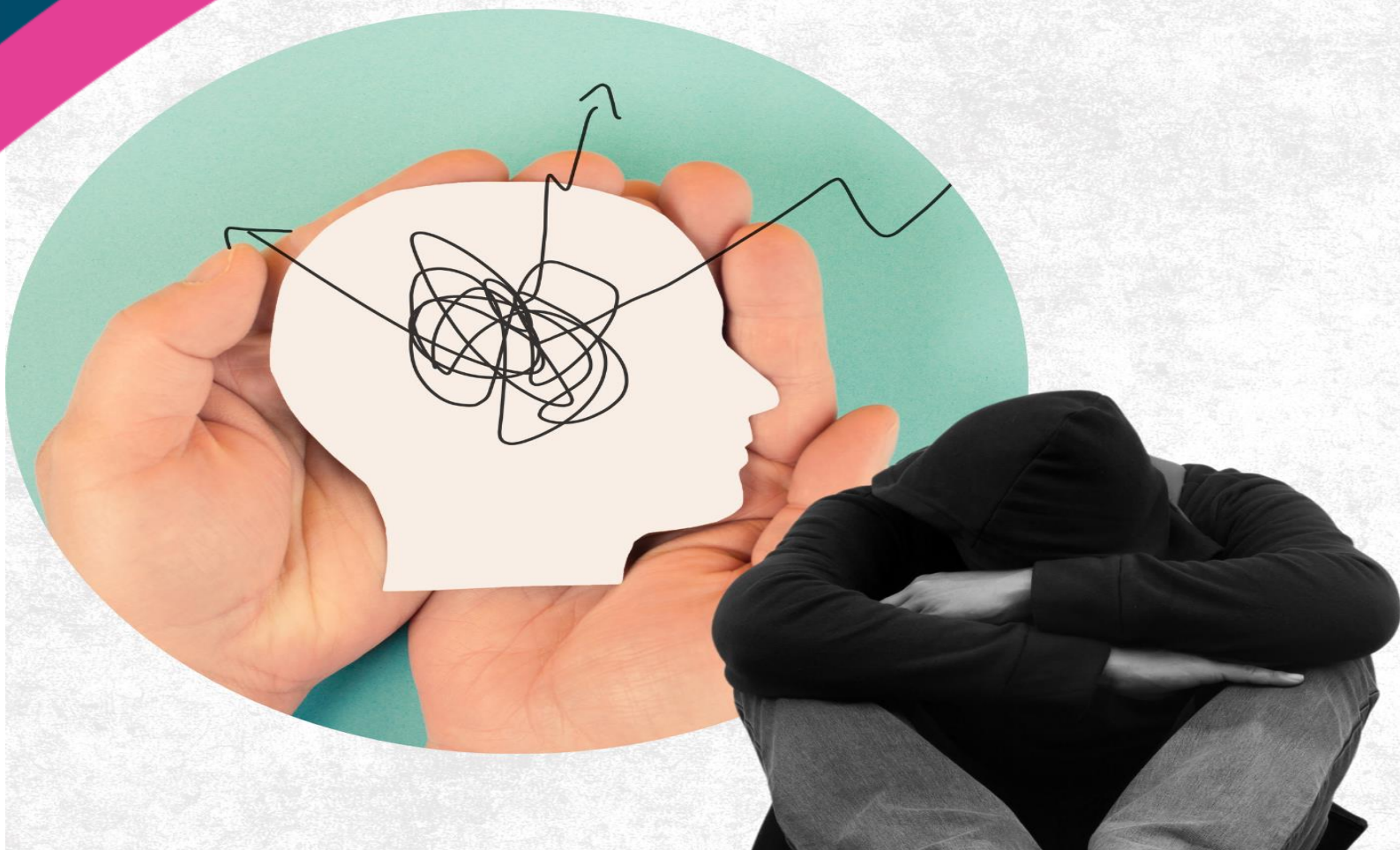
healthwatch Westminster

“Homeless, not hopeless”

The needs and experiences of homeless communities accessing primary mental healthcare services in Westminster

Community engagement report
July 2024



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Introduction

Overview

Healthwatch Westminster developed this project to explore the mental health needs of Westminster's homeless communities, specifically their experiences with or access to primary mental health treatment services. Westminster is the London borough with the highest rate of homelessness.[1] Our community mental health projects,[2] as well as the variety of feedback and concerns received through our targeted outreach and signposting services, suggest that additional support is required to meet the mental health needs of people who are experiencing homelessness in Westminster.

The project's aim is to better understand the mental health needs of homeless people - including those who are rough sleeping, squatting, coach surfing, or staying in night shelters, hostels, second-stage or supported housing - as well as the current gaps in primary mental health care. We also wanted to consider whether variations in age, gender, language ability, or ethnicity affect their experiences, access, or quality of care.

Overall, we discovered a need for primary mental health care to be more accessible and better integrated with specialty services and community-based support networks.

There is a need for more resources about mental health services, symptoms, and where to get help. These resources need to be available in English and in the additional languages spoken by significant migrant homeless communities.

Finally, service providers have the potential to implement a range of initiatives that would better support patients, including trauma-informed approach to services, better continuity of care, staff training, addressing stigmatisation, increased funding for long-term mental health management and resources, and early intervention and support. These issues are examined in further depth on page 15, where we make our recommendations.

[1] https://www.westminster.gov.uk/housing-policy-and-strategy/social-housing-homelessness-and-rough-sleeping-statistics

[2] https://www.healthwatchwestminster.org.uk/report/2023-10-31/community-perspectives-impact-closure-acute-mental-health-services-gordon

Project implications

At Healthwatch, our mission is to integrate the feedback and experiences of local communities into the centre of health and social care services. Our priorities include addressing health disparities, removing barriers to care, and coproducing recommendations to enhance services for all.

This project's findings are critical for understanding the mental health needs and gaps in primary mental health services among Westminster's homeless communities. The data is important for developing strategies to promote the continuity of care, expanding and tailoring services for various populations with diverse mental health needs, and improving access and quality of primary mental health care treatment for Westminster's homeless communities.

We aim to continue our collaboration with homeless communities and relevant service providers through partnership meetings and forums to monitor outcomes and developing needs. We will also be hosting co-production activities with homeless populations and service providers in August. The goal of these engagement events is to provide more opportunities to incorporate residents' concerns and input, as well as to develop new ideas to address the primary hurdles to the mental health needs and provision of homeless communities.

Methodology

Healthwatch Westminster developed the engagement plan with input from key stakeholders in primary mental health care, homeless support services, and the Healthwatch Advisory Boards. We devised a mixed-methods engagement plan that included both online and in-person data collection, as well as quantitative and qualitative methods.

The first stage of data collection comprised an online and in-person survey for service users, which we designed and reviewed with key stakeholders and professionals that serve homeless communities' mental health needs.

The survey inquired about participants' previous mental health experiences, their sources of mental health and wellbeing support, their interactions with mental health and wellbeing services, the factors that positively and negatively impact their mental health, and demographic indicators such as age, gender, race/ethnicity, housing, and financial situation, among others. All surveys were confidential and anonymised.

We published a digital version of our survey on 2 February 2024. We distributed survey links and project leaflets to our stakeholders and partners in mental health and homeless services, such as mental healthcare providers, homeless services, community mental health teams, General Practices, and community centres. In addition, our engagement team distributed questionnaires and posters at community drop-in sessions, Westminster homeless health partnership forums, and the Groundswell community initiative at the Abbey Centre. We received feedback from a small portion of service users in person after handing out our surveys, but none online.

In the second stage of data collection, we conducted focus groups and individual interviews with service providers and professionals who provide mental health services and/or homeless support to diverse populations with mental health needs in varying capacities. We completed a preliminary analysis of the survey data, which we then presented and discussed with each participant.

The Healthwatch team also conducted 13 in-depth semi-structured interviews with key stakeholders to acquire a thorough understanding of how service users access and use primary mental health support. We met with representatives from healthcare services, charities, and residents' groups, as well as a few service users who have lived experience with homelessness and mental health (for more information, please see “Limitation of Findings”). We met with these individuals while visiting community events and reached out to our community networks that provide mental health and/or homeless support services.

Each interview lasted approximately 30 minutes to an hour. Written consent was obtained from each interviewee and, when participants allowed it, we audio recorded and transcribed the conversations for analysis. For the confidentiality and safety of participants, we have modified or removed any personally identifiable information from the findings included in this report.

The interviews covered topics such as service users' experiences accessing and obtaining mental health care, observed changes in mental health provision and community mental health, current gaps in primary mental health services, whether demographics influence access to and quality of care, and recommendations for addressing the gaps. Service users or people with lived experiences were nonetheless invited to participate in the interviews and offered vouchers as compensation.

All service users received a debriefing, a directory of local resources for mental health and wellbeing support, and guidance on making an NHS complaint. Residents may also contact us for mental health resources.

In total, this report summarises the input from 13 service providers who support over 1,000 homeless people with mental health needs, as well as two survey responses from service users.

Findings

Overview

We heard from a variety of healthcare professionals, charitable organisations, homeless resource centres, and service users about the current provision of primary mental health services, the current gaps in access and quality of services for homeless communities, and key recommendations for improving primary mental health care services, particularly for vulnerable communities.

Our findings focused on service users' experiences with long wait times, integration of specialist services, high intervention threshold, trauma-informed care, awareness of access to and use of service, stigma, cultural and language barriers, migration status, dual diagnosis, digital exclusion, funding constraints, continuity of care, staff competency, and recommendations for improving primary mental health services for Westminster's homeless groups.

What are the experiences accessing and/or using primary mental health care in the homeless community?

We surveyed and interviewed respondents to better understand the current barriers to accessing and using primary mental health care services such as General Practice, NHS Talking Therapies, Community Mental Health Teams, and others.

Every participant who provided feedback on gaps in current mental health provision and support referred specifically to the service users' experiences accessing primary mental health care services, the quality of service and/or treatment in meeting the needs of diverse populations with complex mental health needs, and continuity of care when recovering from homelessness and mental health post-treatment.

Access to Mental health services

Respondents reported that high thresholds, stigma, fear of migration status, digital exclusion, meeting complex mental health needs, cultural and language barriers, waiting times, and a lack of awareness of mental health and mental health services all had an impact on their cohort's experience seeking support.

1. High threshold and difficulty of making an appointment

Participants remarked that the criterion used to determine whether people require mental health care is high, to the extent people's mental health worsen significantly whilst waiting to receive support. A nurse expresses worry that the present threshold only supports individuals with severe symptoms. In addition, it is further stated that the phone scheduling process to book an appointment excludes homeless people who do not have access to phones:

"The gap is the threshold to have access to that service is very, very high. The threshold is usually for people that are experiencing psychotic symptoms, so the gap is people have to wait and watch people become increasingly unwell until they reach that threshold, the lower levels of the threshold. So even if the services are for people experiencing homelessness or people that have got experience in that appointment-based systems, telephone-based systems don't work."

An individual who resides at a hostel shared similar challenges using the telephone-based system to access mental health support at the GP:

"It was unhelpful because no one picked my calls or returned my calls."

Another respondent from the Central & Northwest London Recovery and Wellbeing College (RCW), who supports communities including homeless groups with a range of educational resources for people with mental health difficulties, highlighted the digital hurdles in seeking help at first instance, as certain homeless populations may not have an email account:

"And if you don't have an email address, it's almost worse than not having an address. 13% - 20% of our cohort don't have an email address."

Another respondent from Westminster Homelessness Partnership team, who works directly with community organisations that serve homeless communities in various capacities, raised similar worries about the impact of the high threshold:

"You don't know that you need assistance until you are in the in the throes of suicide… it's not just one population group. It's all people"

The respondent also noted that a lack of awareness about mental health symptoms, mental health, and mental health services can impact whether people, particularly the elderly, access and receive, and at what time they seek support:

"I mean, the very elderly reach a point where they are stressed, and they don't understand that they are stress because they think they've got dementia or something else.

Another respondent from Westminster Homeless Partnership team sheds light on the importance in addressing the stigmatisation surrounding mental health, particularly among young people, so that when they are having a mental health problem, they are confident enough to seek support in improving their mental health outcome:

"There are the young ones who don't understand what stress is, because they don't want to know that they've got stress."

2. Stigmatisation

A respondent who supports homeless communities, including hidden homeless groups in South Westminster, highlighted the fear that homeless groups have in obtaining mental health support due to the stigmatisation of mental health, particularly the fear of being denied housing because of their mental health conditions:

"[It's that] feeling of not being able to go to the GP and tell the GP [because they feel that] if they cause a problem with regards to saying that they've got mental health issues, that they may not be given a home."

An alcohol practitioner at Change, Grow, Live (CGL) who serves homeless communities' mental health needs expressed worry about the cultural stigma associated with disclosing a mental health condition, particularly among African men, as indicated by their reluctance to seek mental health care. It is also stated that having a robust community network that represents many populations is crucial in addressing stigmatisation:

"I've spoken to some people of colour, predominantly African men who said that they're not accessing services even though they need mental health support. And sometimes there's a whole bullying aspect that goes along with it. I don't know if it's down to racism or what. African men tend to not be in groups, maybe in groups of one or two at the most. But you'll find, say Eastern Europeans are

more community base, so they've still got more support. And if there's six men from one community and one man from another, you know that there's challenges there."

Similarly, a member of Centrepoint, which provides housing support to young adults aged 16-25, shares:

"Practitioners don't understand the young person is not seeking mental health support because they are not used to having that service. Because they're kind of taught, just get on with it […] and move on with your life."

Another respondent from the Marylebone Project, an organisation providing services for homeless women in crisis, shared similar worries about the stigmatisation of women with mental health disorders, as well as the stigma associated with homelessness:

"Some of the ladies [at our accommodation] are very clearly having mental health issues, but they fall into the cracks of the mental health services, as they do not disclose their conditions. There's a big stigma to being homeless – especially if they are homeless and seem neglected."

3. Migration status

Another barrier to accessing mental health support commonly reported by respondents is the fear of seeking mental health support amongst homeless communities who do not have permanent residency in the UK:

"I think some of them they wouldn't want to be in the system because of risk of deportation."

"Some fear that they might be deported if they seek help."

"Some immigrant communities are less likely to access support than a native community. Sometimes you may not even have recourse to public funds. So, you're less likely to go and seek services, but then also, you're more likely to keep have more pressures on you."

4. Cultural and language barriers

Service providers commonly voiced concerns about the lack of understanding of mental health within migrant communities, as well as the lack of representation

of staff as a barrier to receiving mental health support. A community organisation that primarily supports asylum seekers emphasised:

"And I think one of the concerns that I've picked up is that with asylum seekers, especially those who are coming from either Ethiopia, Eritrea, that kind of region, mental health is something that's not really discussed where they're coming from. So, when they come to the UK, they find it a little bit difficult to access those things because sometimes they don't believe that they're going through what they're going through. And then we have practitioners who may not be relatable or may not understand that struggle."

Other respondents expressed concern about the difficulties for migrant groups to seek and receive support if they do not speak or comprehend English. A mental health worker at the Recovery College Westminster [RCW] provides a very concerning example:

"A lodger for five years who was a Chinese refugee had been street homeless. He didn't actually speak English at all. He'd been in for five years, and most of the time [he'd only speak to himself]. He hasn't actually been able to communicate with anybody who speaks his language. So, I think those kinds of barriers [makes it difficult to put people like him] in touch with health services."

Another member of the College expressed similar concerns:

"Those who speak English as a second/third language or are immigrants are more hesitant to access mental health services."

5. Dual diagnosis

A number of respondents commonly reported their worries about the difficulty of seeking mental health treatment for those with complex needs, particularly those with dual diagnoses.

The term "dual diagnosis" refers to having both a mental health illness and a substance use issue at the same time. An alcohol practitioner who works with homeless groups expressed displeasure with the lack of help for those who have major mental health difficulties and use substances as a coping method:

"I find it really difficult because people may drink, and then mental health services won't accept them because they're consuming alcohol. They've got mental health treatment need, but the treatment need cannot be met, because they're consuming alcohol, which will affect any mental health they have. But

[the services] won't work in conjunction, they'll say they must stop drinking alcohol to address the mental health [which] is not going to work."

It is encouraged that:

"The mental health has to be addressed along with [the] alcohol usage."

6. Waiting times

We also received feedback regarding long waiting times for a mental health assessment. A respondent from the RCW describes the difficulties that homeless groups with mental health needs have in accessing mental health care when compared to non-homeless people:

"So, if you're a normal person [not homeless], you might get six months waiting. However, if you're homeless you might be waiting a year and a half with the necessary issue."

7. Lack of awareness

Other respondents expressed a lack of understanding of mental health support and how to acquire it. One respondent shares:

"Some of the homeless people don't know how to access [healthcare services]. They don't go to these clinics or whatever it is. They just go get food, and they don't actually realise that they need help either."

Quality of mental health services

Many respondents also focused on the quality of mental health care received. When questioned about existing gaps in mental health services, respondents typically stated that a lack of financial stability, continuity of care, trauma informed care, service integration, and staff competency all contributed to the overall experience of receiving adequate treatment.

1. Funding

Respondents expressed concerns about a lack of regular financing and how it affects the resources and staffing needed to provide adequate mental health care:

"When they [housing providers] had taken over the contract by under bidding and undercutting someone else's bid, the current staff either had to take a salary cut, or were given a much bigger caseload. [Consequently], most experienced staff left."

"Ultimately, if you continue selling something off to the lowest possible bidder, you will get the worst possible level of service…the tender cycle is very destructive. And I think it erodes the value of the workers who work there."

Other respondents describe how financial constraints have affected staff service quality and resources:

"Yeah, because the organisation came in [and] undercut everybody else. So, all the experienced workers left, and then they had to employ these new young workers who didn't know the service users [well enough]."

"The people I've dealt with start off saying that they want to help us and then they run out of funding, and then there's no longer any help. So, it's making sure that if you're doing this kind of work, you've got sustainable funding to do it."

"What we found is that obviously, the system is really stretched, and the resources are less and less and that is telling in terms of what people can expect to access and how much input they can get from their mental health professionals."

"We had a financial case. So, it meant that some of the psychotherapist and mental health nurses that were working with our young people, we don't have that anymore in house."

"The other big issue in terms of a gap is people that we know that are experiencing psychotic symptoms that are really unwell mentally, [have been on the waiting list for a Mental Health Act assessment for a very long time]. I understand our mental health colleagues are under severe pressure, shortage of staff, shortages of beds etc."

Similarly, a nurse discusses the difficulties that street homeless people face in getting access to beds due to budgetary constraints:

"We've had people waiting up to a year for Mental Health Act assessment more recently, as the gap in staffing and resources has increased. What we find is that people are on the list, but the team has said they don't have a bed. We don't have enough AMPS [A mental health practitioner who has been authorised by a local social services body to carry out duties under the Mental Health Act] to go out and do the assessment. We have had somebody assessed having a Mental Health Act assessment, the outcome of which was that they needed to be detained for treatment,

but there was no bed. So, it was rescinded. Not because they didn't need treatment, but because there was no bed… I think the street population are very underserved."

2. Continuity of care

An additional area of concern reported by respondents who commented on the quality of care is the lack of post-treatment care that supports homeless groups with mental health needs transitioning out of homelessness:

"A service user recalled 'there's no one there for me'. And I just think something that hopefully is simple to do is to have someone follow them through for a year so that they don't have this mental health breakdown… one of the things is in Westminster for example, is they seem to put them in places outside of Westminster."

"There is no way that you can recognise someone's difficulty and treat someone's difficulty within the eight weeks [in] IAPT [Improving Access to Psychological Therapies now referred as NHS Talking therapies], and then get that person on board to recognise what that difficulty is, and then how to treat it themselves so that when you finish with them, they can do it themselves. There's no way you can do that in six or eight weeks."

"People quite often get discharged to nothing and mental health wards are no different. People quite often get discharged to homelessness, although they try very hard not to. And there are a few people on mental health wards who've been there for [more than they should] because they can't get housing sorted. I knew someone who was discharged to a bush."

3. Trauma informed care

Respondents also expressed concerns about the lack of a trauma-informed approach to mental health services required to improve the quality of care received. A respondent from Westminster Homeless Partnership team commented specifically on the lack of support for service users with childhood traumas:

"There are high levels of childhood trauma, I think services that were geared up to help people with that sort of combination of need, or that experience, [lack in service provision]. It's not particularly well geared up for people who have experienced childhood trauma."

Whilst other respondents comment on the lack of support in addressing trauma holistically:

"A lot of services are not really (...) recovery or trauma focused, and [do] not address what the situation can be."

"Some of the services don't focus particularly around people who've experienced trauma, and not when and where trauma is the reason why they're street homeless."

A One Westminster staff member who receives referrals from the GP and Mental Health Hub expressed concern about the lack of trauma-informed care, especially in terms of mental health support structure and signage support:

"I think if we look at trauma informed services, buildings are often not trauma informed. Reception staff are not aware of how they're receiving people first point of contact, or there's not enough training to make that as trauma informed as it can be. What's your journey like [when visiting the building]? What sort of signs are on the doors and on the walls? [I've been] to buildings before where the wait time is more than 10 minutes unless you've got an appointment. How welcoming are they [staff]? Are they [signage] triggering in any way? Are they very institutionalised?"

4. Integration of services

A member of staff from Westminster Homeless Services expresses worry about the lack of specialist services available to homeless communities living in temporary accommodations:

"People don't seem to have access to a psychologist or proper mental health support and there doesn't seem to be a treatment plan for them."

In contrast, another respondent highlights the specialist services and advocacy group available to support communities in temporary accommodations that enhance mental health support:

"So, there are some specialists and really good specialist services. We've got a psychologist at the hostels on Mondays, and there's been additional services brought in. [The Great Chapel Street offers psychotherapy and counselling]. We've also got the Groundswell peer advocacy group on the ground floor."

5. Staff competency

Many respondents who commented on service quality frequently discuss staff abilities, knowledge, resources, and communication in supporting diverse homeless communities with their mental health. A member of the health and wellbeing team

expresses worry regarding the efficacy of the treatment programs provided, notably Cognitive Behavioural Therapy (CBT):

"Talking therapies for anybody homeless are generally very Eurocentric. I think they're very limited in what they offer. So, it's generally CBT based. There's a lot of barriers to that, such as how many sessions you can access and how you access it. If you miss a couple of appointments, then you have to go back on a waiting list, things like that I think are really challenging for transient communities."

A Service user involvement team member shares:

"Some medical professionals are not specifically trained to work with homeless people."

Similarly, a respondent who works with rough sleepers at the Passage describes the importance for staff training to meet the needs of communities with complex mental health needs, particularly personality disorders:

"The mental health services are just so overstretched...I think, after the pandemic people have more developed mental health issues that are more serious, and there's less resilience. We found it can be really difficult in dealing with things like personality disorders. Personally, I've been involved in two cases where the mental health teacher said these people are too difficult for us to work with. And it's just kind of left to me and my team to try and manage these people in general needs accommodation."

Another respondent who supports young homeless groups expresses worry about the inadequacy of staff training and dialect diversity in meeting the needs of migrant groups who do not speak, or understand English:

"Sometimes interpreters may not interpret exactly what the other person is saying it might be a different dialect."

Another respondent who works with homeless women recognises the importance of staff comprehension:

"Roma people tend to be misunderstood and may use a tone which some professionals mistakenly believe to be aggressive. Some people get frustrated when they are not understood."

Limitations of findings

Accuracy of survey findings

We chose to incentivise participation for service users in the project interviews by providing respondents with the opportunity to redeem a £10 voucher. However, we understand that having an incentive may lead to some participants providing inaccurate details in order to be considered for the project and receive a voucher.

Although the majority of our findings are based on key professionals' observations of the cohorts they work with, service users would have been better positioned to provide the most accurate details of their personal experiences.

While we were able to reach certain service users, we recognise that the nature and sensitivity of the project may have limited our ability to reach as many people as intended. Nonetheless, our interviews with key experts allowed us to gain in-depth knowledge about the access and quality of primary mental health care among the homeless population through the service users they support (please see Next steps on page 13).

Representativeness of participants

We aimed to hear from homeless communities in Westminster with mental health needs. While we were able to reach certain service users, we recognise that the nature and sensitivity of the project limited our ability to reach as many people as intended. We also reached out to homeless groups through our strategic stakeholder network, but were unable to establish contact from street homeless groups, who are often hidden and do not seek support for temporary housing or mental health services.

All of our communication materials, surveys, and outreach were in English. There were no interpreters present during Healthwatch staff's in-person engagement and outreach visits. This may have led to the exclusion of non-English speakers from our project.

Recommendations

We asked service users and key professionals about how primary mental health services and support could be improved to better meet their mental health and wellbeing needs. The following recommendations were developed based on the feedback that was shared by 15 participants across the survey responses and interview discussions.

1. Adopt a trauma informed approach to mental health services

Respondents shared the view that mental health services should prioritise trauma and examine the impact of the negative environment that homeless communities can find themselves living in. Respondents added that a trauma-informed approach should also apply to buildings, staff communication at the initial point of contact and signage on walls and doors.

Furthermore, respondents reported that mental health services did not provide adequate support for homeless communities transitioning out of homelessness.

A trauma-informed pathway should be implemented to provide support for individuals in need of trauma treatment, including language, housing, benefits, support paying bills, specialist services, and other essential support. This requires the collaboration of multiple expert services, rather than expecting traumatised individuals or people with long term mental health needs to transition between services.

Respondents also emphasise the importance of having a designated safe space within the community specifically for people with various trauma triggers, such as a dry space for homeless communities who do not engage in substance use, a designated space for young people, women experiencing domestic abuse, and so on.

2. Provide a service that supports continuity of care

Respondents noted that a lack of continuity of care following treatment had an impact on the mental health outcomes of homeless groups. As a result, respondents recommend that mental health services prioritise drop-in sessions at clinics and GP practices for free mental health support at both

the point of access and delivery. Other respondents proposed having social prescribers stationed at clinics to improve access to services.

3. Provide more information and resources for homeless people's mental health

Another major barrier to getting mental health care was a lack of knowledge about the services available, indicators of poor mental health, and where to go for help. Given that one of the primary concerns about a lack of information was commonly reported by migrant communities that do not speak or understand English, as well as digitally excluded communities, it is critical that services prioritise the quality and accessibility of their resources by making physical resources available in English and other commonly spoken languages among Westminster's homeless populations.

Participants proposed that providers share more information about available resources, symptoms of poor mental health, and instructions on how to get help. This is critical for eliminating stigma within migrant populations, cultural and linguistic hurdles, and enhancing early detection before deterioration.

4. Address stigma, fear, and prejudice in accessing support

Participants in both the survey responses and focus group discussed their difficulties speaking about mental health and getting support as a result of mental health stigma, cultural stigma, and stigma associated with homeless populations' migration status.

Respondents expressed a need for increased public health programming to address mental health stigma, and foster conversations about mental health issues that normalise mental health challenges, particularly among diverse communities. Some have proposed having representatives or spokespeople from various populations in the community to foster communication and share mental health resources.

5. Provide more tailored outreach services and advocates

Respondents emphasised that, in addition to enhancing access and the quality of primary mental health care, it is critical to implement preventive interventions in homeless communities before they deteriorate. As a result, it is proposed that more advocates go out to meet people where they are [on the streets], support

patients who are struggling to meet appointments, building rapport, moving into a new home, assisting with bill payment, and so on.

6. Improve staff training and resources to better support homeless communities from diverse backgrounds and mental health needs

Another important area of concern mentioned by respondents is the expertise, knowledge, and communication required for staff to provide quality support to service users, particularly those from migrant groups. Respondents suggested specific training on the different types of mental health, working in a multidisciplinary setting, interpretation and comprehension, and cultural awareness. Thus, mitigating delays in assessment, diagnosis, and treatment.

7. Develop systems to monitor outcomes and impacts of mental health needs for homeless communities across services in Westminster

Many respondents suggested that it would be beneficial for mental health service providers to have a consistent method of monitoring the current and emerging mental health needs of homeless communities across various services, including homeless shelters, and supported accommodations in improving the overall mental health outcomes of vulnerable communities.

8. Increase sustainable funding

Respondents highlighted the impact of insufficient funding on mental health prevention, skilled staff retention, and wait times. As a result, respondents suggested that mental health services pool more funding to meet the demands of homeless communities' mental health needs, invest in self-management resources for homeless communities, recruit more staff to reduce wait times, and pool resources across services to provide more mental health provisions in dealing with bed shortages.

Next steps

Following the publication of this report, Healthwatch Westminster will be hosting a co-production event to discuss our findings on homeless people's access to and use of primary mental health services in Westminster. The event will be open to homeless persons, people who have lived experience with homelessness and mental health, mental health service providers, and community organisations who work with homeless people in Westminster. The purpose of the session is to discuss important project themes and explore interventions and next actions in accordance with our recommendations. The findings from our co-production event will be used to inform our ongoing work on the health and well-being of homeless people. We will also communicate our project findings and co-production engagement findings to our key partners at the Westminster Homeless Health Partnership meetings and the Bi-borough Quarterly Housing Solutions Homelessness forum.

We are currently recruiting young people through our project and community networks to join Young Healthwatch, a network of young volunteers to support our ongoing research projects, communication campaigns and signposting services. Young Healthwatch volunteers will provide valuable insight and perspective to our projects and priorities and can serve as community ambassadors championing key health issues and concerns for young people in the bi-borough.

Also, Healthwatch Westminster is presently seeking residents with lived experiences of health and social challenges in Westminster to join our Advisory Board, which advises and guides the Healthwatch Team on how to achieve their goals and priorities.

If you are interested in supporting our work, being active in Young Healthwatch, joining our Advisory Board as a member, or staying updated on our ongoing projects, please email info@healthwatchwestminster.org.uk.

Acknowledgements

We would like to thank all the team members and Advisory Board members of Healthwatch Westminster for their contribution to this project. We appreciate the help of local service providers and community organisations in gathering data for homeless communities with mental health concerns in Westminster.

This project would not have been possible without the assistance of the partnered organisations and individuals in reaching out to homeless people, service providers, homeless resource centres, and community organisations in Westminster, as well as the collaboration of service users in sharing their valuable experiences and perspectives with us via the survey and focus group discussions.

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