ABSTRACT

Background

Any person, at any one point of time, is only ever a few steps away from being homeless. Women are very vulnerable on the streets, often leading to sex working in order to fund their substance addiction or merely to survive.

Alongside such unpredictable lifestyles come predictable health problems. Health services as well as other beneficiary services must ensure that they are providing what is needed and when it is needed in order the effectively meet the health requirements of these groups. This will in turn help to close the health inequality gap prevalent between marginalised groups such as the homeless and sex workers and the National Health Service.

Aims

This report will aim to identify the present key health problems within the general homeless population followed by specifically the female sex (street) workers. It will review the key statistics and reports on homelessness.

Method

A full search was carried out on NHS Evidence, using all the major databases and using controlled vocabulary and natural language to maximise the search retrieval. A book search was also carried out as well as primary research from personal visits to the services within Liverpool. Numerous topical articles were read and the most relevant article has been critically appraised.

Results

There is much evidence leading to poor health amongst the homeless and street workers. With many policies now focusing on health inequalities, street workers especially are yet to be prioritised even though they are one of the most vulnerable groups in society.

Conclusion

Although there are a lot of services working with such vulnerable groups, it seems there is still a significant gap between these groups and the health system. Health services need to liaise more closely with non–NHS services. It is also essential that governmental statistics, such as the rough sleeper count begin to uncover the true numbers by changing their methods. Only then can services be allocated effectively.

LEARNING OBJECTIVES

1. To understand the causes and consequences of homelessness, and to be up to date with current literature in this area specifically with female homelessness.
2. To learn about the main clinical problems of the homeless; including substance misuse (drugs and alcohol) and general health problems prevalent with the homeless.
3. To discover the specific health issues that homeless women encounter through the sex trade lifestyle.
4. To explore the best ways to provide sustainable services within the NHS and other providers for the homeless.

CORE LEARNING ACTIVITIES

1. To attend service learning visits especially hostels, shared care GP clinics, drug services (e.g. Addaction) etc.
2. To identify 3 specific case histories of 3 homeless women, one of which to be a street worker.
3. To provide a presentation on a topic deemed currently very important concerning homelessness and health.
4. To complete evaluation forms to further benefit preceding students following this SSM.

ACKNOWLEDGEMENT AND THANKS

I would like to say a special thank you to Dr O' Neill and Dr Sutton for arranging an incredibly eye – opening experience. There has been no SSM until now which has allowed me to visit so many placements and talk to so many interesting people. This has undoubtedly helped my degree in so many ways.

I would also like to say a big thank you to Karen from the Whitechapel Centre. Without her kindness, I would not have learnt as much as I did from the topic.

I also thank Dr. Sandra Oelbaum for spending her time to allow us to obtain the full experience of what it is like to work as a GP in a shared clinic.

I would like to thank Ronnie from the Ann Fowler hostel for all her help with the case histories and the Sisters from Seel Street for their patience and hard work!

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1. INTRODUCTION

> *"Everyone has the right to a standard of living adequate for the health and well being of the individual and of their family"* [1]
>
> **Article 25**
>
> **United Nations Universal Declaration of Human Rights 1948**

Despite years of media attention and Governmental concern, it is still very difficult to reside in a UK town without seeing some form of homelessness.

1.1 Homelessness: Key Definitions

Before considering the health issues surrounding homelessness, some definitions must be clarified.

The term "homeless" has fallen to much a debate due to different perceptions in what is deemed an acceptable definition.

It is a common perception that a "homeless person" is one that can be visibly seen sleeping rough on the streets. This is, in fact, a great misconception which may leave some people with a miscomprehension of the real scale of homelessness.

The most widely accepted definitions can be separated by statutory and non-statutory categories.

1.1.1 Statutory Definition

This is the legal definition of homelessness which is correct for England and Wales according to the Housing Act 1996, Chapter 56[2]. The statutory duty basically falls under three principles, being: (a) "unintentionally homeless"; (b) "priority need" e.g. pregnant with dependent children, vulnerable (elderly, mental health) and (c) "eligible for assistance"[2]

The Local Authority have a legal duty to those who fall under the criteria outlined in the box below[2].

"(1) A person is homeless if he has no accommodation available for his occupation, in the United Kingdom or elsewhere, which he—

(a) is entitled to occupy by virtue of an interest in it or by virtue of an order of a court,

(b) has an express or implied licence to occupy, or

(c) occupies as a residence by virtue of any enactment or rule of law giving him the right to remain in occupation or restricting the right of another person to recover possession.

(2) A person is also homeless if he has accommodation but—

(a) he cannot secure entry to it, or

(b) it consists of a moveable structure, vehicle or vessel designed or adapted for human habitation and there is no place where he is entitled or permitted both to place it and to reside in it.

(3) A person shall not be treated as having accommodation unless it is accommodation which it would be reasonable for him to continue to occupy.

(4) A person is threatened with homelessness if it is likely that he will become homeless within 28 days."

This statutory definition seems to exclude big populations of homeless people such as couples without children and the single homeless. It also excludes sanctuary seekers and will not provide duty of housing to them unless they have applied for asylum upon entry to the UK or if there has been a declaration of upheaval in their originating countries[3].

This is undoubtedly a huge problem as sanctuary seekers make up a significant proportion of the homeless population.

1.1.2 Non-Statutory Homelessness

This is the term given when the person has been considered intentionally homeless and is in no priority need. In this case, the local authorities have no legal duty of housing care.

Other non-statutory definitions are included in table 1 below, quoted from Fitzpatrick et al.[4]

Table 1 – Housing situations that can be defined as Homelessness[4]

Key Word/ Phrase	Definition
"Rooflessness"	*"Whereby only those without shelter of any kind should be considered homeless. This includes people who are sleeping rough, newly arrived immigrants and victims of fire and floods."*
"Houselessness"	*"Includes those who are living in emergency accommodation provided for homeless people e.g. night shelter, hostels and refuges. It also includes people who are in long term institutions because there is no suitable accommodation available in the community; e.g. psychiatric hospitals, bed and breakfast accommodation".*
"Insecure or impermanent tenures Newly known as "hidden homelessness"	*"Those staying with friends or relatives on a temporary basis, tenants under notice to quit and squatters."*
"Intolerable housing conditions"	*"Severely overcrowded or substandard accommodation."*
"Concealed Households"	*"Where such households are involuntarily sharing accommodation on a long term basis because they can not secure separate housing."*

1.2 Quantifying Homelessness

The latest statistics are shown in the Communities and Local Government Report of Statutory Homelessness in the 4th Quarter 2009[5]. This report identifies that **9,430** applicants were accepted as owed main homelessness duty[5]. This figure is claiming to be 22% lower than the previous year[5]. However, the definition of "homeless" is not seen by all as statutory leaving a considerable shadow of doubt that these are indeed the true numbers of homelessness.

In 2009, nationally, there were **464** rough sleepers according to the Communities and Local Government Report on Rough Sleeping[6]. Liverpool itself had **9** rough sleepers, ranking it number 13 out of 76 cities in England[6]. These figures are surprisingly low. The charity CRISIS estimates that on any one night there is at least 700 people sleeping rough[7] indicating a significant difference with official statistics. However, if in a previous year, there has been less than 10 but more than 0 rough sleepers in a city, a further full count is not necessary for the following year[8]. One could argue this would be assuming too much based on just one snapshot view. Due to the methodology, any number between 0–10 would be classed as 0 making the number all the more misleading. Furthermore, Schapps report on "Roughly Sleeping"[9] highlights that the technique of the rough sleepers count means that the counts only take place in areas with a substantial known amount of rough sleepers (hot spots). Other areas are missed out clearly showing methodology based on assumption. Counts could only be taken from the people who were actually sleeping and not from those who could have been awoken due to other factors (sleep / mental health difficulties)[9]. One could argue that only when the true numbers of the homeless population are known, a better allocation of services and more specifically health services can be organised.

1.3 Women Homeless Statistics

Due to the lack of gendered data, there are no recent data for women homelessness alone. Many women choose to remain invisible hence avoiding all sources of data collection. Many women tend to "sofa surf" hence do not go to the Local Authorities for homeless status but this does not ensure a secure accommodation every night. There is significant evidence that an increasing number of women are turning to sex working in order to avoid the streets[10]. A study carried out by CRISIS [11, 12] conducted with 144 single homeless women across 19 towns and cities in England proves that despite policies and current legislation, homeless women are continuing to suffer silently. Statistically, it was found that over 60% of the women they interviewed had slept rough but only 12% had been found by rough sleeper teams[11, 12].

1.4 Causes of Homelessness

The charity Shelter carried out two studies[13, 14] to establish directly from the homeless, what reasons led them to become homeless. The causes identified were friends and family being unable to accommodate them, loss of assured tenancy, relationship breakdown (including domestic violence), childhood/ sexual abuse, mental health problems, substance misuse issues, post prison and involvement in crime from a young age[13, 15].

1.5 Health Problems Associated With Homelessness

A study carried out by CRISIS[16] on the relationship between homelessness, health and mortality produced a shocking report that the average life expectancy for a rough sleeper is just 42 years old. This is almost 40 years less than the National life expectancy for a female in the UK according to the National Statistics Online[17] where males should expect to live up to 74.4 years old and women to 81.6 years old. Considering that many of the homeless struggle to find essential shelter, warmth and food supplies, it is understandable that for many, personal health is not a top priority.

The World Health Organisation (WHO) definition of health[18] can be considered below:

> *"Health is a state of complete physical, mental and social well – being and not merely the absence of disease or infirmity"*

Rough sleepers, in particular, are one of the most vulnerable groups in society. The Griffiths Report[19] on *"Addressing the Health Needs of Rough Sleepers"* found that compared to the general population, rough sleepers are 35 times more likely to kill themselves. Furthermore they have a 4 times higher likelihood of mortality from unnatural causes e.g. assaults, murder, accidents, drugs or alcohol poisoning[19].

There are three categories of ill health that seem to go foot in shoe with homelessness of all types. These are:

1. **Physical ill health**
2. **Mental ill health**
3. **Drug and Alcohol dependency**

1.5.1 Physical Ill Health

One of the largest studies to be ever carried out on homeless people in the UK was by St Mungo's, a London based homeless charity, entitled S.O.S Sick of Suffering[20] highlighted the main physical health problems associated with the homeless. This report led to a Lancet editorial titled SOS from the homeless[21] highlighting the results and the need for change.

The emphasised physical health problems are shown in the table below.

PHYSICAL DISEASES FOUND AMONGST THE HOMELESS POPULATION

"Physical trauma

- *Injury*
- *Foot trauma — due to walking for long times in inappropriate shoes, standing or sitting for long periods leading to venous stasis, oedema and infection, frost bite, skin anaesthesia due to alcoholic peripheral neuropathy, lack of hygiene due to over wearing of unwashed clothing, or overgrown toe nails*
- *Dental caries due to self neglect.*

Infections

- *Blood-borne virus — hepatitis B,C or HIV*
- *Hepatitis A101,102*
- *Skin infections — cutaneous diphtheria103 impetigo, viral warts*
- *Secondary to louse infestations — typhus (caused by Rickettsia prowazekii), trench fever (caused by*
- *Bartonella Quintana) or relapsing fever (caused by Borrelia recurrentis)29,104,105*
- *Fungal — most commonly tinea*

Inflammatory skin conditions

- *Erythromelalgia*
- *Pediculosis*
- *Seborrhoeic dermatitis*
- *Acne rosacea*
- *Eczematoid eruptions*
- *Xerosis*
- *Pruritus*

Skin infestations

- *Body louse*
- *Scabies*

Respiratory illness

- *Pneumonia — common pathogens Streptococcus pneumoniae, Haemophilus influenza b, aspiration of anaerobes or Pneumocystis carinii (the latter occurring almost exclusively in immunocompromised patients).*
- *Influenza*

Minor upper respiratory infections

- *Tuberculosis (often latent)"*

[22]

1.5.2 Mental Ill Health

Mental ill health has been described as a cause and effect of/to homelessness[23]. The most common mental health issues amongst the homeless are depression, schizophrenia, personality disorders, psychoses and affective disorders[24].
The following box[4] indicates the most common signs seen with depression.

- *"Consistent low mood with a duration of two weeks or greater.*
- *Insomomnia or hypersomnia*
- *Decreased libido*
- *Decreased appetite*
- *Suicidal ideation*
- *Thoughts of self harm*
- *Social decline*
- *An overtaking feeling of guilt.*
- *Anxiety*
- *Loss of faith for change"*

[4]

In many cases, dual diagnosis is seen. This is where mental health issues are associated with substance misuse e.g. "cocaine – induced psychosis".

1.5.3 Drug and Alcohol dependency

In the year 2010, around 39% of clients presenting in homeless services in England had issues with alcohol abuse and 42% had a current issue with drug dependency according to the Survey of Needs and Provision[25].
The numbers are estimated to be significantly higher when the general homeless population is considered rather than solely clients. In fact, every client that was personally seen on placements within Liverpool had drug issues with around 50% with alcohol dependency.

The table below indicates the common dependent drugs seen on placement amongst the homeless and their health effects.

DRUG	ADMISSION ROUTE	EXPERIENCED EFFECT	HEALTH COMPLICATIONS
Heroin	• Injected • Smoked • Dissolved in water • Occasionally snorted.	• "Rush / buzz effect" rapidly after taking. • Later creates sleepy effect (more commonly seen with larger doses) • Often relaxing with a feeling of warmth and wellbeing.	• Mortality from overdose. • Low breathing rate leading to respiratory failure. • Injecting complications ➢ DVT ➢ Pulmonary embolism, ➢ Viral hepatitis (B and C) ➢ HIV infection ➢ Septicaemia ➢ Encephalitis ➢ Cellulitis ➢ Abscesses ➢ Gangrene
Cocaine	• Crack Cocaine – Smoked • Powdered Cocaine – Snorted • All forms - Injected	• "Top of the world" feeling. • Alert, wide awake and "top of your game" • Fully confident like you have "worth". • Usually taken with heroin - "Speedball" to alleviate the paranoia and depression after cocaine use.	• Mortality from overdose • Hyperpyrexia • Convulsions • Respiratory and Heart Failure • Depression • Anxiety/ Paranoia • Injecting complications (see above)
Cannabis	• Smoked • Tea or food products	• Relaxed • Happiness • Sickness • Hunger • More aware of senses • Loss of concentration.	• Anxiety, panicky, paranoia • Lung disease • Cancer • Tachycardia / High BP • Increase risk of developing psychotic illness.

[26, 27]

Alcohol is a substance which is easily accessible to the majority of the UK population. Throughout placement, a significant proportion of the clients had chronic alcohol issues. The health complications here include *"gastrointestinal, hepatobiliary, cardiovascular, neurological or metabolic complications"*[26]. There is also high risk of depression and suicide [26].

There was a recent report from the ACMD titled Pathways to Problems[28] headed by Professor David Nutt. This report highlighted that there is not enough being done to reduce alcohol consumption in the country even though the health effects are severe. In fact, the health consequences have proved to be significantly more severe than many other classed drugs[29]. As the report was silently released, no changes in policy have been yet seen.

1.6 Access to Healthcare

> *"Less than 1 in 3 of the population of homeless people who need medical treatment are actually receiving it*

[20]

A shocking statistic, especially when one refers back to the core principles of the NHS (shown below)

> ***"The NHS will help to keep people healthy and reduce health inequalities***
>
> *The NHS will try to prevent, as well as treat, ill health. It will recognise that health is affected by social, environmental and economic factors such as deprivation, housing, education and nutrition, and, with other public services, will intervene before as well as after ill-health occurs."*

[30]

The Acheson Report in 1998[31] became the cornerstone for change in health inequalities but health inequalities are still heavily prevalent in our society.

First, the definition of health inequalities must be considered.

> *"..differences in health status or in the distribution of health determinants between different population groups"*

[32]

Next, the GMC duties of a doctor[33] can be considered.

"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* [33]
- *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."*

These are good foundations for health care system yet over 60 years on from their birth, populations such as the homeless, substance addicts and street workers have found themselves easily marginalised from this system.

1.6.1 Accessibility of Health Services

The Griffiths Report[19] recognises some of the major barriers to be:

- *"Institutional factors such as opening times, appointment procedures, location and discrimination leading to somewhat poor or limited access to physical and mental healthcare services .*
- *Strong financial disincentives for general practitioners to register rough sleepers particularly if GPs believe the person is transient .*
- *Lack of integration between mainstream primary care services and other local services (e.g. housing, social services, criminal justice system and the voluntary sector), which can prevent people from being linked into the services they need at the earliest opportunity.*
- *The rough sleepers themselves nor prioritising their health, as other issues are more pressing, or not knowing where to find help."*

[19]

1.6.2 The Inverse Care Law

This was proposed by Julian Tudor Hart in 1971. The law stated:

> *The availability of good medical care tends to vary inversely with the need for it in the population served.*

[34]

This is relevant to our current day situation where GP specialist services specific for homelessness are few and far between and are usually only found in larger cities thus ignoring the need present in many other areas of the country.

1.7 Street Working: The Health of Vulnerable Women

> *"I am alive except for when I choose to play dead"*
> ***Miss A, Street Worker, Liverpool 19 /04/10***

Sex workers stand arguably as one of the biggest health inequality groups in our current system.

Similar to the risk factors leading to homelessness, sex workers usually have a history of drug abuse, poverty, violence and child abuse[35].

There are numerous generic policies on attempting to stop prostitution by fines and arrests, yet very little policy on how to actually help these women change their lives. For example, the report titled "Paying the Price"[36] has a lot of emphasis on helping the community but much les emphasis on helping the women themselves.

In fact, evidence has proved that when fines have been issued, these women have had to return to the streets with more desperation in order to pay the fines[37].

It can not be argued that there is a lot of health issues associated with sex working. As clients offer more money for unprotected sexual activities[38], there are higher risks of HIV infection and sexually transmitted diseases. Furthermore, a large proportion of street–based prostitutes have claimed to experience serious sexual and physical violence[10].

Despite such significant health issues, there are still low attendance rates with health services, low incidences of cervical screening (38%) and low numbers actually vaccinated for hepatitis B (24%) – a national requirement for all sex–workers[39]. Furthermore, less than 50% are estimated to have been screened for sexually transmitted diseases.

There have been lots of revolutionary changes since Acheson's report[31] on health inequalities but street workers are yet to be classed as a real issue on the health inequality scale and so remain a highly marginalised, vulnerable group in society.

The main barriers to healthcare seem to be through depression and anxiety experienced by women in the thought that they will have to disclose information about their lifestyles[39]. Others found appointment times to be a difficulty and desired a drop in service[39] away from the judging eyes of the general public.

A "managed zone" may be beneficial which would include a health clinic within that zone that all sex workers would have to register with[40].

A further concern is that of trafficked persons being forced into the sex trade[41]. In the UK alone, there are around 860 identified trafficked persons a year[41]. In April 2009, the Council of Europe Convention on Action against Trafficking in Human Beings came into force in the UK[41] which requires all people identified as trafficked to receive minimum standards of health care[41]. This is very worrying and begs the question whether health is a human right.

1.8 Media Portrayal

There have been variable media influences on the topic of prostitution.

Billy Pipers highly watched ITV aired show of "Secret Diary of a Call Girl" seems to focus prostitution in a good light, giving a perception of lots of money and a glamorous lifestyle. There is portrayal of neither the health issues nor the violence that the majority of real working women face.

[42]

A much more serious and impacting media coverage of the topic is the devastating murders of 5 women in Ipswich in the winter of 2006.


[42]

These women were prostitutes working in the Ipswich red light district to fund their drug addictions. They were all killed by the same "punter", Steven Wright. This highlights the vulnerability of the women on the streets and emphasizes the danger and risks they take in order to "survive".

It is unquestionable that the media can play a huge part in society's attitudes towards serious issues. This is clearly shown in the 1966 BBC television drama "Cathy Come Home". This programme is known as the most important piece of drama on homelessness ever to be shown on national television. The large audience for this programme and the influence it had on the British population led to great support for the homeless charity "Shelter" moving from being a small organisation to one with a national reach.

[42]

2. CASE STUDIES

These 3 women were personally interviewed as part of research for this project.

Miss X, 38 years old.
Miss X lost her property in summer 2009. This was due to domestic violence leading to constant police involvement to the house. She is still with her violent partner.
At first, Miss X sofa surfed until she had no more friends to rely on.
She found the female hostel (Ann Fowler) by word of mouth. She is now on a resettlement course.
Miss X started using Heroine from the age of 21. Last usage was a month ago. An average of £50 of heroine was smoked each week. Twice a month, £100 of cocaine was also injected. She also has smoked tobacco since 13 and still continues to smoke 20 a day and occasionally smokes cannabis. She is now on a Methadone script of 80 mls.
She tends to drink alcohol socially.
Miss X was caught shop-lifting whilst on the streets and carried out a prison sentence of 3 years.
Miss X has drug induced epilepsy diagnosed 3 years ago. She currently has asthma for which she takes inhalers. She occasionally experiences depression.
Miss X has 2 children and her first was born when she was 17. Currently, she does not have periods so does not take contraception. She does not have regular cervical

Miss Y, 34 Years Old
Miss Y got evicted from her house in February 2009 due to anti – social behaviour. Her sons were constantly getting arrested for automobile theft. They are both now in prison. She does not visit them. She has herself been in prison for 4 months for assault.
She came straight to the Ann Fowler hostel and has never slept rough on the streets. She is currently looking or a new house.
She was sexually abused as a child and kept it to herself for 20 years.
Currently smokes Heroine and crack cocaine together for 15 years. She was unable to state the amount she used. She sold drugs to get finance. She is recently on a Methedone script of 35ml and is set to start subutex in the next few weeks.
Her reason for use of drugs was to block out her past. She has also taken Cannabis in the past but does not consume alcohol.
She has smoked tobacco for 25 years.
Last year she was 4 ½ stone due to the loss of appetite she experienced from the drugs. She is now 6 stone.
She has drug – related asthma and has continual chest infections. She also is a type 1 diabetic.
She, for several years, has significant mental health issues- depression, stress, psychosis and anxiety.. She has been hearing voices for years telling her to “kill someone” or even “kill herself”. She has tried to hang herself twice in the last year. She has also overdosed on Paracetamol. She is now currently on Olanzapine, Mirtazapine and Zoplicone. She regularly attends her GP at Brownlow Clinic where she is completely satisfied with the services.

Miss Z, 29 Years Old

Miss Z has been sleeping rough for a year with her partner in the Liverpool area behind a church.

She started smoking heroine and crack cocaine from the age of 17. She started it out of boredom and because her boyfriend of the time was also using. She got kicked out off the family house at 21 and has been living with various friends before sleeping rough.

She currently takes £30 of heroin and £50 cocaine a day.

She is on no methadone script nor does she have any contact with any aid services. She is not interested in them as she does not believe they work for her. She has had no recent contact with the GP.

She works as a street-based prostitute to fund her drug addiction. She does not like the lifestyle she leads but feels she has to in order for herself and partner to survive.

She uses contraception in the form of condoms, however, will sometimes go without if paid more. She has not had any health checks within this year. She will not go for any sexual health checks as she is scared of the result.

She has experienced depression and anxiety, is prone to chest infections and has asthma.

She no longer has any contact with family.

She is waiting for her friend to move into a house so they can sofa sleep

3. METHODS

Firstly, in order to attain a full comprehension of topic area, a book search was carried out. This took place at Liverpool University Harold Cohen Library, Fade Library and Arrowe Park Hospital McCardle Library.

Following this, it was deemed important that some primary research be undertaken to develop an eyewitness picture of the true issues in Liverpool itself. The following table shows the organisations visited and their role in aiding care.

ORGANISATION	PURPOSE
The Whitechapel Centre	A voluntary organisation who provide services which aim to improve the quality of life of people who are homeless. Services include day centre, breakfast bar, outreach, resettlement and supported housing projects and meaningful occupation projects. Over a month was spent with this organisation, where the opportunity was given to spend time with the Doctor from Brownlow Practice, talk to the homeless within the day centre and visit those who have been newly placed in housing.
Croxteth Addaction Project	Known as Britain's largest specialist drug and alcohol treatment agency. Provide a free and confidential service for adults affected by drugs. Here, an introduction to primary care treatment of drug users, an assessment of a drug user and harm reduction intervention (syringe exchange), a talk from the alcohol team and from the stimulant worker were given. This

	provided valuable insight into the works of a shared care team.
Fleet Street Clinic - Addaction Project	Another shared care practice scheme with a criminal justice foundation. The drugs intervention programme (DIP) playing an essential role within the practice. Client engagement is not voluntary leaving the risk of missed appointments with a potential arrest. Here, case histories were taken and GP shadowing. Methadone scripts were observed issued and an opportunity to talk to the DIP team was taken.
Long Lane Medical Centre	Here, time was spent with a very well known and highly respected drug worker within the drug user community. There was a chance to view the urine tests and talk to her clients about their experiences with drugs and homelessness.
Ann Fowler House	This a female hostel supported by The Salvation Army who aims to provide short term accommodation, Christian support, food, training and resettlement. This was an essential part of the primary research as specific assignment topic case histories were taken from this hostel.
Missionaries Of Charity	Run by kind sisters, this house provides dinner for the homeless. An essential observation of how many people attend this service and their high appreciation to the sisters and the volunteers. Very inspirational.

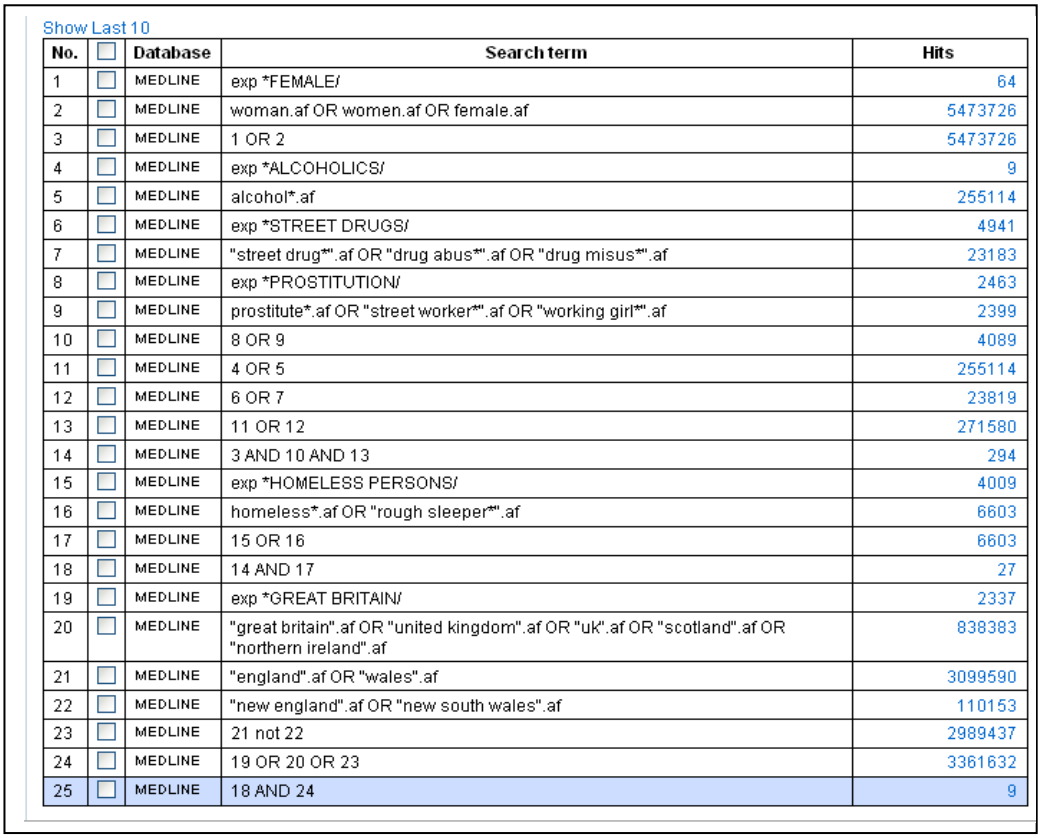
Loango Hostel	Male and female short term accommodation.
3 - 5 Rodney Street (Drug services)	Another example of criminal justice drug intervention.
The Armistead Centre	A centre which aims to provide a confidential assertive outreach and support service to women involved in street sex work and support those wishing to exit. Also to refer and actively support these women to access appropriate health, drugs and social care services in response to client need.

After obtaining a first hand view of the current situation and associated health issues within Liverpool and how organisations are trying to help, it was then essential to review all relative literature on the topic to see if there is a similar situation nationally. The literature consisted of both white and grey papers.

The search strategy used was through NHS evidence. This began with a Medline search strategy which was then extended through the other databases. A combination of controlled vocabulary and natural language were carried out to maximise search retrieval. The criteria used and the results that preceded this search strategy are shown below.

Criteria	Reasoning
Year of Articles – 1980 – present	Effort was made to incorporate the most current studies.
Country of study – Not limited to UK	The majority of pivotal studies were not carried out in England. The majority were from USA and Australia. Therefore, whilst UK studies were preferred, the other countries were not ruled out.
Language – English	Translation accepted.

Print Screen of Initial Medline Search



Show Last 10

No.		Database	Search term	Hits
1		MEDLINE	exp *FEMALE/	64
2		MEDLINE	woman.af OR women.af OR female.af	5473726
3		MEDLINE	1 OR 2	5473726
4		MEDLINE	exp *ALCOHOLICS/	9
5		MEDLINE	alcohol*.af	255114
6		MEDLINE	exp *STREET DRUGS/	4941
7		MEDLINE	"street drug*".af OR "drug abus*".af OR "drug misus*".af	23183
8		MEDLINE	exp *PROSTITUTION/	2463
9		MEDLINE	prostitute*.af OR "street worker*".af OR "working girl*".af	2399
10		MEDLINE	8 OR 9	4089
11		MEDLINE	4 OR 5	255114
12		MEDLINE	6 OR 7	23819
13		MEDLINE	11 OR 12	271580
14		MEDLINE	3 AND 10 AND 13	294
15		MEDLINE	exp *HOMELESS PERSONS/	4009
16		MEDLINE	homeless*.af OR "rough sleeper*".af	6603
17		MEDLINE	15 OR 16	6603
18		MEDLINE	14 AND 17	27
19		MEDLINE	exp *GREAT BRITAIN/	2337
20		MEDLINE	"great britain".af OR "united kingdom".af OR "uk".af OR "scotland".af OR "northern ireland".af	838383
21		MEDLINE	"england".af OR "wales".af	3099590
22		MEDLINE	"new england".af OR "new south wales".af	110153
23		MEDLINE	21 not 22	2989437
24		MEDLINE	19 OR 20 OR 23	3361632
25		MEDLINE	18 AND 24	9

No.	Database	Search Term	Hits
26	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	exp *FEMALE/	6341
27	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	woman.af OR women.af OR female.af	10047684
28	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	26 OR 27	10048019
29	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	exp *ALCOHOLICS/	1030
30	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	alcohol*.af	777906
31	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	exp *STREET DRUGS/	6059
32	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	"street drug*".af OR "drug abus*".af OR "drug misus*".af	36196
33	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	exp *PROSTITUTION/	5657
34	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	prostitute*.af OR "street worker*".af OR "working girl*".af	10143
35	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	33 OR 34	13613
36	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	29 OR 30	777906
37	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	31 OR 32	36320
38	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	36 OR 37	132929

39	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	28 AND 35 AND 38	924
40	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	exp *HOMELESS PERSONS/	7277
41	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	homeless*.af OR "rough sleeper*".af	50991
42	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	40 OR 41	50991
43	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	39 AND 42	201
44	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	exp *GREAT BRITAIN/	3345
45	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	"great Britain".af OR "united kingdom".af OR "uk".af OR "scotland".af OR "northern ireland".af	5281679
46	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	"england".af OR "wales".af	3753817
47	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	"new england".af OR "new south wales".af	305176
48	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	21 not 22	3448641
49	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	44 OR 45 OR 48	8035404
50	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	43 AND 49	78

Other research conducted was by using:

- Google
- Google Scholar
- Government policies
- Local Policies
- Clinical Guidelines
- Relevant websites e.g. http://www.homelesspages.org.uk and http://www.crisis.org.uk

4. RESULTS

4.1 Article Review

After a full search of the essential databases was carried out, the results of the literature search revealed the most relative article.

This article is "A health needs assessment of street–based prostitutes: cross sectional survey"[38] by Jeal and Salisbury.

The aim of this paper was clearly set to identify the wider health problems associated with street–based prostitutes. It was seen as an important article as research carried out previously only focused on the sexual health of street workers. This article appears to have much relevance to current issues as street workers have one of the widest gaps on the health inequality scale. Nevertheless, this population group is still failing to be identified as a high priority. This marginalisation is of the worst kind, as there is no intent of change in any of the recent policies. This leaves this group much more vulnerable with respect to health than any other previous groups mentioned earlier.

This is proven by the researcher from the lack of importance given to this group in the Tackling Health Inequalities Review 2002[43] and the Sexual Health and HIV Strategy[44]. To ensure this claim was still viable, the most recent Tackling Health Inequalities Review 2009[45] was checked and there is still yet a mention to street based prostitutes as a priority group.

There are weaknesses in this article. The researcher has not clearly justified the research design in order to address the aims of the research. There is no written indication of the process which determined their chosen methodology. They used the Charity One25 who estimated the population of street – based prostitutes in Bristol and took control in picking the sample size through "kerb crawling" and word of mouth. There was no reason as to why this specific charity was chosen to be used. Furthermore, there was no justification of a significant sampling size. It seems it was decided on luck.

The times of recruitment led to one of the biggest limitations within the study. The recruitment times only took place up to midnight. One could argue that midnight to

09:00 may be the prime time for street workers with very little women operating before then. This, in fact, may have caused the low sample size. One25 estimated that there were 120 street workers yet only 71 took part. There was no explanation to why some of the women refused to take part when given the choice.
The women who chose to take part had already come into contact with One25 and their services. It can be argued that these women represent the more stable and less chaotic population of street workers. Therefore, the reality of health issues of the full population of street workers in Bristol can not be fully determined by this study. In fact, it is likely that these results may even underestimate the true morbidity for the whole population.

The women who decided to take part were given £20 to cover child care and travelling expenses. This, however, raises ethical issues. These women endure a lifestyle that most of them dislike for money. Hence, offering money leads to responder bias in that many women will agree to the study and may even go so far as to produce results that one would like to hear.

One25 is a charity working with street workers and can be seen as having a "vested interest" in the results. This study can therefore be accused of researcher bias as they did all the recruiting and interviewing.

The study, despite its faults did come out with valid points that need to be considered seriously by health authorities. It found that the street workers in Bristol have higher rates of stillbirth as well as high incidences of chronic illnesses (e.g. longstanding illnesses/disability, anxiety/depression, vein abscess, recurrent chest infections, etc). It also showed that many of the women were forced into prostitution by their partner to fund both their drug habits. Violence was seen in 73% of the cases, including assault, rape and use of guns, chainsaws and machetes. Sexual health was also an ever –growing concern with the women being offered more money for unprotected sexual activities. The cervical screening attendances were also low for this population.
It is unquestionable that all these above provide serious health implications. Future studies are needed into off – street sex workers.

5. DISCUSSION

After all evidence considered, the following recommendations can be made:

Global Perspectives

Since homelessness and prostitution strikes all geographical areas – from the most developed to the most deprived countries, it is essential that a consistent global importance is set.

A possible suggestion would be to have a **global awareness day** for homelessness and sex workers in order to emphasise that it is not a lifestyle of choice and these people really do need help. This may help change the attitudes of the general population worldwide. Less judgement placed on these people means a higher likelihood of them attending and engaging with health services and other beneficiary services.

Local Perspectives

1. *To have one or more General Practitioner linked to every aid service in the North West.*

The main problem within Liverpool itself is linking NHS services with these non - health services. There seems to be a complete disengagement between the two links yet they both desire the same result.

2. *To have more services which aid specifically women.*

There seems to be under representation for women in the North West with a lot of services focusing on homeless men.

During visits to the female hostels, it was noted that there were very limited places and the managers have admitted that they denied many desperate women on many occasions. This may force these women into the dangers of the streets. More hostels and more beds are needed within the existing ones.

3. *More GP practices within Liverpool to be specific for homelessness.*

At present, Brownlow Medical Centre is the only GP practice in Liverpool that is commissioned by the Primary Care Trust to offer an enhanced service to homeless people. They register homeless people and also hold a surgery once a week for those who are unregistered. This is however based in Liverpool Centre thus accessibility may be an issue for those who reside further away.

National Perspectives

1. *A fairer statistical count of the homeless and other vulnerable groups.*

One of the most important changes that can be done nationally is to change the ideology behind the method on governmental statistical counting of the homeless and street workers. One cannot only count numbers based on those who are accepted by their local authority as homeless. Furthermore, the rough sleeper count methodology is highly unjustified. A count should be taken in every city in the UK over a longer period of time and results standardised in order to produce more realistic numbers. False statistics have only proved to be counter productive. It gives a false perception that with lower percentages than the year before the situation is significantly improving.

2. *More services are needed nationwide that work directly with sex workers.*

It is difficult to find, communicate and liaise with the street – workers as it is still a very "hidden profession".

A possible effective strategy would be to have services ran by ex street workers. This would provide realistic hope for these people.

3. *A higher number of specialist GP services.*

If the real, higher statistics are revealed, the Department of Health may consider organising more special targeted GP services which work against all barriers that these groups are known to experience in a mainstream clinic e.g. drop in service orientated GP clinics.

4. *A national recognition of sex workers as a health inequality priority in Department of Health reports.*

These women are extremely vulnerable and the current health system is allowing them to slip through the net. Their health status is dramatically declining. The Tackling Health Inequalities report must identify this group as important otherwise no change will occur.

5. *More effective discharge Policies and Actions.*

Health is seen as physical, mental and social well–being yet hospitals are discharging homeless people back onto the streets or to inadequate accommodation. This is not an effective discharge policy leading the homeless back into the cycle of poor health. The joint guidelines on discharge for the homeless published in December 2006 by the Department of Health and Department of Communities and Local Government need to be more closely followed.

6. CONCLUSION

This essay reveals 3 key points:

- The homeless have very chaotic lifestyles and often do not prioritise their health. Drug addiction and alcohol abuse is a common habit leading to numerous health complications.
- Street–workers have wider health problems than just sexual health issues.
- There is still a large gap between these groups and the health care system.

There are many vulnerable groups within our society. Some are visible yet many are hidden. Although, there is somewhat of recognition that these groups have poor health, there is not enough being done to actually help them effectively. Change is desperately needed from all angles.

Health inequalities are a major concern to many health professionals. More education is needed from medical school to ensure ignorant attitudes do not reside in the health system

There are more to the homeless and street workers than just a drug addiction. There is a history, there is a life and there is a future.

After all, we are all; at any time only a few steps away from homelessness. How would you like to be treated?

Limitations

The major limitation with this paper was the word count. With only a 3300 word margin, it was extremely difficult to do justice to the detailed issues affecting the homeless and sex workers. Much of the content is broadly spoken about with the intention of references as guidance to more detailed reading.

Therefore, this paper can be considered as only an overview of the issues.

Furthermore, some interesting studies were inaccessible due to the lack of University or NHS subscription.

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