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Views and experiences of local mental health services for people with experience of homelessness or insecure housing

Ang Broadbridge and Sheila Blatchford

healthwatch
Newcastle

FULLING LIVES
Newcastle Gateshead

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LIVES**




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HOUSING**



About Healthwatch Newcastle and Healthwatch Gateshead

Healthwatch Newcastle and Healthwatch Gateshead are two of 152 local Healthwatch organisations established throughout England on 1 April 2013 under the provisions of the Health and Social Care Act 2012. We have a dual role to champion the rights of users of publicly funded health and social care services, and to hold the system to account for how well it engages with the public. We collect feedback on services from people of all ages and from all communities. We do this through our network of voluntary and community sector organisations, during events, drop-in sessions and listening events at a range of venues across the city, online through the feedback centre on our website and via social media.

Healthwatch Newcastle and Healthwatch Gateshead, have chosen mental health as one of our priority areas to look at this year. We decided to concentrate on gathering the views and experiences of groups or communities who have not been involved, or have had only limited involvement, in the ongoing review of local mental health services. We have undertaken some of the research ourselves but have also offered local organisations the opportunity to apply for a small grant of up to £1000 to enable them to carry out work on our behalf. This has allowed us to hear the views of groups Healthwatch would otherwise have struggled to engage with within the limited time scale of this project. Healthwatch Newcastle awarded Fulfilling Lives Newcastle and Gateshead (FLNG) a small grant to carry out work on their behalf, FLNG's Experts by Experience explored how people who are homeless or living in insecure housing experience local mental health services.

Introduction

The Fulfilling Lives programme is an 8-year national learning programme funded by the Big Lottery Fund, ending in 2022 with twelve programmes operating across England. The level of funding and longevity of the programme allows us to make a serious impact upon the lives of people with complex needs and improve responses of the services that support them.

In Newcastle and Gateshead, supported by our Core Partnership of Changing Lives (Lead Partner), Mental Health Concern and Oasis Community Housing we work with people who are often excluded from the support they need, and experience a combination of at least three of the following four issues:

- homelessness
- offending
- substance misuse
- mental ill health

FLNG have five strands to our work:

- 1) system change practitioners continue to provide direct client support to people with multiple and complex needs; this will end 31st March 2020 and is led by the Operations Lead

- 2) our co-production workers facilitate and grow a network of Experts by Experience to ensure the voice of people with multiple and complex needs is heard and informs all programme activity
- 3) all members of the team help the Workforce Development Lead to build multiple and complex needs awareness and capacity through learning and co-production
- 4) led by the System Change Lead, supported by all members of the team we will support the system to think differently about multiple and complex needs focusing on mental health, transitions and commissioning
- 5) led by the Research and Evaluation Lead, supported by the team to get our evidence out there!

Rationale

Fulfilling Lives Newcastle and Gateshead's Experts by Experience have been trained to NVQ Level 2 in Peer Research Skills and FLNG host a monthly Peer Research Network for peer researchers to explore issues coming out of their research and explore potential new pieces of work. Healthwatch Newcastle are concentrating on gathering the views and experiences of local people who may not have been involved in or only had limited involvement in Deciding Together, Delivering Together¹, the current review of local mental health services. FLNG's Experts by Experience saw this as a great opportunity for them to carry out funded research into an issue that forms part of our core System Change offer, access to and experiences of mental health services.

October to December 2018 FLNG carried out a piece of co-produced peer research work across three Changing Lives projects, Fulfilling Lives Newcastle Gateshead, Multiple Exclusion Team and SIB entrenched rough sleepers service, reaching out to people who are homeless and living in insecure accommodation. All three programmes of work have strong relationships with people who are homeless/living in insecure accommodation.

At FLNG we want peer research to be genuinely co-produced, we want to see a shift from service user involvement led by professionals to peers defining the remit and research questions. Our cohort often experience power imbalances and voicelessness, peer research can be a powerful tool for empowering and giving a genuine voice. As well as securing responses to the Healthwatch identified questions (Appendix 1) in relation to mental health using a range of research methods our peer researchers wanted to take a creative approach to securing data. We supported them to explore a wide range of methodologies.

Methodology

Peer research

FLNG's peer researchers are trained to co-produce all aspects of research project design, from developing research questions and delivering interviews, focus groups and art sessions, to analysis and write up of findings. Hearing the voice of lived experience at every level of this project secures rich data, delivers ethical research which enables access to the views and experiences of isolated and marginalised communities and ensures that people are not just 'given a voice' through consultation but that their experiences are understood and they receive feedback and are involved in follow up

¹ Deciding Together, Delivering Together is the Clinical Commissioning Group (CCG) led work to redesign all adult inpatient and community mental health services across Gateshead and Newcastle

activity so that the work has the potential to have a positive impact on participants as well as a positive impact on local people's experience of mental health services.

Participants responded positively to the peer researchers, as one participant highlighted:

"It's actually been nice for me to share, I've quite enjoyed it, sometimes it's nice to just sit down and have someone listen, to just release...with someone who has been there"

Methods

Data was collected using 1:1 semi-structured interviews and focus groups. Audio recordings were made with participant's permission, transcribed verbatim and analysed by the peer researchers and the Lead Researcher. Interview and focus group data was thematically analysed to identify patterns of similarity and difference in the data to address the research questions. Scrutiny and analysis of all data took place on a continuous basis, and early findings used iteratively as the research progressed, to inform further data collection and analysis. Discussions with the peer researchers and participants informed analysis of interim findings and their implications for practice.

Study participants were recruited using purposive sampling from a range of settings in Gateshead and Newcastle through the three CL services outlined above: the accommodation sector (supported housing) and in sectors other than housing (FLNG programme, drop-ins, drug and alcohol services). The peer researchers sent out and/or verbally gave information to potential participants to let them know the research is taking place, supported by FLNG, SIB and MET teams to publicise and identify participants. A participant information sheet, and consent form were made available and participants completed a reply slip to indicate their willingness to take part in an interview or focus groups. A total of 23 participants were recruited to the study, 20 participants were people experiencing mental health issues as well as homelessness or vulnerable housing, and three participants were recruited from the frontline workforce to explore trends in our data capture. We spoke to a roughly 50/50 split of male and female participants, 55% of participants had experience of accessing support in Newcastle and 45% in Gateshead. Almost all participants identified as having mental health issues, we note this because two participants reported not having any issues with their mental health, however one spoke about caring for a family member with mental health needs.

Creative data capture

Healthwatch Newcastle were interested in original research projects which secure creative data, especially in relation to asking participants to identify three words which describe a first-class mental health service. Visual tools have proved helpful in developing FLNG's offer, we have been working with Roots and Wings and Northumbria University to produce a print and electronic graphic novella called *#WhatDoYouSee?* This has five short stories touching on MH and rough sleeping issues inspired by the audio recordings of two people who are FL clients. We have used the anthology during the MCN training exercises with positive feedback and used the anthology to encourage participants to say what they see, using arts-based methods to secure visual responses to these questions.

FLNG Experts by Experience developed a scrapbook with decorative cards for participants to record their three words which describe a first-class mental health service. Images from this scrapbook are shared throughout this report.

Findings

- **Access to mental health support**

Perhaps inevitably given that most participants had multiple and complex needs, many of the stories we heard about access to mental health support were clustered around accessing support in a crisis, and around dual diagnosis. There was a sense from people that their situations needed to escalate in order for them to get access to mental health support:

“It was like “just go away”, until something serious happened, how serious did it need to be before anybody would listen? So, you’d go away to do more, to self-destruct, asking for help wasn’t enough, if it’s not that bad you’re not heard. GP, Police, them wanted to help but when it come to the mental health people you went thinking you’d have to cut a bit deeper, take more tablets to get heard.”

Three participants spoke about their escalating chaos as a ‘cry for help’ which saw them come into contact with the criminal justice system:

“It was difficult when I was homeless, I had to go to an extreme which was breaking the law before I got help. I was living homeless under a bridge for about three/four months and it come to one day where, thinking about suicide, I was gonna do it. I went into a shop and I went to rob it, it was a cry for help really and I accessed MH through the crisis team. It took the extreme of doing something silly, and putting other people in danger, to get help.”

“I was told if you have problems ask for help. When I have asked for help I have been refused it, I asked for help the wrong way and I knew if I acted violently they take you to hospital and you get the help, that was the only way I knew I could get help”

One frontline worker told us that *“for many people the route to help is your GP, you and I would go to the GP, our clients, it’s a very different, difficult pathway”* – this was reflected by participants who spoke about feeling “too complex”. This chimes with previous research by FLNG exploring our Operational Group’s experiences supporting people to access secondary mental health services. Generally services highlighted similar themes to those our participants identified, and also highlighted that the voluntary and community sector experience challenges in securing crisis support for clients, though reported positively on the support people received once they were able to access support.

People spoke about feeling stigmatised by services because of their complex needs, four participants described speaking to their GP about their mental health needs and feeling stigmatised by their complexity, *“I think (she) my doctor was a bit distressed, I’d crack up in there”:*

“Accessing community mental health support in Gateshead was the worst experience of my life...GP’s, they told me I’m out of their league”

Comments clustered heavily around dual diagnosis, one frontline worker reflected *“there feels like a disconnect between what is on offer and what people feel able to access in terms of dual diagnosis “we can’t help until you get drug and alcohol treatment”*

People spoke of their frustration at not being able to access support whilst using drugs and alcohol, two peers shared the view that mental health and drug and alcohol treatment should be offered together; *“If you help the mental health the addiction would get better, I think both should be worked*

together” *“Dual diagnosis dual therapy”*. Some people felt they had to lie to get access to support, others feel let down and have not returned to seek mental health support:

“I went to my new GP, asked if I could get help, the problem was I was living at a hostel, went to the appointment and sat for an hour with a social worker, told him about my issues, that I self-harm when I get depressed...the psychiatrist said come back when your treatment’s finished for alcohol use. I felt let down, I haven’t been back to mental health support. He just didn’t seem interested. It did make me relapse, breach me housing conditions...I’ve a bitter taste about mental health services”

“Dual diagnosis massively was a big barrier, the drug use...I told lies at the end to get that help I needed but I hadn’t completely stopped using”

“Anyway, I had a can of drink, mental health worker says “I can’t work with you today, it doesn’t help with your anxiety, the therapy won’t work” – and I’ll be like yes it can, I’m still here and I’m listening”

- **Experiences of mental health treatment**

“Therapy broke me before I could put myself back together”

In the main themes around treatment and effectiveness were clustered around two areas, talking therapies and medication and people told us that their experiences about both came up short. Interestingly four people told us that their experience of talking therapy did not meet their expectations which were high before they accessed this type of treatment because of how it was explained to them, it struck us as significant that two participants used the words ‘magic wand’ here too:

“I got six weeks, maybe eight weeks, I’ve spent a lifetime with this problem, I thought brilliant, someone’s going to sort this out in a matter of weeks!”

And another participant reflected on how she didn’t know what talking therapies was, and commented on the need for aftercare for people with complex trauma:

“I thought I was going to get cured, this person was going to wave a magic wand, talking therapies, you’ve fought that hard to get help and I had no idea what that even was. That I’d have to unpack all that, it was something, hope, knowing that the appointment was coming, but I didn’t realise what they’d drag up. It’s something I’d go back to now I’m on the road to recovery though...6 weeks, an hour and then it’s over, another door closed, 6 to eight hours for a lifetime of trauma and then shut that door, and that’s scary... I ended up coming out and using drugs, you bring stuff up, needed extra support out there after bringing all this stuff up”

Two participants spoke about group therapy settings as being inappropriate for them:

“There was a lot of things, group therapy and that...I don’t like talking in large groups I can’t deal with like loads of people, and it didn’t seem like enough support, like once a week”

Overwhelmingly people told us that they wanted someone to talk to, that sleeping rough and living in insecure accommodation and experiencing mental distress is lonely and they would like to have more people to talk to, and more time with people in support roles, and a free phone number for support:

“There should be a free number so you don’t annoy the 999 people looking, we don’t want to sit in waiting rooms, we want to speak to someone, the right professional - there should be an emergency line for mental health not just the NHS, people on 999 don’t see mental health as an emergency.”

I felt as though I needed someone to be there all the time, I’d spent so much time on my own homeless. I see the CPN once a month, there’s a lot of things I’d want to talk about in between time”

“My phone bills were huge, just calling all of these people for help...my friend in desperation was just phoning around, phoning around”



People’s experiences around medication varied widely, from self-medicating with drugs and alcohol to not being able to access medication they had previously been prescribed, some people had been on a journey to getting the right medication for them and reflected positively on this. Those participants who had not been able to access medication said that they self-medicate while trying to have their prescriptions re-instated. People told us that they did not understand health professionals’ reasons for changing their medication and would like support to understand these reasons, and to follow up:

“I can understand when you’re turning up with alcohol on your breath they say well we can’t help you...I drink because I want my anxiety medication”

“I changed surgeries...when I was up the surgery they took us off me pregabalin completely without reducing it... why’ve they only put us on 25mg which is not helping us and I used to be on 200mg? I’m not happy about that. I was drinking, but pregabalin was working really well and I ended up having a relapse, I’m still waiting from me new doctor for a prescription now...I smoke cannabis to self-medicate, I’m smoking more now that my medication has been removed so I don’t feel as on edge...“There was no conversation about why there wasn’t a reduction and the medication was removed”

FLNG’s Client Journey [Report](#) highlights the prevalence of mental health diagnoses within a rough sleeper insecurely accommodated cohort. Our current data shows that 67% of our active clients have a diagnosed mental health issue; 24% have depression, or anxiety and depression, 19% have a personality disorder diagnosis, 6% psychosis and 5% a schizoaffective disorder or schizophrenia. Interestingly whilst some people noted issues getting access and support, some participants reported having multiple diagnoses, and treatment and support in place, yet they feel they are not getting the right kind of support for them:

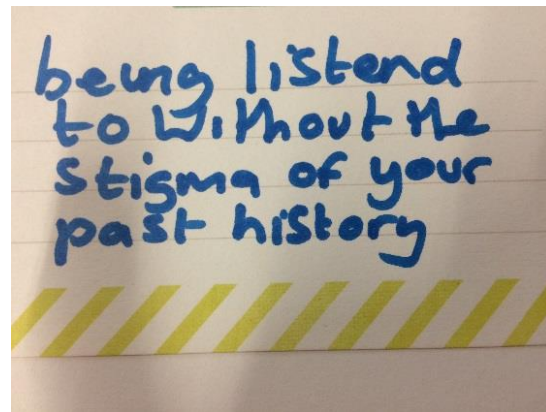
"On paper I have a lot of support, I have two CPNs, a social worker, lots of people but (name of FLNG worker) is the only one that's doing anything for me."

"I've got a personality disorder, I've got bi-polar, I've had a few assessments like, CPNs they seem to come and go, so why am I not getting the help?"

- **Stigma of past history**

We expected people to talk about stigma in relation to their mental health, however we found that people were most vocal about being stigmatised by services because of their drug, alcohol and offending histories:

"I've got a reputation, you know, they see me coming, oh look at him he's got mental health, he's after food, drugs, cigarettes, on the take"



"The crisis team refer back when you've been using drugs and alcohol and assume you're using and there's a stigma...stigmatising people's past, looking back on it I remember the morning clearly I said I'm taking all these pills and the first question was just putting the blame on drink and drugs, there was no drugs or alcohol that day it was just my mood...If they'd give us just five minutes, how are you? how are you today? how can I help? how can I make it better?"

- **Crisis response**

Generally people we spoke to had come into contact with Crisis services at multiple points and with mixed results, at one end of this continuum a participant had made a complaint about this experience as contact with the Crisis team on the telephone had made them feel significantly worse and led to relapse, others had positive experiences, some people reported accessing emergency services and accident and emergency to bypass Crisis services:

"I kept going to hospitals and going help me, help me, help me, begging...give me something to calm me down"

"Living on the streets and going to the hospital, taking just enough tablets to overdose and be kept in because I felt broken, and I'd do that maybe twice, three times a year"

"I can never knock the staff at that hospital, but that first port of call was the crisis team, I won't ring them, I don't think I probably ever will, I'd go straight to A&E"

“I’ve got the crisis team, they’ve been good, Step Up team helped us and referred us to a CPN Nurse and talking therapies, but they said I could be waiting a while”

- **Timeliness, transience and accessing medical appointments**

Lots of comments in our scrapbook featured timeliness of support, *“the waiting times are literally beyond the joke”* and *“waiting, not having no end in sight, is this going to go on forever”*- participants recognised that services want to help them but are stretched *“to the max”* and one participant told us that it was very clear to him that services wanted to help but *“red tape and funding mean they couldn’t.”*

We found a relatively high level of transience in the cohort we interviewed; as well as people with no fixed abode finding it difficult to register with a GP, other participants had moved between Gateshead and Newcastle and two participants felt happier staying with their GP practice and did not have the financial resources to travel to appointments:

“I don’t want to change; the doctors would switch so having to bring it all up again. Sometimes I’d take the tablets cos talking about it all again, like explaining what’s happened to me to get to this is a big trigger”

Five participants commented on their housing needs exacerbating their mental health issues:

“I don’t feel safe where I am now, I want to get me own place, get away from the hostel, cos every day I wake up and I don’t know how I’m gonna get through it, the noise, the people, it’s got me head done in”

- **Despair and desperation**

Sadly, we found a high level of despair and desperation coming through in our interviews, as peer researchers we found this hard to hear but feel compelled to share the details of these interviews to bring across how sorry a picture this paints. From a prevention point of view some of the people we spoke to had multiple diagnoses and their presentation was so pronounced made us feel concerned and there was a general feel of ‘surely they should have some help?’

People told us that they had lost friends to suicide, that they were worried about people close to them, and that they themselves had made attempts to take their own lives:

“I’ve self-harmed to the extreme, twice I’ve ended up in hospital, just desperate man, something has got to change”

“It’s easier for people to run away on the streets, down an alley way and I believe there needs to be, not a cult, but like a massive surge of people going onto the streets to help people. When you’re not well you want to get away from it, you can live in the cold, with the terrors of the streets when people come out the pubs and attack you, eat food out of the bins. If I didn’t drink I’d have been dead a thousand times over because that’s how I coped”

A frontline worker with FLNG told us about a client who uses new psychoactive substances to escape:

“Mark reported that he feels his “life is a mess” he uses NPS to “escape” his problems because it is the “nearest to death I’m gonna get” – when accommodated he feels as though the walls are closing in on him and he feels safer on the streets.”

Some people we spoke to are still in a very despairing situation, voluntary sector staff we spoke to spoke of how anxiety provoking this is for them in their support roles and about how the voluntary sector is filling the gaps in services. Three participants found it very difficult to talk about their experiences accessing mental health support and were focussed on living in the moment, one of these participants describe life as being *“stuck in a loop, I don’t go anywhere...for weeks on end... and them what’s supposed to be helping us...well nowt changes.”*

- **What could have made things easier? What does first class look like?**

Healthwatch Newcastle asked us to explore with people three words, what would a first-class mental health service look like? Participants contributed their words to a scrapbook which has been provided to Healthwatch, below is a table that shows the frequently repeated words throughout the research project.

People shared 79 words about what a first class service would look like. Of these 79 words some participants felt one word was not enough and gave us a short sentence, shown below in table 1. We collected 57 individual words, some were repeated more than once. Whilst collecting these words, showing people the scrapbook and explaining the research project people were agreeing with words that were already in place, saying they would have said listen, trust, or time etc, and so chose different words. The most frequently used words are presented in the chart on p9.

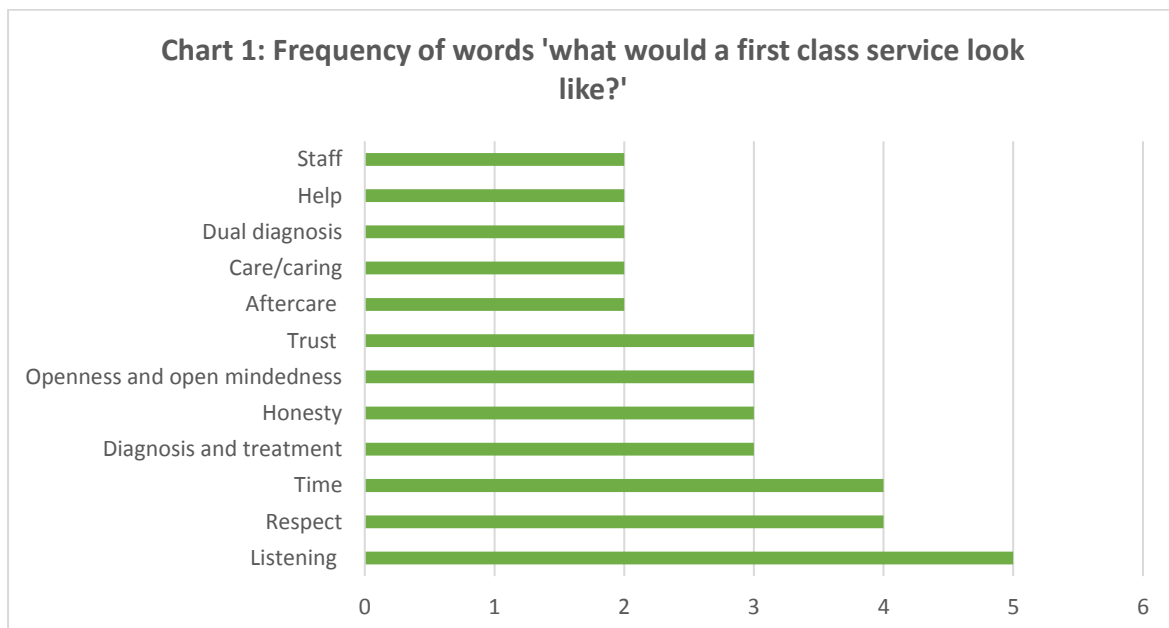


Table 1: what would a first class mental health service look like:

Being given a voice	Light in the dark
Respect (mutual respect)	Listen to ME
Better trained staff	More friendly staff
Don't be scared of peoples knowledge - use it-	More Reliable staff
Dual Diagnosis training	Please Listen Carefully
Choice in female or male workers	People CAN be experts in their own treatment
See passed addiction	Peer support
Something that works	Non Patronising
Case closed	Mental Health Nurse on site
Time framing	Getting into recovery
Fully Resourced	Learning (when you get it wrong)
Enough staff to patient ratio for effective therapy	Being listened to without the stigma of your past history

Generally these words cluster around themes of trust, caring, listening, honesty, openness and respect, we expected that these words would be important given what people told us about stigma, difficulties accessing services and feeling like they were not listened to or decisions were not explained to them.



In addition there was a strong theme around dual diagnosis and seeing passed people’s past histories, addiction and their previous experiences with services, and a strong theme around empowerment and listening ‘learning when you get it wrong’ and using people’s knowledge of their own mental health needs, not being ‘scared of people’s knowledge.’ This really chimes for Experts by Experience too, who want to use their lived experience to influence change within the system.

Concluding comments

Our findings contribute to a growing body of evidence demonstrating that people with experience of homelessness and those living in insecure accommodation face barriers to accessing mental health support, and once people access support this is with mixed results. Supporting this population is having a significant impact on the multiple and complex needs workforce and services report filling gaps to keep people safe. Our findings speak to wider research by FLNG about how statutory services work with both people with multiple and complex needs and the voluntary sector more generally. We found significant concerns across the board about the resilience and suicide risk facing people

experiencing homelessness and those in insecure accommodation which leads us to make a series of recommendations to improve both access to and experiences of people in the mental health service.

Recommendations

Our recommendations cluster around three key areas; treatment and support, workforce development and service thresholds and commissioning:

Treatment and support:

- We recommend people are given support to co-produce their own mental health treatment plans - respondents told us that they did not always understand why decisions were made about their treatment and they said that a first class service would use their knowledge of their own mental health and not be scared of it
- Mental health services should adopt an assertive outreach approach to enable people to access support and treatment in the community in a timely way
- Mental health services should work with housing and drug and alcohol services to help people to have support that wraps around their mental health treatment
- This wrap around support should extend to support after treatment has come to an end, which participants highlighted as particularly important in relation to accessing talking therapies

Workforce development:

- Some participants highlighted that the response they received in crisis fell short of their expectations. We recommend that crisis services attend RESPOND training² which is a multi-agency simulation training package for professionals involved in mental health crisis care which has been co-produced with people with lived experience
- Adopting a Psychologically Informed Environments (PIE) approach within supported accommodation services is shown to have beneficial effects for both staff and clients in working with people experiencing current or previous trauma

Service thresholds and commissioning:

- Commissioners and providers should ensure mental health services are inclusive for people with trauma histories and coexisting mental health and substance use issues. This inclusivity should include timeliness of support, accessible information and information which appropriately prepares people for treatment, and widening of service thresholds to support people with multiple and complex needs.
- As local supported accommodation provision is being reviewed across Newcastle and Gateshead we recommend including the adoption of Psychologically Informed Environments (PIE)³ within supported accommodation service specifications.

²See <http://uecnetwork.co.uk/our-work/respond/>

³ A Psychologically Informed Environment (PIE) "is one that takes into account the psychological makeup – the thinking, emotions, personalities and past experience - of its participants in the way that it operates." (Robin Johnson, www.pielink.net)

Finally we identify **three areas for further exploration** and discussion locally:

- People told us that continuity around their GP is important to them, we recommend further exploration around how this could be maintained, for example telephone appointments, access to repeat prescriptions to help address limited travel resources, particularly for at times when people are transitioning between local areas
- There was a strong theme around needing someone to talk to, and for that someone not to be a clinician but someone who has the time and remit to talk
- We identified a gap in relation to people who are rough sleeping, it was not clear to people we spoke to what support they can access when rough sleeping, and so we highlight this as a gap for further exploration to develop this pathway

Acknowledgements

We would like to thank everyone who participated in this research and shared their experiences with us. We would like to thank Healthwatch Newcastle for funding this piece of work and Lyndsay Yarde from Healthwatch Newcastle for her support and encouragement of our Experts by Experience. We are grateful to Oasis Community Housing, in particular staff at the Basis drop in, Changing Lives staff at the City Road drop in, SIB and MET teams for their support in accessing participants and venues to carry out peer research. We also thank Sheila Blatchford for administrative support in addition to co-authoring this report and FLNG colleagues including Lou Thorpe Co-Production Worker for their support of the Expert by Experience peer researchers.

Appendix 1: Mental Health Questions and Prompts:

1. What are your experiences of trying to get help with your mental health?

Maybe think about:

- Barriers to making the initial approach (cultural, family issues, not knowing where to go/who to speak to, practical issues)
- Difficulties in getting a GP appointment
- Difficulties in getting to see your preferred GP
- Attitude of GP or other practice staff
- Communication issues – language/cultural barriers/shyness/not being listened to
- Waiting times

2. If you managed to get help, what sort of help did you get and how effective was that help?

Examples might be:

- Medication, talking therapies, peer support & group support, alternative therapies, creative therapies?

Also consider:

- What worked and what didn't work and why?
- How are you now?

3. What could have made things better or easier for you?

Maybe think about:

- Accessibility & attitudes
- Treatment
- Waiting times
- Location/venue of treatment

4. Choose three words that describe what a first-class mental health service would look like to you?

Pick the three words that describe what is most important to you

Appendix 2: Peer researcher reflection

From delivering the presentation with Ang Broadbridge and giving my honest opinion about peer research, what it is, how it works and how it can help; to getting the funding to complete the research I have felt compelled to give this my best. As I mentioned at the presentation peer research is a very important tool for gaining knowledge, sometimes people do not feel comfortable talking to professionals, or they will give answers that they expect the professionals are looking for. Peer Research is people from the same background who have suffered the same issues going out and having a conversation to get information to try and instigate change and raise awareness.

During this project I have found it very emotional talking to people and hearing their stories; how they were 'normal' before a crisis, they had lives, jobs, families and friends. But due to a breakdown, or addiction or other issue they have been left out in the cold quite literally, with nowhere to turn, and unable to find help in many cases.

When coming together to write up the project, we were torn between using some quite hard-hitting quotes, or putting the 'nicer ones' in. In order to remain true to the project we decided that we had to keep the report real and these quotes are just that. Real people's experiences; voices, waiting to be heard

Sheila Blatchford, co-author