Homelessness and Health:

The modern management of deep vein thrombosis among IV drug users

“But you must defend those who are helpless and have no hope. Be fair and give justice to the poor and homeless.”

Proverbs 31 : 8-9 (The Bible)[1]

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Abstract

Background: Homelessness represents an increased risk to health. The homeless have very different life and health outcomes compared with the rest of the population, and multiple morbidity is common. Homeless people often have the greatest health needs, yet access to health services is difficult.

Aims: To appreciate the difficulties faced by homeless people in accessing healthcare services. To understand the main clinical problems of the homeless, in particular drug and alcohol abuse. DVT is a major complication of IV drug use. To compare the management of DVT among IVDUs with that of non-IVDUs. To learn about the aetiology and modern management of DVT, and to identify whether DVT care pathways meet the needs of the homeless and IVDUs.

Method: Information was gathered from various sources. A literature search was conducted using the Ahmed, BNI, Embase, HMIC, Medline, PsycINFO and Health Business Elite databases. The following search terms were used: "Homelessness", "Homeless", "Deep vein thrombosis", "DVT", "venous thrombosis", "IV drugs users", "drugs misuse" and "drug addicts."

Results: The literature search found 9 relevant articles. One article was selected for critical appraisal. The article was based on a retrospective study of 109 patients presenting with DVT in a general hospital. The study sought to identify differences in the management of DVT in IVDU patients and non-IVDUs. Several key findings were made. A greater proportion of IVDUs were admitted for inpatient care, their hospital stay was longer, and their treatment differed to that of non-IVDUs.

Conclusion: There has been little research on the investigation and management of DVT among IVDUs. This group are at increased risk of developing DVT, and should be investigated as high-risk patients.

Contents

Learning Objectives

- To understand the causes and consequences of homelessness, and to appreciate the main clinical problems of the homeless, especially with regard to substance misuse.
- To learn about the aetiology and modern management of deep vein thrombosis (DVT), with particular reference to IV drug users.
- To compare and contrast the management of DVTs among IV drug users and non-IVDUs, and to explore the best ways to provide NHS and other services.
- To reflect upon the extent to which care pathways for DVT meet the needs of the homeless and IV drug users, in the light of the particular problems faced by this client group in accessing healthcare services.

Core learning activities

- Service learning visits
- Case histories
- Journal club presentation

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Introduction

Homeless people have very different life and health chances compared to the rest of the population. They are a hidden group, as they are likely to be omitted when official statistics are collected. Anyone can become homeless.

The term homelessness is used to describe people who are 'roofless' and living on the streets and those living in temporary accommodation, such as homeless hostels. The 'hidden homeless' are a group not deemed by councils to be in priority need, yet having no accommodation of their own to occupy. The main illnesses associated with homelessness include skin infections, respiratory infections, alcohol and drug abuse, and mental illness.

- There were 74,690 households in England in temporary accommodation (up to June 2008). 483 people sleep rough on any one night in England (June 2008).[2]
- A study by *Crisis* found that life expectancy for rough sleepers was 42 years, compared with the national average of 74 years for men and 79 years for women.[3]
- A number of different personal and social factors can contribute towards people becoming homeless. The homeless charity, *Shelter,* found that the most common reasons for being homeless were relationship breakdown, including domestic violence (41 %), drug and alcohol problems (31 % and 28 % respectively), and mental health problems (19 %).[4]

This study will look at various aspects of the health of the homeless, and will concentrate on the specific health issues surrounding the diagnosis and management of deep vein thrombosis (DVT), a significant medical complication for those homeless people who inject drugs.

The GMC duties of a doctor (see Appendix 1) emphasise the importance of fairness and justice in dealing with patients, whoever they may be. In medical practice, this means never discriminating unfairly against patients.

Beauchamp and Childress set out four principles of medical ethics, namely:

- Patient autonomy
- Beneficence (the principle of promoting good)
- Non-maleficence (the principle of avoiding harm)
- Justice

The principle of justice within the medical context refers to the allocation or distribution of resources amongst the population. Homeless people often have the greatest health needs, yet access to health services is difficult.

Key statistics for Liverpool

In 2004-2005, Liverpool had a total population of 912 homeless people in priority need.[5] There were 43 people sleeping rough in Liverpool, as of April 2001.[6] There are no comprehensive national statistics for homelessness among asylum seekers. In March 2009, Liverpool had a total of 35 asylum seekers in receipt of subsistence-only support.[7]

Media portrayal of the homeless and substance misuse

The media play an important role in setting the news agenda and influencing public opinion. The BBC has a reputation for impartial news reporting. A search of the BBC News website found a range of stories from the past year, casting the homeless and substance abusers in both a positive and a negative light. One "good news" story that received coverage was a scheme in Scotland whereby homeless people and former drug addicts have been offered training in order to help fill job vacancies in the social care sector.[8]

The Daily Mail, a leading mass-market tabloid, makes no pretence to impartiality in its reporting. A search of *The Daily Mail* website found many new stories relating to the homeless and substance abusers. Very few of these could be interpreted as being positive. *The Daily Mail* displayed bias towards substance abusers in a story which appeared under the headline "350,000 heroin and crack addicts claim a staggering £1.6bn in benefits."[9] Having stated that addicts are "raking it in" up to £1.6billion a year in benefits, only by reading the article further does it become clear that these are not official figures, and that the £1.6billion figure would only be true if every addict was entitled to the maximum rate of Incapacity Benefit.

The UK asylum process

In 2008, a total of 25,670 people sought asylum in the UK[10]. 70 % of all initial asylum decisions made in 2008 were refusals[10]. Asylum seekers are not allowed to work to support themselves or their families, and have "no recourse to public funds." Instead, they have to rely on benefits which are significantly lower than basic income support. Large numbers of failed asylum seekers are left homeless. An estimated 450,000 failed asylum seekers in Britain are currently denied free treatment on the NHS.[11] A total of 11,640 asylum seekers and their dependents were removed from the UK during 2008[10].

Case history

I met Mr D over breakfast at the Liverpool City Mission Cafe in Liverpool city centre. Mr D, who is aged 25, sells *The Big Issue.* He is currently staying in a hostel for the homeless. He attends the Mission Cafe every week day (Monday-Friday), where he is given a free breakfast, and has the opportunity to meet with those in a similar predicament. His right leg is heavily bandaged, and he walks with the aid of crutches. Mr D has a history of deep vein thrombosis (DVT) through injected drug use. He first started injecting drugs when aged 16. The veins in his arms eventually collapsed, and he then began to inject into the vein in his right groin. Mr D first developed a DVT six months ago. Initially, Mr D thought his leg would be all right, and he carried on injecting into his groin. But every time he did so, the clot in his leg got worse, and he eventually presented himself to hospital. His leg was scanned, and he was told it was the worst case that they had seen in a long time. Mr D now smokes crack cocaine instead of injecting it. He has also sought to cut down on his drug use over recent months. Whereas previously his drug habit cost him between £60 and £70 a day, it now costs him around £25 a day, funded in part through sales of *The Big Issue.*

A second episode of DVT occurred six weeks ago. Mr D experienced severe pain in his right groin area, and a constant ache behind his right knee. He was unable to walk or weight bear, and was taking painkillers for several days. A member of staff at the hostel where Mr D is staying called an ambulance, and he was taken to A&E at the Royal Liverpool Hospital, where his leg was assessed and scanned. He was prescribed a low molecular weight heparin (Fragmin) for six months. Then four weeks ago Mr D also developed three ulcers on his right lower leg. His leg became inflamed, and Mr D applied dry dressings himself, which he bought from over the counter. Mr D only sought medical attention after two weeks. His GP at the Brownlow Hill group practice in Liverpool dressed his leg once, and then referred him to a leg ulcer nurse at a different GP practice in the city. Mr D waited a week for his initial appointment to see the nurse. A compression bandage was applied to the leg. The leg ulcers will be continually assessed daily.

At 8 am my interview with Mr D is over, and he excuses himself as another day selling *The Big Issue* on the streets of the city centre beckons.

Key health problems of British born homeless: an overview

Common health problems among the homeless include:

- drug and alcohol addiction
- mental health issues (depression, PTSD, personality disorder, psychosis)
- respiratory conditions
- skin complaints
- musculoskeletal problems
- foot problems
- sleep disorders

Problems associated with poverty, such as poor diet and inadequate heating, also increase risks to health.

Homelessness can exacerbate already poor health, which can be compounded by poor access to medical care. Homeless people are less likely to be registered with a GP, which in turn means that they are less likely to receive health promotion advice and health prevention services such as screening and immunisation. Many homeless people resort to the use of hospital A&E departments, with no proper follow-up care. GPs have been reluctant to provide care to the homeless because of fears that they might be abusive and disruptive.[12] Homeless people in turn have been reluctant to access GP services because of the perceived judgemental attitude of GPs and reception staff.

The most common health needs of homeless people relate to drug misuse, alcohol abuse or mental illness. Dual diagnosis is frequent, and multiple drug use, especially heroin and cocaine, is common.[13]

Different models for the management of homeless people exist in primary care. These include the 'general practice with a special interest', whereby a mainstream general practice takes on an extended role in providing primary care for the homeless. A 'specialised' general practice only registers homeless people. They tend to be concentrated in the main urban centres.

Halton and St. Helens primary care trust in Merseyside established their own Health for Homeless team four years ago, so as to enable better access for homeless people to mainstream health services. Various schemes have proved successful, including special drop-in clinics where homeless people can get primary care attention without an appointment.

Homelessness and substance misuse

The extent of drug abuse among the homeless population is unclear, partly because of the difficulty in gathering reliable statistics. It is estimated that 60 out of every 500 heroin users are homeless. Homeless drug users are more likely to inject rather than smoke heroin.[14] Therefore their health is at risk from multiple direct complications of injection such as death; overdose; cardiac arrhythmias; endocarditis; pulmonary inflammation and oedema ('crack lung'); DVT/pulmonary embolism; abscesses and cellulitis; drug-induced psychosis; and blood-borne viruses (hepatitis B and C, and HIV).

It is estimated that 70 % of IVDUs in Chester are hepatitis C positive. Most of these do not seek treatment.[15] The main reason for the high levels of hepatitis C in IVDUs is the sharing of injecting equipment such as spoons and filters.

DVT in IVDUs is usually due to a combination of poor hygiene and repeated skin puncture. Abscesses occur as a consequence of IVDUs missing the vein when injecting.

The main aim of clinical management in primary care is to reduce risky drug-taking behaviour such as injecting, and to encourage engagement with the local drugs service. Drug services offer effective interventions based on the prescription of substitute opiate drugs, such as methadone; hepatitis A, B and tetanus immunisation; safe injecting advice, and access to needle exchange schemes to reduce the prevalence of blood-borne viruses.

Housing is a particular problem among homeless drug users. Many hostels are reluctant to accept homeless people with drug or alcohol problems. Basic stability, such as having a bed of one's own, is needed in order to get people off drugs.

Method of search

Information was gathered from various sources. In order to obtain relevant articles, the literature was reviewed by searching the Ahmed, BNI, Embase, HMIC, Medline, PsycINFO and Health Business Elite databases. The following key terms were used in various combinations: "Homelessness", "Homeless", "Deep vein thrombosis", "DVT", "venous thrombosis", "IV drugs users", "drugs misuse" and "drug addicts." I also undertook a search of the internet using key words. Two articles were found. One article was found via a link on the GP notebook website. Another was found through searching the BMJ website.

The University of Liverpool catalogue was searched, and a total of four relevant books found. One book was obtained from the FADE library.

A search was made of the official websites of leading UK homeless charities, such as *Shelter, Crisis*, etc., as well as the Office of National Statistics, in order to obtain up-to-date and accurate information.

Results of literature review

A summary of the results of the literature search is contained in the following tables:

Medline Search Results:

Search term	**results**
1. Homeless persons	3911
2. Homelessness OR homeless	4954
3. 1 OR 2	5809
4. Venous thrombosis	27996
5. Deep vein thrombosis OR DVT OR venous thrombosis	22995
6. 4 OR 5	39268
7. 3 AND 6	0

Search Results for all databases (Amed, BNI, Embase, Medline, CINAHL, etc.)

Search term	**results**
1. Homeless persons	6974
2. Homelessness OR homeless	21115
3. 8 OR 9	22387
4. Venous thrombosis	50558
5. Deep vein thrombosis OR DVT OR venous thrombosis	46082
6. 4 OR 5	72771
7. 3 AND 6	1
8. IV drugs users OR drugs misuse OR drug addicts	6766
9. 5 AND 8	14

A total of nine articles were found as a result of the literature search. The abstracts of each article were read to determine which one would be most relevant for the purposes of this study. The article I deemed most relevant and selected to critically appraise was "**Deep vein thrombosis among injecting drug users in Sheffield.**"[16]

Critical appraisal of journal article

The authors of the article set out to identify what proportion of DVT patients in a general hospital in Sheffield were also injecting drug users (IVDUs). They aimed to establish whether there were any differences in the investigation and management of IVDUs compared with non-IVDUs. They also sought to determine whether IVDUs

are managed as inpatients more or less often than non-IVDUs. The decision whether to investigate patients symptomatic of DVT is often reliant on the use of a diagnostic scoring system, such as that devised by Wells (see table).

IV drug use does not feature as a risk factor for DVT on the Wells model

Wells pretest clinical probability scoring for DVT[17]

In patients with symptoms in both legs, the more symptomatic leg is used.

Clinical feature	**Score**
Active cancer (treatment within last 6 months or palliative)	1 point
Paralysis, paresis, or recent plaster immobilisation of leg	1 point
Major surgery or recently bedridden for > 3 days in last 4 weeks	1 point
Local tenderness along distribution of deep venous system	1 point
Entire leg swollen	1 point
Calf swelling > 3 cm compared to asymptomatic leg (measured 10 cm below tibial tuberosity)	1 point
Pitting oedema (greater in the symptomatic leg)	1 point
Collateral superficial veins (non-varicose)	1 point
Alternative diagnosis as likely or more likely than that of DVT	-2 points

3 or more points: high probability; **1-2 points:** intermediate probability;

0 or less points: low pretest probability of DVT.

Source data for 109 patients with DVT was obtained retrospectively from patient records. The study found that all the patients known to be IVDUs tested positive for DVT on Doppler ultrasound. A higher proportion of IVDUs were admitted for inpatient investigation and treatment (45% of IVDUs testing positive for DVT were admitted, compared to 25% of non-IVDUs). IVDUs also had a longer inpatient stay (6 days on average, compared to an average inpatient stay of 4 days in non-IVDUs). The study also found that with only one exception, all non-IVDUs DVT patients were treated with low molecular weight heparin (LMWH) followed by warfarin. 60% of IVDUs with DVTs were treated with LMWH only.

The authors found that limited evidence exists as to the optimum treatment for an IVDU with DVT; the current situation being a suggestion to follow local guidelines. The article's key conclusion was that IVDUs are at increased risk of developing

DVT, and that IVDUs presenting to A&E with symptoms suggestive of DVT should be investigated as high-risk patients.

The article has several strengths:

- It is recent (2006), reliable and readable. The article was published in a reputable journal (a subsidiary of the BMJ). It is concise, clear and easy to understand.
- It is a useful and relevant study. There was a need for the study. Little has been written about the investigation and management of DVTs among IVDUs.
- The aims of the study were clearly stated, and the results of the study answer the original study aims.

The article also had several limitations:

- The study sample size was small (109 patients), and the duration of the period of study was relatively short (16 months). A larger study, continued for longer, with follow up, would have made the results more credible.
- The study was a retrospective study, which meant that it was unable to assess and compare the incidence of complications or morbidity from DVT among IVDUs and non-IVDUs. Also, the data from inpatient records was incomplete in some instances.
- Little statistical analysis was done on the source data.

The study identifies the need for future research. A future study of the investigation and management of DVT in IVDUs and non-IVDUs should be able to monitor or identify the incidence of complications or the recurrence of DVT in both groups.

Discussion

The aetiology and modern management of DVT

Thrombosis or clotting of the blood is a pathological event caused by the interaction of several clotting proteins in the blood. A thrombus is formed, which may then completely occlude a vessel. A potentially fatal complication of DVT is embolism to the pulmonary arteries, causing a pulmonary embolism (PE).

DVT may be suspected with slow onset deep-seated unilateral leg pain, associated with swelling, tenderness, skin warmth, and low-grade pyrexia. However the classical features of DVT are noted in only half of cases, and life-threatening DVT may be asymptomatic.

Diagnosis is by history, physical examination, and duplex ultrasonography, with D-dimer testing. All patients with raised D-dimers should undergo definitive

investigations. DVT is confirmed either by poor flow on Doppler ultrasound scan, or by a blockage seen on venography.

The main aim of therapy is to prevent PE. Anticoagulation therapy is with anticoagulant drugs (drugs that inhibit clotting).

- Anticoagulation therapy can consist of IV unfractionated heparin, which requires regular blood monitoring, and should only be used if LMWH is unavailable.

- LMWH given subcutaneously is commonly used for the initial treatment of DVT. They have a longer duration of action, do not require monitoring, and there is less risk of bleeding. Once-daily administration of LMWH allows out-patient treatment of DVT.

- Warfarin is used for long-term anticoagulation. It is started immediately and heparin is stopped when the INR is in the target range (usually 2.5). This requires INR monitoring with regular anticoagulant clinic appointments. Warfarin has many serious drug interactions, and care is needed when other drugs are co-prescribed.

More than 20% of DVTs recur within 5 years, and the risk is higher if there are underlying risk factors.[18] DVT is a common cause of chronic venous insufficiency and postthrombotic syndrome, which, in turn, is the most common cause of leg ulceration.

The aetiology and incidence of DVT among IVDUs

The femoral vein is frequently used to gain vascular access by IVDUs. There is a tendency among IVDUs not to access health services when they have a DVT, in part because they are unaware that DVTs and accompanying ulcers are life-threatening.

Little has been written about the aetiology of DVTs among IVDUs. One study found that the overall effects of intra-arterial injection are "most likely a result of particulate emboli, vasospasm in distal vessels, and endothelial injury resulting in venous thrombosis."[19]

I was unable to find any data relating to the incidence of DVT among IVDUs; although one study found that IVDUs accounted for 10.7% of all community acquired DVTs.[20]

The management of DVT among IVDUs and non-IVDUs

IVDUs are a group in whom both diagnosis and immediate and long-term clinical management of DVT are difficult and poorly defined. There is no NICE guidance, although national guidance suggests that treatment with LMWH is an alternative to oral anticoagulation in patients with venous thromboembolism secondary to IV drug use.[21]

- Trust guidelines for the diagnosis and management of DVT at Whiston Hospital, St Helens and Knowsley NHS Trust, include use of the Wells score; a flow chart for managing a patient presenting to A&E with a suspected DVT; LMWH (enoxaparin) doses according to patient body weight; outpatient treatment protocol, and contact numbers for anticoagulation nurses and for booking a Doppler or venogram. The Whiston management guidelines for suspected DVT differ for IVDUs in that they state a Doppler scan should be booked for an IVDU, and that they should be admitted for treatment if this proves positive. IVDUs are also excluded from the ambulatory or outpatient management of DVT at Whiston.

- The Countess of Chester Hospital NHS Foundation Trust also makes use of the Wells score in assessing cases of suspected DVT. However, despite having suspected DVT referral pathways for outpatients, out-of-hours and obstetric patients, there is no separate protocol for the treatment of suspected DVT in IVDUs.

- The Royal United Hospital Bath NHS Trust's guidelines for patients presenting with a suspected DVT treat IVDUs as high-risk patients. This precludes IVDUs from the need to have an initial structured clinical risk assessment, involving a Wells score and D-dimer testing.

The clinical diagnosis of DVT is generally thought to be unreliable. The choice of investigation performed to evaluate the patient with suspected DVT remains dependent on local practice. At Whiston Hospital, a Duplex Doppler scan is done.

It is difficult for radiologists to tell the difference between old and new DVTs. Therefore new DVTs are difficult to diagnose. Evaluation of DVT among IVDUs is further complicated by soft-tissue pathology and venous access difficulties, which hinder diagnostic ultrasound and venography.[20]

Diagnosis of DVT is solely clinical. In primary care, this means that the decision whether to give LMWH to patients rests with the GP.

How do DVT care pathways fit in with homeless clients and IVDUs?

Management of DVT in IVDUs is problematic because of poor venous access, non-compliance with prescribed treatment, on-going IV drug use and co-existent sepsis. A further complication is that anticoagulation with warfarin is not felt to be safe in the majority of these patients.

The difficulty in managing DVT among IVDUs in the community is one of compliance. They find it difficult to keep to strict times for appointments for injections of LMWH.

The difficulty of managing DVT among IVDUs in hospital is that they often refuse to stay in hospital. One nurse told us that if IVDUs were persuaded that they would receive the same treatment as everybody else in hospital, then compliance would increase. Also, maintaining an IVDU's prescribed dose of methadone whilst in hospital is critical. If for whatever reason a dose is missed, then the patient will discharge himself.

Conclusions

- Homelessness has a direct impact on health and can affect anyone. The provision of affordable, adequate housing is an important aspect of a policy for health. There is a need for accessible, appropriate and good quality primary healthcare services for homeless people.

- Inter-agency cooperation is essential between healthcare professionals and those agencies working with the homeless in order to identify those schemes which work best in terms of access to housing and health services.

- There are no instant solutions to the problems of homelessness and substance misuse. Homeless drug users may require long-term contact with drug and health services. This in turn requires patience and a long-term commitment on the part of healthcare professionals to meet the needs of their clients.

- IV drug use is a common risk factor for DVT, which is not widely recognised in medical literature reviews.

Recommendations

For the UK:

- Health professionals should consider the extent to which their patients' illness is the result of their housing conditions, in order to ensure that poor living conditions do not exacerbate illness or hinder their recovery.
- Properly resourced specialist primary and mental care services for homeless people are required, so that help can be offered early and in order to guide patients into mainstream healthcare.
- IV drug use should be included in lists of the usual causes of DVT. Prospective studies on the more accurate diagnosis and optimal treatment of DVT are needed.

For Liverpool:

- GPs should be provided with the training, knowledge and resources to enable them to deal effectively with homeless people's health needs.
- DVT investigation and management pathways should be streamlined in order to take account of IVDUs, who should be managed as high-risk patients.
- More services should be provided for homeless people who are drug users, so that their drug use does not remain hidden, and that interventions such as harm reduction initiatives can be implemented.

Reflection

Homelessness is a hidden problem. I had not given the subject much thought prior to this SSM. Everyone has a stereotypical picture of a homeless person in their mind's eye. The homeless people that I spoke to were just ordinary people. They were clean, tidy, and easy to talk to.

I have learnt that many homeless people have low self-esteem, and feel judged by healthcare professionals and society. One homeless woman told us that she took drugs because she hated herself. She asked us never to look down on anyone and to be compassionate as doctors.

I have learnt that the churches and the voluntary sector play an important and invaluable role in providing services to homeless people. Besides accommodation, food, heat and clothing, they provide companionship, social and spiritual support.

I have discovered that little research has been done on the subject of the investigation and management of DVT in IVDUs, because IVDUs have been excluded from most prospective studies due to their chaotic lifestyle and the difficulty of follow-up.[20] This meant that it proved very difficult to fulfil the original terms of reference for this study.

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Appendix 1

Good Medical Practice (2006) [22]

The duties of a doctor registered with the General Medical Council

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- Make the care of your patient your first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
    - Keep your professional knowledge and skills up to date
    - Recognise and work within the limits of your competence
    - Work with colleagues in the ways that best serve patients' interests
- Treat patients as individuals and respect their dignity
    - Treat patients politely and considerately
    - Respect patients' right to confidentiality
- Work in partnership with patients
    - Listen to patients and respond to their concerns and preferences
    - Give patients the information they want or need in a way they can understand
    - Respect patients' right to reach decisions with you about their treatment and care
    - Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
    - Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
    - Never discriminate unfairly against patients or colleagues
    - Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Appendix 2

Timetable of study

Week 1: Week commencing 31st August 2009

Monday 31st	Tuesday 1st	Wednesday 2nd	Thursday 3rd	Friday 4th
Bank holiday	Introductory meeting with Dr. O'Neill, Chester	Visit to 103 Day Centre, St Helens Visit to Cornerstone Surgery, St Helens with Dr. Sutton	Visit to the Lighthouse Project, Bootle Clinic with Dr. O'Neill	Visit to Charles Thompson Mission, Birkenhead Visit to Ark Project, Birkenhead Visit to The Basement Evening Drop-In, Liverpool

Week 2: Week commencing 7th September 2009

Monday 7th	Tuesday 8th	Wednesday 9th	Thursday 10th	Friday 11th
Prepared power point slides for Journal club article presentation	Journal club article presentation with Dr. O'Neill, Chester	Visit to Aqua House, Chester Visit to Chester Aid to the Homeless, Harold Tomlins Day Centre, Roodee House	Visit to Liverpool City Mission Breakfast Club Self study	Self study SSM write up

Week 3: Week commencing 14th September 2009

Monday 14th	Tuesday 15th	Wednesday 16th	Thursday 17th	Friday 18th
Self study SSM write up	Self study SSM write up	Journal club article presentation with Dr. Sutton, St Helens Self study SSM write up	Self study SSM write up	Self study SSM write up

Week 4: Week commencing 21st September 2009

Monday 21st	Tuesday 22nd	Wednesday 23rd	Thursday 24th	Friday 25th
Self study SSM write up	Self study SSM write up	SSM write up	SSM write up	Submission of SSM

Appendix 3: Definitions

Health: the constitution of the World Health Organization states that: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[23]

Human Rights: "Human Rights are universal legal guarantees protecting individuals and groups against actions which interfere with fundamental freedoms and human dignity."[24]

Inverse Care Law: Introduced by Tudor Hart (1971), this states that "the availability of good medical care tends to vary inversely with the need for it in the population served."[25] More and better health care therefore tends to be provided for more affluent populations who need it least. Whereas people living in poorer areas are further deprived by lower standards of healthcare.

Health Inequalities: Health inequalities are where people living in different socio-economic environments face very different risks of ill health and death. In general, those people at the bottom of the social scale have much poorer health from birth to old age than those at the top.[26]

Poverty: Poverty is hunger. Poverty is lack of shelter. Poverty is being sick and not being able to see a doctor. Poverty is not having access to school and not knowing how to read. Poverty is not having a job, is fear for the future, living one day at a time. Poverty is powerlessness, lack of representation and freedom.[27]

Homelessness: Homelessness is the problem faced by people who lack a secure place that they are entitled to live in. It is about more than rooflessness. A home is not just a physical space: it provides roots, identity, security, a sense of belonging and a place of emotional wellbeing. Homelessness is about the loss of these.[28]

Rough Sleeper: Sometimes used interchangeably with "rooflessness" or "street homelessness", rough sleepers refers to anybody with literally nowhere to stay and who is sleeping on the streets or elsewhere outside.[29]

Substance Misuse: the nonclinical or recreational use of pharmacologically active substances such that continued use results in adverse physiological or psychological effects. Substances commonly abused include alcohol, amphetamines, cannabis, cocaine, Ecstasy, heroin, LSD, and organic solvents.[30]

Harm Reduction: Harm reduction is a term that defines policies, programmes and services that work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs.[31]

Asylum seeker: An asylum-seeker is someone of any age who has fled their home country to find a safe place elsewhere. Under the 1951 Convention on Refugees, an asylum applicant must be able to demonstrate a well-founded fear of persecution in their country of origin for reasons of political opinion, religion, ethnicity, race/nationality, or membership of a particular social group.[32]

Sanctuary: Sanctuary means providing a safe place for people who need it, or providing a safe haven to those people fleeing from persecution.[33]

PTSD: post-traumatic stress disorder is an anxiety disorder caused by the major personal stress of a serious or frightening event, such as an injury, assault, rape, or exposure to warfare. The sufferer experiences the persistent recurrence of images or memories of the event, together with nightmares, insomnia, a sense of isolation, guilt, irritability, and loss of concentration. The condition usually settles with time, but support and skilled counselling may be needed.[34]

Depression: A mental state characterised by excessive sadness. Activity can be agitated and restless or slow and retarded. Behaviour is governed by pessimistic or despairing beliefs, and sleep, appetite, and concentration are disturbed. Treatment is with antidepressant drugs, cognitive therapy, and/or psychotherapy.[35]

Drug Related Death: The definition widely adopted across the UK is "deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances controlled under the Misuse of Drugs Act (1971) are involved."[36]

Suicide: The act of intentionally killing oneself. Suicide results from a person's reaction to a perceived overwhelming problem, such as social isolation or financial problems. It is often the result of a psychiatric illness, such as severe depression or schizophrenia.[37]

Domestic violence: The government defines domestic violence as "any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality."[38]

Street worker: A person of either sex who prostitutes themselves for financial gain. The term 'common prostitute' has recently been removed from the 1959 Street Offences Act. High levels of drug dependence have been found among street workers, but not among indoor sex workers.[39]

Appendix 4: Resource list

Key Contacts:

1. **Dr Jean Sutton,** General Practitioner.
   Fingerpost Park Health Centre, Atlas Street, ST. HELENS. WA9 1LN
   Tel: 01744 738 835
   Email: cornerstone.surgery@hsthpct.nhs.uk

2. **Dr Joseph O'Neill,** General Practitioner.
   Global Inclusion, C18 Stanlaw Abbey Business Centre,
   ELLESMERE PORT. CH65 9BF
   Tel: 0151 355 4008
   Email: global.inclusion@yahoo.co.uk

3. **Julia Cottier,** Clinical Services Manager, Chester and Ellesmere Port Drug Service. Aqua House, 51 Boughton, CHESTER. CH3 5AE
   Tel: 01244 344 999
   Email: Julia.cottier@cwp.nhs.uk

4. **Robert Bisset,** Chief Executive, Chester Aid to the Homeless.
   CATH, Watergate House, 85 Watergate Street, CHESTER. CH1 2LF
   Tel: 01244 314 834
   Email: robert.bisset@cath.org.uk

5. **Kieran Lamb,** Head of Library Services.
   Fade Library, Regatta Place, Brunswick Business Park, Summers Road, LIVERPOOL. L3 4BL
   Tel: 0151 285 4495
   Email: library.services@fade.nhs.uk

6. **Carol Hamlett,** Manager, The Basement.
   The Basement Evening Drop-In, 8 Copperas Hill, LIVERPOOL.
   Tel: 0151 707 1515
   Email: donna@basementdropin.org.uk

7. **Jean Lucas,** Finance and Administration Manager.
   103 Homeless Centre, 103 Church Street, ST. HELENS. WA10 1AJ
   Tel: 01744 20032
   Email: jean@hotmail.org.uk

8. **Steve Cossack,** Manager, City Centre Early Morning Cafe.
   The Mission Cafe, 20 Mount Pleasant, LIVERPOOL. L3 5RY
   Tel: 0151 702 5381. Email: admin@livercm.org.uk

9. **Pastor Rob Jeffs,** Superintendent, Charles Thompson's Mission.
   Charles Thompson's Mission, 2 Hemingford Street, BIRKENHEAD. CH41 4AP
   Tel: 0151 647 7303. Email: admin@livercm.org.uk

10. **Kevin Hogan,** Hostel Manager.
    Wirral Churches' Ark Project, Mary Cole House, 6 Sandford Street, BIRKENHEAD. CH41 1BN
    Tel: 0151 649 0111
    Email: kevinhogan@wirralark.org.uk

Useful Websites:

www.shelter.org.uk

Shelter

www.crisis.org.uk

Crisis

www.homelesspages.org.uk

Homeless Pages

www.statistics.gov.uk

Office for National Statistics

www.gpnotebook.co.uk

General Practice Notebook

www.fade.nhs.uk

Fade Library

www.library.nhs.uk

Health Information Resources

www.livercm.org.uk

Liverpool City Mission

www.gmc-uk.org

General Medical Council

www.who.int

World Health Organization