So, that is… has worked really well. Because it means I can fulfil all my appointments and I am not delaying any treatment. Which is very good, it means I can get better and diagnosed a lot sooner."*

*Figure 19: Graph showing the reasons why participants could not access healthcare*[21]




Some women spoke of how they felt that services did not understand the specific issues they experience as homeless women and/or that services did not take their issues seriously. We asked the participants to what extent they agreed or disagreed with this statement: *"healthcare services understand the issues I face as a homeless woman*". While 45% either strongly agreed or agreed, 37% strongly disagreed or disagreed[22]. One participant described how she felt: *"it's very hard (accessing health services); I don't trust them. They don't take my issues seriously"*. Another participant made a point about trusting services, including charities and NHS services more generally.

> *"So you are not sure to trust because you have trusted so many people before, so you lose confidence in yourself and trust in others. So wanting to access … centres or places where you*

[21] It should be noted that this does not include all participants but those who have been unable to access healthcare
[22] 18% neither agreed nor disagreed

*can get support, you don't come… you are not.. you don't readily feel that you can come forward with the problems that you have, because you are wary that you're going to be judged or not believed. Because sometimes they have like people that are maybe volunteers, but you can tell that they just don't seem to have any idea. Like I have told stories to volunteers where they are gasping and things like that. And that just makes me feel like oh my god my life is a lot worse than I thought. I thought I was doing fine."*

This participant makes an important point about the need for awareness of the issues amongst staff and volunteers and for reactions not to make the participant feel they are doing badly.

Participants felt that NHS services did not understand the practicalities of being homeless*: "and they don't understand that you are homeless, you haven't got an Oyster, or it took you time to get here".* This woman spoke of how her GP didn't understand that despite having temporary accommodation, she couldn't work because of her health:

*"Because they tell me to go to work. Why you not work? Because I am not well. How am I going to work? I am on the street. But now you have place. GP tell me you are not on the street now, you have a place now, why you don't work? So, she don't understand health. Sometimes people can have a home, but they can be ill at home."*

However, when asked the extent to which participants agreed with the statement:*" I feel I am able to be honest with staff in health services*", 73% of women felt they could be honest, and 19%[23] disagreed. Therefore, this suggests that while many women experiencing homelessness do not feel that staff understand their situation, most felt that they could be honest. In some instances, it was the women themselves who didn't want to tell services about their circumstances because they felt ashamed of their situation.

Participants spoke of the support and understanding they received from staff at specialist homelessness GP surgeries and in-reach services at homelessness day centres. Specialist GP surgeries, for example, Dr Hickey's, Great Chapel Street, Greenhouse and E1 GP surgeries, are greatly appreciated by participants. One participant explains the support they received: *"Dr Hickeys is amazing, easy to ask for sick note. They understand homeless situation whereas others GP were suspicious".* Many spoke about how the specialist services were supportive because they understood the issues homeless people face:

*"They have been very good because they have had experience with people in my situation. And the majority of clients - they are now patients, sorry - of my situation, so they can help you".*

Participants frequently told us that being able to get lots of medical services under one roof, either in a homelessness day centre or at an NHS centre, was highly beneficial to their health and wellbeing. This participant stressed:

[23] 8% neither agreed nor disagreed

> *"It's all in one place… for clinics, all in one place. You don't have to travel to go to a hospital or clinic. And they can get you specialists treatment. As quickly as possible. And if they don't have ID, they can tell you how you can acquire that ID. Like, you know, if you have lost it or anything like that, has been misplaced."*

This participant also explains that such specialist surgeries, because they work with people experiencing homelessness, do not ask for ID. Participants also spoke of how services working together was supporting their health and wellbeing, as this participant gives an example of how the GP and the social worker worked together:

> *"The GP I had there was really good, so I didn't want to change GP. He would write to my social worker then saying I was really depressed, and they think they should move me. I was really agitated my blood pressure was very high; they kept saying to them they can't do anything until I get my leave to remain then I can get a bigger space. So, the GP and social worker working together was very helpful".*

We also found that participants greatly benefited from women only services or women only drop-ins in mixed services. Many services had sessions and organised activities where participants could get something to eat, receive support and talk to fellow clients, staff or volunteers.

For those who had experienced domestic and/or sexual violence, the support they received varied considerably. While some of them received support, others either did not receive any, the support was not enough or had not told anyone about what happened in order to be able to receive it. One woman spoke of how she was unable to get mental health support for the violence she had experienced because she was living in a squat (see section below on mental health). Another woman spoke of how she is on the waiting list to get support but while she is waiting, she told us she is suffering significantly. Many women who had been affected by violence were either too scared to talk about it with a professional or to report it to the police, and/or felt it would again be re-traumatising to get help. This woman described the help she received and the challenges she had faced talking about it.

> "*So, domestic violence when I was sixteen. I received counselling for that. Not straight away though, because I wasn't honest about it. And then I received medical treatment back in December for sexual exploitation. And then I also received it again when I came back in March".*

### The Mental Health Catch-22

Another significant problem that the research found was the barriers that seem to be in place to get mental health support, especially for those who were rough sleeping, sleeping on transport or squatting. Women spoke of not being able to receive the full support they needed for their mental health because of their housing situation or other issues they were experiencing. As this participant expressed:

*"I wanted to sign up for CBT (Cognitive Behavioural Therapy), but I can't access as they think I have bigger problems; they think I need a house first. And I can't refer myself as told need a caseworker – don't have one as I am squatting".*

One woman spoke of how her mental health issues were dismissed and put down to her immigration issues. She explained:

*"They just refused to care for me because they said you don't have mental health problem. You're just depressed! That's what they used to say to me. Because you have immigration issues, but you don't have mental health problems. But I was taking anti-depressant before I came to Britain. I didn't understand what they were talking about. And I couldn't be housed. There was nothing there for me. So that's why I ended up getting abused, sexually abused, into porn and things like that".*

This was also a common problem for women who had coexisting issues with mental health and substance misuse, sometimes known as 'dual diagnosis'. Women spoke of how they could not get support for their mental health unless they controlled their addiction.

When access was possible, participants spoke of how it took a considerable time, in many cases over nine months, from an initial appointment with a GP to getting support from a counsellor and/or psychiatrist. As mentioned previously, since people experience homelessness can be moved around a lot, referrals that are made are not always followed through correctly. This participant described what happened to her:

*"I was asking to be preferred for my mental health, at the time they were giving me Mirtazapine. And I said the tablets are helping, but they are not a long-term solution. Can you refer me for therapy? And the referral never got through. I was getting told I had been referred to this place. Then I am phoning the other place and they haven't received any referrals for me. So, I was going there and just told to up the dose of tablets. It was just mong her out, give her another 10 mg of them and... So, I just stopped taking the tablets, and I went to A&E. And that was where I got all the help. The triage nurses there did everything they could, and within six weeks I was referred…That A&E – they were the ones that did it, weren't they?"*

This participant highlights another important finding in this research that unless their situation was an emergency, they were not going to get support. In some cases, participants explained how they felt that they had to talk about self-harm and/or suicide or enact on it in order to get support. This quote also echoes feelings among other participants in this research that there is a tendency among health professionals to favour medication rather than other forms of therapy.

Another participant describes how not having a front door that shut properly in the hostel she was living in made her anxious. However, instead of fixing the problem of her door – her key workers felt she should be sectioned. She told us:

*"But I am OK, know what I mean? I am not going to do anything stupid. I am just worried about coming out of my room at night, and there is dramas kicking off. Know what I mean? Which is normal. Which is a normal f*cking reaction to what was going on in the house at the time. So that completely relinquished all my trust in keyworkers. Because I thought rather than doing your job, you are going to put it on me, like I was so unwell that I felt unsafe in myself. Or that other people were unsafe around me. That you were just going to try to get me sectioned to get me out of the problem rather than fixing the problem."*

The mental health challenges that women faced, often from previous traumas, meant that specialist and personalised mental health support was needed. Often mental health support was inconsistent, and women felt they could not build relationships with counsellors. One of the volunteers wrote the following in their notes: *"she has accessed counselling and says it has helped but says that the staff are always changing and would like to see a regular person."*

This section illustrates the multiple different catch-22s participants face either around their immigration, housing, addiction or other issues. There was a perception among participants that other issues they are facing were depicted as the main cause of their mental health issue, and that until those other issues were resolved, support for their mental health would be limited. This perception seemed to be shared by staff in services who found it very difficult to get appropriate and sufficient mental health support for their clients.

## Conclusion

This study has explored the health issues homeless women experience and their experience of accessing health services. It is unique in that it is the first to exclusively examine the health needs of women who are homeless. Further to this, it is the first of its kind to be conducted and led by women with experience of homelessness. The peer research element of this study was critical to its success and reiterates the transformative power of this approach for the participant and the researcher.

Participants have long and complex histories of homelessness; with many being homeless multiple times. It was rarely one reason for homelessness, but rather a combination of intersecting factors. The three main reasons participants cited for becoming homeless included relationship breakdown and/or family breakdown, physical health issues and domestic violence. Most participants also felt that their health (physical and mental) had contributed to them becoming homeless. This research reiterates the often-overlooked fact that health is a key factor in homelessness prevention.

This research found that women were living with several health conditions that were aggravated by living conditions and the stresses of being homeless. Of the participants, 74% had a current physical health issue. The most commonly diagnosed physical health issues were joints, bones and muscles, blood conditions, problems with feet and stomach issues. The conditions that showed the biggest increase upon homelessness were issues with joints, bones and muscles, blood conditions, heart conditions and problems with feet. It was apparent that living conditions caused new health issues and exacerbated existing ones. In addition to this, the stress of homelessness caused hair loss,

headaches, stomach pain, eye irritation, rapid heartbeat, panic attacks, chest pain and early menopause. Participants had issues with sleeping, finding enough food, keeping clean and were affected by on-going sexual and/or domestic abuse.

Issues with mental health were common among participants. Of the participants, 64% expressed that they were experiencing mental health issues, compared to 20.7% of the general population; the most commonly diagnosed issues include depression, anxiety/phobia and post-traumatic stress disorder (PTSD). Some mental health issues existed before homelessness. However, many developed new mental health issues because of their housing situation. Self-harm and attempted suicide were not uncommon. Furthermore, addiction was both a cause and consequence of homelessness; 24% of participants felt an addiction was affecting their day-to-day life.
This research found that participants were reliant on the support provided by healthcare services and not-for-profits. In-reach health support at homelessness centrers was highly valued, as were women-only hours and drop-ins. Most participants felt that they struggled with the motivation and confidence to deal with their health issues when they are homeless. Participants often spoke of how they had other priorities, such as finding something to eat or somewhere to sleep. In other cases, women spoke of how they did not value themselves enough to get the support they needed. This research also found that further training is necessary, as over half of the participants didn't feel that the health services understood their situation. Accessing mental health services was often difficult; women were often told they needed to sort out their housing issue and/or addiction before they could receive support. Historical and current violence was common; notably, (35%) spoke of violence they were currently experiencing. Support for trauma caused by domestic and/or sexual abuse was often insufficient.

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