Homelessness and Health

Alcohol Misuse and Ex-Service Personnel

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Figure 1[1]

"When what's needed most is a helping hand"[1]

Special Study Module Six

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Abstract

Aim: To obtain an understanding of the main problems faced by the homeless and how the available services can help them, how they are utilized and how they maximise the care provided.

Introduction: Homelessness is a multi-faceted concept, with many precipitating and maintaining factors. Homelessness is a significant issue throughout the UK, in 2009 there were 4 451 homeless in Merseyside. The homeless population have significant health issues and poor access to healthcare. Alcohol abuse is a major influence as a precipitating and maintaining factor that compounds the difficulties of recovery.

Method: OVID, Medline, Cochrane Reviews, media websites and the RCGP and NICE were searched to find relevant articles, reviews and reports. Merseyside homeless and alcohol services were visited and case studies were taken.

Results: Most literature agrees that homelessness is an important issue, and that one of the most important contributory factors is poor access to healthcare. The media portray homeless as anonymous figures, compounding their sense of loss of identity. Case studies helped to provide first hand experiences of local services and the problems faced by the homeless.

Discussion: The differences in causes and experiences of homelessness globally, nationally and locally prevent generalisations about the provision of care. Often specific methods of care are needed for specific social environments. This makes the application of research to local services unreliable and prevents national developments in the care of the homeless.

Conclusion: Health and social care for the homelessness raises complex physical, social, psychological and spiritual issues. It is not just being without a home.

Learning Objectives

Core Learning Objectives

- What is ‘Homelessness’ and what are the main health problems the homeless face?
- What services are available for the homeless and how do they mitigate the barriers to healthcare that the homeless face?
- What is the impact of alcohol and service in the armed forces on the homeless?

Core Learning Activities

- Visit services for the homeless and people with linked problems
- Visit services for ex-servicemen
- Service users case histories

Aim

To obtain an understanding of the main problems faced by the homeless and how the available services can help them, how they are utilized and how they maximise the care provided.

Introduction

This paper is a qualitative study into the services provided for the homeless with alcohol abuse problems in Merseyside, looking particularly at ex-service personnel and their risk of homelessness and alcohol misuse.

Causes of Homelessness

Homelessness is a heterogeneous term, encompassing many different people in many different circumstances[2]. It is a multifaceted problem, involving physical, psychological, social and spiritual factors[2-5]. The homeless include people living on the streets [6], 'sofa surfers'[6] (for definitions see appendix II), people in temporary, vulnerable or inadequate accommodation and those at risk of losing their homes[6,7]. There are many and often multiple factors associated with people becoming homeless, which can be precipitating and potentiating factors[3], as displayed in Table 1.

- Significant life events[4,8]
- Substance abuse[8]
- Criminal activity to fuel drug habits and inprisonment[3,8]
- Mental health problems[4,8]
- Leaning disabilities[4]
- Family and relationship breakdown[8]
- Lack of social support and family ties[4]
- Domestic Violence[8]
- Previous service in the Armed Forces[9]
- Criminal record[3]
- Asylum seekers[8]
- Previous child abuse or neglect[4]
- Institutionalisation in childhood[4]
- Low levels of education[3,5]
- Significant financial stresses and bankruptcy[8]

Significant Health Problems in the Homeless Population

Care of the homeless is a typical example of the inverse care law.

"The availability of good medical care tends to vary inversely with the need for it in the population served[10]*"*

Those who need the care most have the least access to healthcare[3], due to the precipitating factors and the consequences of their situation[3]. As a result of these combined effects the homeless population have one of the highest mortality rates in the UK [4,8]. The mortality rate of homeless males between the ages of 16 and 29 is 40 times higher than the general population[4] and the life expectancy of a 'rough sleeper' is just 42 years[8]. The homeless have significant and specific health and psychosocial needs, and often suffer from multiple morbidities[2], examples of which are shown in Table 2.

- General poor health maintenance, foot care, dental hygiene and diet[5]
- Infections and Infestations[2,3,5]
  - Pneumonia and influenza[3]
  - Impetigo[3]
  - Lice infestations and scabies[4]
  - Tuberculosis[4]
- Cancer[4]
- Cardiac disease[4]
- Substance abuse[4,5]
  - Hepatitis B and C and HIV[4]
  - Deep vein thrombosis[3]
- Alcohol abuse[3,4]
  - Alcoholic hepatitis, pancreatitis and gall stones[11]
  - Alcoholic liver disease and cirrhosis[11]
  - Vitamin deficiencies - neuropathies, Wernicke's encephalopathy and Korsakoff's psychosis[11,12]
- Self harm and suicide[3,5]
- Mental health disorders[4,5]

- Poor self-esteem and coping strategies[5]

Barriers to Healthcare

The human rights created by the Universal Declaration of Human Rights, represent a global idea of how human beings should be treated[13], Article 25 which states that – everyone has the right to a standard of living adequate for, health and well being [13] – this right is at risk of being breached for many homeless, when they are faced with barriers to the access and provision of healthcare causing inadequate treatment and management.

"*Access to primary healthcare is a prerequisite for effective treatment of health problems*."[14]

Not only are these rights breached, so too are a doctors duties, when their needs are not met. The General Medical Council created the Duties of a Doctor to guide British doctors in professional practice[15]. It states that it is a doctor's duty to promote the health of patients, to respect their dignity and to act without discrimination. These duties are at risk of being broken when it comes to the care of the homeless[15] (for further information see Appendix II). With or without these rules and guidance every doctor should ensure they abide by their own set ethics and morals, following for example the four ethical principles described by Beauchamp and Childress[16]. This means that doctors should not allow the homeless to suffer for lack of healthcare available to others.

Table 3 displays factors acting as barriers to healthcare for the homeless[4,5]. They mean that the homeless often use Accident and Emergency units[5] and present with late stage problems: not ideal for them and an inappropriate burden of care on secondary care [5].

- No home of residence causing difficulties in registration with primary care or follow-up of care[4]
- Fears, beliefs and suspicions held by the homeless[4]
- Fears and beliefs of healthcare workers[4]
- Financial barriers to accessing healthcare[3]
- Violent, anti-social and chaotic behaviour[4]
- Learning difficulties of service users[2-5]
- Mental health problems, causing difficulties in care[2,5]
- Poor patient knowledge of care available[4]
- Criminal activity and records[3]
- Poor communication between services[4,8]
- Difficulties in maintaining appointments and waiting in waiting rooms[4]
- Problems associated with treatment of substance abuse[11]
- Service users low self esteem, prevent them from accessing services[4]

In 2005, the government set up a strategy called 'Sustainable Communities: Homes for All', to reduce the number of homelessness by increasing housing supply, affordability and quality by 2010[8]. Whether this has worked is difficult to gauge, as homelessness is not simply a state of not having a home[5], but as previously mentioned, is a multi-dimensional, complex situation.

Homelessness in Merseyside and Cheshire

There are different causes of homelessness throughout the world, such as natural disasters in New Orleans and Haiti and war and violence in Sri Lanka and Rwanda. Each has specific healthcare needs, such as food and water in New Orleans and treatment of major injuries from war in Rwanda but in all cases healthcare is difficult.

Even without major natural disasters and war in the UK, approximately one billion pounds is spent on managing homelessness each year[8], 3.3 million of which was allocated to the North West[8]. Unfortunately this still is not enough. Data collected the Office of National Statistics illustrates this[7]. Table 4 shows numbers of people who were homeless in 2008[7].

Homelessness	England	North West	Merseyside
Total statutory homeless	112 900	13 750	4 451
Total in temporary accommodation	64 000	1 360	335

Unfortunately even these figures may not illustrate the true size of the problem in the UK. The Statutory homeless are the officially recognised homeless[4,5,7], unlike the non-statutory homeless (hidden homeless)[e], the 'invisible' individuals of society. The hidden homeless are not accounted for in official data collection[4,5,7], this because they are rough sleepers in unknown locations on the streets, or reside in others houses as sofa surfers[6].

Figure 2[8]

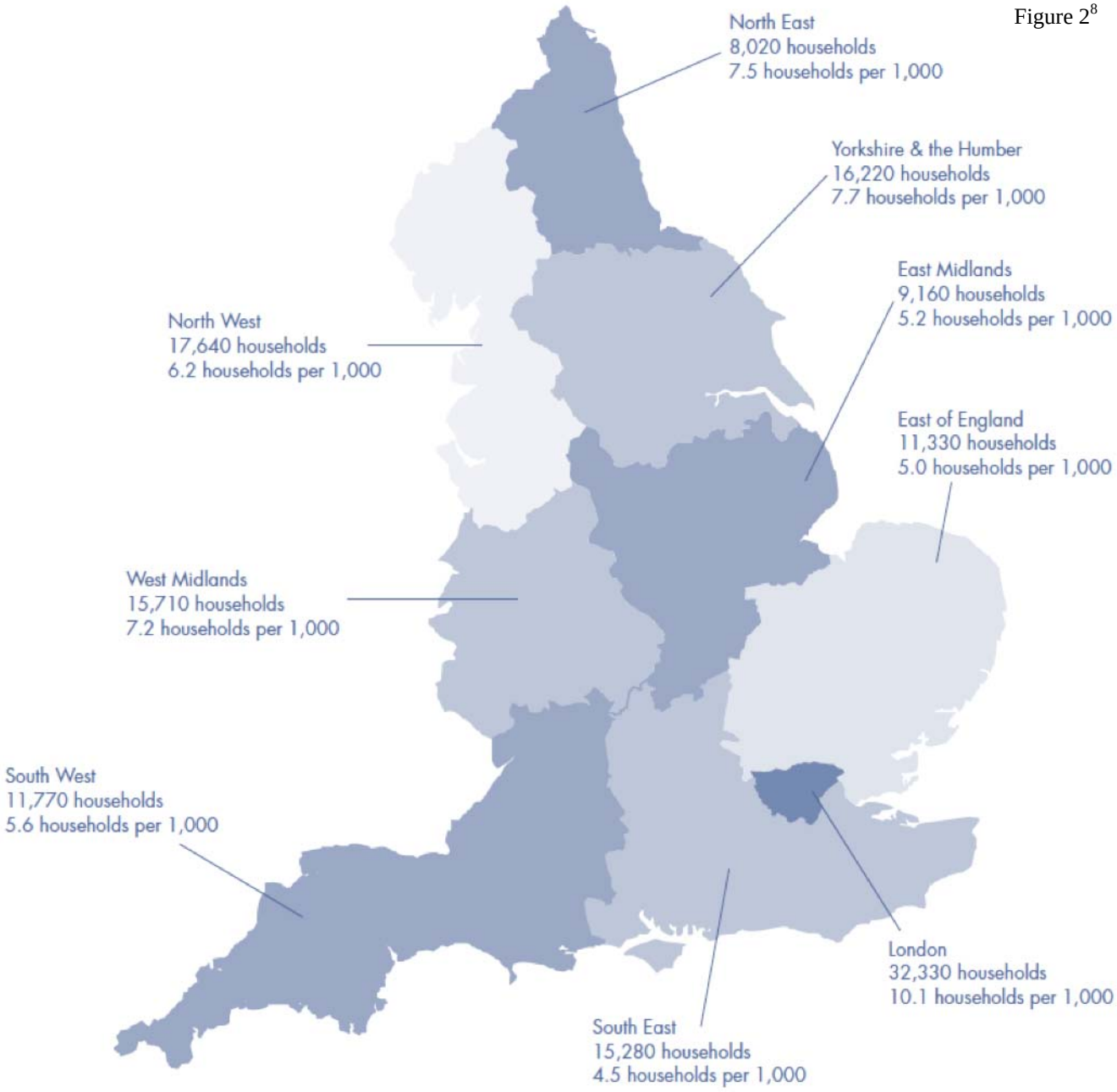

Figure 2 illustrates the level of statutory homeless households throughout England in 2003[8]. In the same year the charity Crisis estimated that there were approximately another 400 000 hidden homeless in the UK[6].

Services in Merseyside

The main roles of specialised homelessness and alcohol misuse are to remove healthcare barriers[1] and to improve access to specialised care provision. Examples of services available in Merseyside are listed in Table 5.

- General Practitioners with a specialist interest in the homeless
- Specialist General Practices
- GP services in hostels and night shelters[4]
- Health visitor patient advocates in General Practices[4]
- Detoxification and Rehabilitation services
- Drop in centres
- Community support services
- Alcoholics Anonymous
- Key Workers at homeless hostels
- Health prevention and promotion services e.g. Needle exchange
- Hostels
- Internet based support charities[1,6,13]
- Alcohol Specialist Nurses
- Psychiatric Care – Out and In (prisons)-reach teams[4]

Alcohol and Homelessness

Alcohol misuse is a major problem in the UK, 20% of patients presenting to their GP report drinking alcohol at high risk and hazardous levels[11], there were 9 031 alcohol related deaths in 2008 alone[17]. This is a significant health issue for the homeless[3], a population already at such high risk of multiple morbidities and early mortality[17]. Whether alcohol is a precipitating or a potentiating factor of homelessness depends on the person but more often than not it will make any situation or circumstance worse[3]. Many people turn to drink during difficult times in their lives, as a method of coping. Homeless people often lack coping strategies and have very poor self-esteem[3]. This combination of problems makes rehabilitation and abstaining from alcohol extremely difficult once dependence has taken root[11].

Leaving the Armed Forces and Homelessness

Many ex-service personnel leave the forces and go on to lead a successful civilian life[18]; unfortunately the percentage who at some point experience homelessness is higher than that of equivalent professions[19,20]. Research in the 1990's suggested that over one quarter of the homeless population had served in the Armed Forces[19,21], and that homeless ex-service personnel tended to be more disadvantaged than other homeless[20]. Associations between homelessness and ex-service personnel are displayed in Table 6.

- Sudden change in social settings and role in society[22,23]
- Return to civilian life from 'total institutionalisation'[18]
- Loss of structure and guidance to everyday life[18]
- Re-entry into civilian life with little or no job prospects[20]
- Lack of professional skills applicable to civilian jobs[20]
- High alcohol consumption culture of the services[24]
- Level of traumatic experiences during service[18,23]
- Acquire long term physical injury and disability[18]
- Development of post traumatic stress disorder[19,25]
- Increased risk of anxiety and depression[29,23]
- Loss of social identity[20]
- Lack of social support structures, due to recurrent change in residence[20]
- Leaving the forces single, without family ties[18]
- Relationship breakdown[19,23]
- Stigma surrounding dishonourable discharge[20]

There is also the possibility that in some situations the association with homelessness and service in the armed forces may be an epiphenomenon[19], for instance youngsters who have experienced conflict within their families or have been involved with the police are more likely to join the forces[19] and are also, independently more likely to become homeless[3,4].

Method

To provide comprehensive knowledge of the links between homelessness, health, alcohol abuse and ex-service personnel a number of methods were employed.

1	Relevant, high quality articles were found by using the Internet search engines; Medline, OVID, Cochrane Library and the Lancet and BMJ archives. Limitations were imposed that the articles had to be in English, from the UK and printed in the last 10 years. Keywords used were Homelessness (AND) Health, (OR) Alcohol misuse, (OR) ex-service personnel, (OR) veterans. The top 15 abstracts from each search were then reviewed.

2	Governmental resources including the NICE database, NHS Evidence and Royal College of General Practitioners (RCGP) were also used, to gain an impression of the resources and guidance available pertaining to homeless and alcohol misuse issues. A number of newspaper websites were also searched, to gauge the media's view of homeless, ex-service personnel and those who abuse alcohol.

3	Local services were visited to gain an understanding of the local services provided in Merseyside. (A comprehensive list of the services visited is found in Appendix V)

4	Service users were interviewed to gain an insight into their stories and to understand the benefits and difficulties they experienced in accessing and using healthcare.

Results

Literature

There were a number of articles found during the literature search, which were reliable and informative. The majority reflected similar views and ideas, as reflected above in the introduction and discussed later.

Services

A number of services were visited (a list is described in Appendix VI). The most useful services were the homeless clinics with Dr Sutton, the Alcohol Brief Interventions at AddAction, and the Alcohol Specialists nurses at The Royal Liverpool and Aintree hospitals.

Case Studies

Two case studies were also taken, the first at Dr Sutton's Homeless Drop-In clinic and the second was a phone conversation from a man who used to serve in the armed forces and has since encountered many difficulties in life. The studies were an extremely useful resource to draw from to help develop areas of discussion and conclusions. They provided a first hand account of the effectiveness and accessibility of services and the main problems they have suffered from.

Media

The media portrayal of homelessness often varies depending on the message wanting to be expressed. Here are a number of news headlines from the local newspaper the Liverpool Echo[26]:

Homeless man banned from parts of Wirral after being given anti-social behaviour order - December 22nd 2009

Homeless man admits killing a Wavertree man – June 4th 2009

Four arrested after attacks on homeless men – July 20th 2007

An overriding theme is the way in which the homeless lack any form of identity in the media, simply referred to as 'a homeless person' and are often viewed in a derogatory light. This illustrates the way in which losing one's house can lead to losing ones identity and in turn ones self esteem and ability to cope.

Case Study 1

Sex: Male

Date of Birth: 15/09/65

Age: 44

Current Status: He suffers from back pain and the occasional abdominal pain associated with his gallstones. He has drunk since being admitted to hospital for the gallstones, he has found the detoxification quite difficult and has suffered symptoms of tremors but he was supported in the community on a Librium detoxification programme with his general practice, which he says has helped. The main difficulty with staying of the alcohol has been socialising with previous friends who still drink, so he has taken to avoiding situations where they are drinking to prevent him relapsing. He has found his appetite has improved recently, now eats full meals, though mainly ready meals due to the cost and easiness of them. He has had trouble sleeping for a long while, it is currently mainly due to his back pain he suffers from. In an average night, he goes to sleep around 11pm, and then wakes at 3am, where he stays in bed but often does not sleep until he gets up at 7am

Past History: five years ago he broke up with his girlfriend and long time partner, he feels this is where his problem drinking started, due to a combination of this event and his depression. He used to only drink socially, but the levels he drank gradually increased, he was eventually mainly drinking white lightening because it was so cheap, and would drink a number of bottles a day. Over the next five years he lost his job as car salesman and eventually became homeless three years ago, where he was homeless for six months. He found this time hard because he lost all contact with his family, as they would not speak to him. During this time he accessed the 103 Centre for support and attended the Windsor clinic via a referral from the lifestyle team and eventually regained some accommodation with the help of the services. He successfully detoxed two years ago after finding his new flat and was abstinent for a year and a half before he started drinking again in December.

Social History: He currently lives alone in a council flat. He has a high level of contact and support from his mother, which he is very grateful for. He smokes around 30 cigarettes a day and is on both income support and incapacity support. He currently feels that he would not be capable to work at the moment.

Forensic History: He was put on probation in December for assault.

Past Medical History: He has previously suffered from delirium tremens on a number of occasions over the past 5 years, but not for a while and suffered from acute pancreatitis in 2008 for which he was hospitalised for 5 weeks. He was hospitalised 4 weeks ago with gallstones, but was discharged without surgery.

Medications: Citalopram – for depression

Cocodamol – for back pain

Psychiatric History: He was diagnosed with depression 5 years ago, but feels he may have suffered from it for up to 9 years once the symptoms were explained to him.

Family History: His father died three years ago at a similar time to his best friend, which worsened his drinking. His mother is still alive, though suffers from a long history of depression.

Summary: He is a 44-year-old male, with a five-year history of alcohol abuse, depression and has previously been homeless and is currently unemployed on income and incapacity support. He is currently coping relatively well, in stable accommodation, with good family support and has not drunk alcohol since being admitted to hospital with gallstones four weeks ago.

Case Study 2

Sex: Male

Situation and History: During his life he has served and completed his contract in the armed forces and has since developed post-traumatic stress disorder, had times in his life when he was homeless, developed an alcohol addiction and is currently out of work.

Difficulties with the Case Study: At the introductory phone call with Mr S, he was unable to commit to a longer conversation and so we arranged a time where I would phone him back to discuss his history. He was more than happy to do this, but unfortunately he was then unavailable at any future date during the eight further times I tried to contact him, at times members of his family answered the phone and would ask me to call beck, but when I did the phone would ring-out.

Conclusion: This displays a classic example of some of the problems with care of people who have suffered from issues such as this man has. If it is so difficult to, stick to a minor commitment and find time to conduct a 15-minute phone conversation, it must be many times harder for more major commitments such as managing appointments and keeping to a care plan. I found this frustrating, but it must be much harder for those trying to provide a service for health and social care.

Discussion

Global Perspectives

For as long as there are people with homes, there will always be those without. As cultures and societies change throughout the world so too will the issues surrounding homelessness, and so must those with the responsibility of care change and adapt to provide support without discrimination or prejudice.

National Perspectives

The work provided by the charities for alcohol misuse problems and ex-service personnel, such as Crisis[6], St Mungo's, Shelter and Combat Stress[22] provide essential care and support. These services could not succeed without the care and devotion shown by these people. Each success story illustrates the reason for work like this.

When considering the guidance provided by the RCGP and the General Practitioners Committee of the British Medical Association, alcohol always seems to have the lowest priority when compared to other substances of abuse[27], often considered as an after though of management after all other problems have been solved[27]. This seems illogical, as service users with alcohol problems are the most destructive, with their substance abuse having the highest impact on their lives and families[11,12]. Not only does alcohol greatly affect health, but also social and psychological wellbeing[12]. It is the only substance of misuse a person can die from when withdrawing[28]. If policy is revised for care and management of substance misuse in the community, the management of alcohol misuse must be prioritised.

Leaving the Forces and Homelessness

Recently, measures have been put into place to reduce the level of homelessness of ex-service personnel. The Ministry of Defence's pre-discharge resettlement service[9], the Joint Service Housing Advice Organisation[20] and the Housing and Urban Development–Veterans Affairs Supported Housing[25] have all worked towards this goal. They provide assistance and information about accessing services, such as housing and support for mental health issues[25].

Unfortunately they still fall short, often due to inadequate support, removal of eligibility for conventional housing application or the failure to take into account people whose lives deteriorate later on, often due to aggravating factors associated with their previous experiences in the forces[25]. Even though the significance of housing difficulties has more recognition, other problems such as post-traumatic stress disorder still frequently go unrecognised and under-diagnosed, especially when associated with alcohol and substance abuse[19].

Fortunately there are a number of charities that do take this into account. Combat Stress and Veterans Aid provide excellent services[21], safe and supportive environments, residential and community support and information from specialised professionals[22].

Local Services – Differences in Care

Services in Merseyside exemplify the variety of ways alcohol misuse can be managed. The Alcohol Specialist Nurses at the Royal and Aintree hospitals demonstrate this. There are factors that dictate the differences in the methods they use, such as the quantity of clients and location, but the differences in practice go further than that. At Aintree the approach was far more supportive and personal. They knew a lot of the hazardous drinkers in the area, and kept track of where they were and how they were getting on, whereas in the Royal the patient load was so great that patients were often completely unknown. At Aintree, service users would attend clinics regularly as part of their rehabilitation, with the nurses providing an excellent and effective support network and the assurance that there was always someone they could talk. At the Royal clinics were only for community alcohol withdrawal and detoxification, with little to no follow-up or further support. The fact that two services within the same region work so differently from each other displays how differently their role can be interpreted.

The man in Case Study 1 had previously managed to abstain from alcohol but relapsed and was on his second attempt, a common picture in the management of alcohol abuse. Healthcare workers need to ensure they provide a supportive and non-judgmental environment for when relapses occur, to encourage future recovery and abstinence. Whether the practice at Aintree is better than the Royal or vice versa, or whether one way could have managed the situation in Case Study 1 more

effectively is difficult to gauge as each favours a different method of care in their different environments.

Local Services – Pros and Cons

The majority of services were very effective in what they aimed to do, and generally the service users were happy with what was available. However service users did find it difficult to discover what services were available and relevant to them. The services were designed to look at specific aspects of a person's care, such as their housing status, alcohol abuse problems or mental health, and users had to be cross referred between services to meet all their needs. It turned out to be easy for referrals to be lost or to take months to go through. Many service users find it difficult to access care in the first place and if help is not easily available in a timely manner, they may well give up on it altogether.

Local Services – Best Methods of Care

An addiction can never be cured, simply managed, for this; long-term provision of care is required. From the information gathered and services attended the most effective methods of alcohol detoxification and rehabilitation seem to revolve around time and continuity of care. Services have to be adapted to work with the patients who often lead chaotic lives and find it difficult to maintain contact with care services as shown by Case Study 2. Patients who stayed with services and had the opportunity to return to the same people during their care seem to do the best.

This was shown again and again by the work done by the Alcohol specialist nurses in Aintree, Nikki the inclusion officer and Dr Sutton at her Homelessness clinic. Though this approach may seem to be time consuming and ineffective, the amount of money saved by just one patient becoming abstinent for life could be thousands of pounds. One needs only to consider the money saved from preventing that person from developing alcoholic liver disease or even the money gained for the economy if that person reintegrates into society and starts working again. These services indicate the strong need for a multidisciplinary, holistic approach to care, with good communication between specialist services to provide joined-up care, perhaps by shared access to homeless service records. It should go without saying, homeless people deserve the same quality of healthcare as everybody else.

Conclusion

What is 'Homelessness' and what are the main health problems the homeless face?

- Homelessness is a multifaceted problem, with many complications. The majority of health problems are associated with poor health maintenance, such as poor diet, poor hygiene and poor foot care, which all in turn predispose to infections. Other problems associated with the culture surrounding homelessness, such as substance misuse and sexually transmitted diseases are discrete issues in themselves but they may precipitate, potentiate or prolong the state of homelessness.

What services are available for the homeless and how do they mitigate the barriers to healthcare that the homeless face?

- There are many local and national services that provide specialist care from people experienced in the field. They provide advice and support on all areas of health and social care. They act as advocates for vulnerable, homeless people.

What is the impact of alcohol and service in the armed forces on the homeless?

- Alcohol and previous service in the forces are both significant factors causing homelessness. People in the armed forces are trained to follow orders, dissuaded from independent thinking and often join from young ages and so on leaving often lack the necessary skills to cope with and manage in civilian life. These people often do not leave the forces without a home, but follow a downward spiral towards homelessness and the problems it brings with it.

Recommendations

Recommendations for the UK:

- National Guidance for the management for acute alcohol withdrawal, taking into account co-intoxication of other substances.
- Set up national conferences for specialists in homelessness, with the aim to provide better more uniform care across the board.
- More nationally accredited research into homelessness and a holistic approach to its care is required.

Recommendations for Merseyside:

- Improved communication between services, including the use of shared access to different homeless service records, to facilitate multi-organisational care.
- Local protocols on care provision and emergency management of alcohol misuse.
- Local services for ex-service personnel: the closest Combat Stress centre is currently in Shropshire.

Reflection

This module has helped me to develop an understanding of the main issues faced by the homeless, alcohol abusers and those ex-service personnel who become homeless. Previously I did not realise just how much a holistic, multidisciplinary approach is required, and just how entwined they all are. My main learning point is how significantly alcohol abuse can affect someone's life, and the extent to which it is overlooked in provision of healthcare services to the more 'glamorous' substances of abuse such as heroin or cocaine.

I feel I have only brushed the surface of these topics and would benefit greatly from more time and further study. This module has taught me a great deal about the problems of homelessness, but more importantly, the dedication and enthusiasm shown by the service providers has inspired me so much, I hope I can learn form this experience and that it has helped me in my development as a future doctor.

Strengths

This paper was strengthened by many sources it was able to draw from, with information from research articles, reports, reviews, national guidance, media resources, service experiences and case studies, each aspect of the area was covered.

Limitations

This essay was limited by a number of factors. There is little national protocol for the management of the homeless with alcohol abuse problems, therefore the provision of services and the types offered will vary in different areas. The services assessed within this essay were all in Merseyside and Cheshire and so are not representative of the care provided throughout the UK. The majority of research is American, but differences in culture, relevant problems and health and social care service provision makes the results incomparable with problems in the UK, let alone Merseyside.

Further Study

Homelessness is a vastly complex issue and so to gain a full understanding of the problems involved a detailed study must be undertaken of each issue. So far only a brief review of alcohol misuse, homelessness and ex-service personnel has been

conducted, and the next step would be to look into the other major issues of homelessness, such as mental health, substance misuse and blood borne viruses. This essay has focused on secondary and tertiary prevention and harm reduction; study of the available primary harm prevention would be worthwhile.

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Three Best References	
Reference	**Reason**
Crisis. *Falling Out: A Research Study of*	This is a fantastic website for information, resources,

Homeless Ex-Service People. www.crisis.org.uk	links to other sites and definitions within the topic of homelessness. The charity also seems to be very effective and of a massive help to the homeless.
How can health services effectively meet the health needs of homeless people? Wright NMJ, Tomkins CNE *British Journal General Practice* 2006: 286-293	This was a really useful resource for providing an excellent background to the problems faced by the homeless, and how they are handled in primary care.
Theorizing Continuity: From Military to Civilian Life. Highgate PR. *Armed Forces and Society* 2001; 27: 443-460	This was a fascinating article, a real eye-opener about the problems faced by ex-service personnel when they have to re-integrate back into society.

Three Best Books	
Bibliography	**Description**
Ethics and Human Sciences (Amarakone K, Panesar SS, Crash Course, Elsevier Limited 2006	A comprehensive summary of ethics and public health, this was helpful for looking into the ethics and practice of a doctor.
Homelessness: A Primary Care Response Wright N, Royal College of General Practitioners 2002	Provides a comprehensive text on homelessness in primary care, from the history of its development to the common clinical problems encountered in the field of homelessness. This provided essential background information for the essay.
Good Medical Practice, General Medical Council, 2006	This describes the ethical basis of the duties of a doctor and establishes professional standards for doctors in the UK

Ten Best Internet Resources

Internet Resources	Description
Alcohol Concern www.alcoholconcern.org.uk	Alcohol concern is the leading national agency on alcohol misuse; this site provides information, contacts, news and support.
Crisis www.crisis.org.uk	The national charity for single homeless people. With information about recent relevant national policies and how to effect change.
Veterans Aid www.veterans-aid.net	The site provide information about the organisation, where the organisation is based, what it does and a section focused on recent news and media.
Combat Stress www.combatstress.org.uk	Provides information about the charity, the service it provides.
Office of National Statistics www.neighbourhood.statistics.gov.uk	This site provides comprehensive data on the national Census and other statistical populations.
General Medical Council www.gmc-uk.org	Provides advice and information to ensure good medical practice in all areas.
Whitechapel Centre www.whitechapelcentre.co.uk	An information site for the service, with information about relevant national and local news.
Homeless UK www.homelessuk.org	This site provides links to information and research regarding homelessness and contacts for homeless services.
British Medical Journal www.bmj.org.uk	A site with large database of journals published by the British Medical Journal Association.
St. Mungos www.mungos.org	This is the site of the organisation of St. Mungos, which provides support and advice for the homeless.

Appendix II – Information Relevant to Special Study Module

During this special study module, I have come across a number topics which were originally unfamiliar to me, below are key definitions from this essay:

Universal Declaration of Human Rights: was drafted by the United Nations Commission on Human Rights and was adopted and proclaimed by the General Assembly of the United Nations (UN) on 10th December 1948[13].

General Medical Council: the governmental organisation in charge of regulating doctors, ensuring good medical practice[15].

Beauchamp and Childress, Four Ethical Principles:

- **Autonomy:** one should be allowed to reason and think about one's choices, to decide how to act and to act upon that decision[16].
- **Justice**: the fair treatment of equals within the health-care system[16].
- **Beneficence**: the principle of 'doing good', improving the welfare of patients[16].
- **Non-Maleficence**: 'not harming patients', to above all do no harm[16].

Statutory Homeless: the official number of homeless, quoted by the Office of National Statistics[7].

Non-Statutory (Hidden) Homeless: any person considered homeless who is not included in the Office of National Statistics (ONS) data; these include sofa surfers and rough sleepers who are in areas inaccessible by the ONS[7].

Rough Sleeper: someone who lives on the street, they may often more around, but also have regular places of relative comfort to stay. This is the stereotypical position of a homeless person[2,6].

Sofa-Surfer: a homeless person who alternates where they sleep, staying in friends and acquaintances houses, often on spare beds or sofas, hence the name. Sofa surfers do not always consider themselves homeless[2,6].

Homeless Household: one unit per family, the family may vary in size[8].

Hazardous Drinking: a pattern of alcohol consumption, which causes physical and mental harm[11].

Alcohol Abuse:

- Lower Risk: Men <3-4 units/day, Women <2-3 units/day[11].
- Increasing Risk: Men >3-4 units/day, Women >2-3 units/day[11].
- Higher Risk: Men >8 units/day, Women >6 units/day[11].

Librium: Chlordiazepoxide hydrochloride, a benzodiazepine used as an adjunct with acute alcohol withdrawal, along with thiamine and vitamin supplements to prevent, Wernicke's encephalopathy, seizures and death. It can cause respiratory depression if alcohol or other illicit drugs are used simultaneously[28].

Brief Interventions: provide a way to prevent people experiencing severe alcohol related problems and reduce the current harm among high-risk drinkers[12].

Ex-service Personnel: a person who has previously served in the Armed Forces.

Institutionalisation: the idea that someone loses or does not learn the skills of everyday living, such as buying groceries, cooking food, and cleaning, due to the environment they find themselves in taking over these duties for them[18].

Multiple Morbidities: the homeless often suffer from more than one problem at a time these are called multiple morbidities. For example someone may have alcoholic liver disease, depression and a chest infection, displaying three different morbidities, all linked together and impacting on each other. Homeless Ex-service Personnel in particular often suffer from multiple morbidities[3].

The **General Medical Council (GMC) Duties of a Doctor**[15] highlights the reasons work on homelessness is still required, as some of these duties are not always met.

All sections highlighted are areas that are at risk of being breached in relation to care of the homeless, and are relevant within in this essay.

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[15].

The Universal Declaration of Human Rights[13]

Every right represented by the Universal Declaration of Human Rights is relevant to each and every human being within the United Nations. There are however a number of acts, which are particularly relevant to the homeless. Unfortunately this is because these are the rights at highest risk of being breached in today's society.

- **Article 5**: No one shall be subjected to torture or to cruel, inhuman or degrading treatment, or punishment.

This right is a risk for the homeless as they may treated cruelly or unfairly by others, either because of societies fear instilled by the stereotype of a homeless person or due to their vulnerable situation.

- **Article 13**: Everyone has the right to freedom of movement.

This right may be breached by practical inability to fulfil this act, a person without a passport would simply be incapable to travel out of or back into the country.

- **Article 17**: Everyone has the right to own their own property.

Though there are services and procedures in place to enable homeless people to obtain homes there can be many barriers in the way which are not always due to the homeless themselves.

- **Article 21**: Everyone has the right to take part in the government of their country. The will of the people shall be the basis of the authority of government.

Those without an address or those in prison are unable to vote, therefore losing this right.

- **Article 25**: Everyone has the right to a standard of living adequate for, health and well being.

The homeless often encounter barriers to accessing healthcare, like discussed in this SSM, these barriers may be due to their own activities and attitudes but they can also be due to the attitudes of others, removing this right form them.

Appendix III – Statistics[7]

This table displays the homeless population in 2008/2009, in England, the North West and Merseyside, from the Department of National Statistics

Homeless	Cheshire & Merseyside (Strategic Health Authority)	North West (Region)	England (Country)
Statutory Homeless; Total	**4 451**	**13 750**	**112 900**
White/White British Origin	1 735	4 640	37 310
Mixed Origin	20	100	1 430
Asian/Asian British Origin	15	180	3 310
Black/Black British Origin	45	260	6 630
Chinese Origin or Other	22	150	1 930
Ethnic Origin Not Known	94	170	2 820
Temporary Accommodation; Total	**335**	**1 360**	**64 000**
Bed & Breakfast Style Accommodation	14	80	2 450
Hostel Style Accommodation	198	480	5 170
LA or RSL Owned Accommodation	85	510	10 480
Private Sector Housing	11	40	37 450
Other Types of Accommodation	27	260	8 460

Appendix IV - One-Week Project

A weeklong project focused on education about the problems of alcohol misuse in the homeless population.

Learning Objectives:

- What is homelessness?
- What are the major health problems for the homeless?
- How and why are homelessness and alcohol abuse related?
- How is alcohol abuse managed in the homeless population?

Reason for Project:

The management of homelessness and alcohol misuse is such a considerable issue and can at times seem overwhelming. The solving of issues surrounding homeless may seem insurmountable when faced with statistics and treatment failure rates. Therefore I believe only by personal participation in the management of these clients and the experience of individual success cases can someone see the true worth and importance of these services. That is why I believe a module like this should be a compulsory requirement of any medical course curriculum.

Time-table

The time-table shows what I believe to be an effective one-week project, incorporating all of the most beneficial aspects of the SSM I have undertaken. In the hope that students will gain an insight into the problems associated with and services available in Merseyside.

	Activity	
Day	**AM**	**PM**
Monday	Introduction Global Inclusion for Health C18 Stanlaw Abbey Business Centre Dover Drive Ellesmere Port CH65 9BF Tel. 0151 355 4008	FADE Library Regatta Place Brunswick Business Park Summers Road Liverpool L3 4BL Tel. 0151 285 4493
Tuesday	Shadow Alcohol Specialist Nurses in A&E and MAU Sarah Hayward Accident and Emergency Aintree Hospital Tel. 0151 529 2429 E-mail: sarah.haywood@aintree.nhs.uk	Visit the Basement, to talk to homeless service users, obtain case histories. 36 Bolt Street Liverpool L3 5LX Tel. 0151 707 1515 E-mail: support@basementdropin.org.uk
Wednesday	Attend alcohol detoxification and rehabilitation clinic. Sarah Hayward Ward 12 Aintree Hospital Tel. 0151 529 2429 E-mail: sarah.haywood@aintree.nhs.uk	Homeless Drop-In Clinic, Dr JM Sutton Cornerstone Surgery Fingerpost Park Health Centre St. Helens WA9 1LN Tel. 01744 738835

Thursday	Inclusion Officer Session, Alcohol Community Support 2nd Floor Millennium Centre St. Helens Tel. 0174 462 7400 Contact Nikki, through Dr Sutton's practice on Tel. 0174 473 8835	Inclusion Officer Session, use this time to talk to service users, about their stories. Nikki Newton Boy's and Girls' Club 19 Haydock Street Earlestown Newton-Le-Willows Tel. 0192 522 6149
Friday	Brief Interventions Team Harm Reduction Service 83-93 Stockbridge Lane Croxteth Merseyside L11 4SJ Tel. 0151 546 1175	Visit other services in AddAction, including the needle exchange service, clinics, relapse prevention and counselling services.

Appendix V – Presentation and Poster

Review of article: *How can health services effectively meet the health needs of homeless people?*

N Wright and C Tompkins

(British Journal of General Practice, April 2006)

Heather Sullivan and Janine Brazier

Homelessness and Health

Health problems facing homeless people:

- Access to health services, delays in presentation
- Increased substance abuse- drug and/or alcohol dependence
- Mental health problems
- Higher rates of smoking
- Poor nutrition
- Infectious diseases (HIV, Hepatitis, TB) higher prevalence

Primary care provisions

Need to have clear provisions in place for homeless people in order to avoid barriers in accessing services

- Mainstream GP with a specialist interest in homeless care
- Integrates care into community
- Specialised GP, registering only homeless people
- More intensive and focused care, only viable in large cities

Primary prevention

Important in a population, who as a whole, are more likely to contract disease and less likely to seek medical attention.

Includes;

- Vaccination schedules
- Needle exchange programmes
- Washing and laundry facilities
- Podiatry interventions

Management of co-existing problems

- Drug dependence- no clear cut answer. Important to get people into services. UK management is safe opiate medication substitute.
- Alcohol dependence. Supportive intervention programme and personal motivation, more strongly associated with recovery.
- Mental ill-health. Community treatment programme, active case management integration with social services. This results in fewer inpatient admissions and crisis intervention.

Stability. It is hard to begin up taking people who live unstable lives with no fixed abode, onto these intense management programmes

Conclusions

- Homeless people have multiple morbidity and premature mortality.
- This is in common with homeless populations worldwide
- Effective interventions do exist- needle exchange programmes, alcohol dependence
- Evidence base is limited. UK is lacking in research into the effectiveness and availability of outreach programmes

Heather Sullivan & Janine Brazier

Homelessness and Health

Special Study Module 6

Introduction

During our special study module we visited services throughout Merseyside, talked to service users and service providers and spent time researching literature on the topic of homelessness and *health in relation to alcohol* misuse. This poster summarizes the main issues we encountered.

Risk factors for homelessness

- Low social class
- Substance abusers
- Mental health
- Ex-servicemen
- Ex-Offenders
- Asylum seekers
- Childhood abuse
- Significant life events

Health problems faced by the homeless

- Poor general Health
- Poor Diet
- Poor Dental Hygiene
- Substance misuse
- Alcohol Abuse
- Sexually transmitted infections
- Barriers to healthcare access

Services available in Liverpool

- GPSI in homelessness
- Detoxification Services
- Rehabilitation centres
- Service drop-in centres
- Needle Exchange services
- Hostels for the homeless
- Alcohol Specialist Nurses
- Psychiatric Care

Conclusion

This SSM enabled us to gain an understanding of the barriers that the homeless experience in obtaining healthcare, and how services have been adapted to overcome this.

It has highlighted the need for better communication between services, more GPSI's in homelessness and especially the lack of national guidance for alcohol misuse and emergency management of drug overdose in the community.

Appendix VI – Resources

Below is a list of services visited during this special study module, in order of usefulness.

Merseyside Services	Description
Nikki – Inclusion Officer Alcohol Dependence Community Support 2nd Floor Millennium Centre St. Helens Tel.	A safe and friendly service for those with alcohol problems, providing a number of sessions each week, focused on socialising, and activities. Getting people active and out and about , instead of focusing on their problems. This includes arts and crafts, pool and darts and creating plays of key issues such as alcohol abuse and blood borne viruses. The service employs mentors for six-month periods, from those successfully abstinent from alcohol, to help and support others
Homeless drop-in clinic Dr JM Sutton Cornerstone Surgery Fingerpost Park Health St. Helens WA9 1LN Tel. 01744 738835	This is an open drop-in clinic for the homeless of St. Helens, as homeless or vulnerable housed people often find it difficult to make and attend appointments. It helps to integrate them into a registered general practice and improves access to primary care.
Alcoholic Specialist Nurse Sarah Hayward Accident and Emergency Aintree Hospital Tel. 0151 529 2429 E-mail: sarah.haywood@aintree.nhs.uk	The team provides this service each day. They consist of three specialist nurses, who visit the wards of Aintree Hospital, attending to any patient who has been admitted and is suffering from alcohol withdrawal, and those who are known to the team due to alcohol abuse. They give specialist advice to both the patients and the attending staff, to ensure effective care for the patients.

Alcoholic Specialist Nurse - Clinic Sarah Hayward Ward 12 Aintree Hospital Tel. 0151 529 2429 E-mail: sarah.haywood@aintree.nhs.uk	The team also provide a community alcohol detoxification and rehabilitation clinic. Service users may attend this clinic weekly for as long as they need. They provide support and advice for those who are currently going through detoxification and for those in rehabilitation.
103 Centre Phil Clarke Church Street St. Helens WA10 1DQ	This is an open centre for the homeless and is run by both paid and voluntary workers. It is safe and friendly environment where service users may collect their post and get advice, have showers, wash their clothes and on Mondays, Wednesdays and Thursday they can eat food provided there.
Alcoholic Specialist Nurse – Clinic Dr Lynn Owens Room 1 Ward 4Y Royal Liverpool Hospital Tel. 0151 795 9395 E-mail: lynno@liverpool.ac.uk	This service provides a community alcohol detoxification clinic, held in A&E. Service users may be referred to or self-refer to this clinic. They provide a day-by-day prescription of Librium to patients who are showing signs of withdrawal. The patients must attend each day for their next prescription of Librium.
Stoak Lodge Stoak Gardens Ellesmere Port CH65 0DW Tel. 0151	This is a homeless hostel, run by a number of paid employees and volunteers. This hostel caters for single men, women and families. Exclusion criteria include anyone with GBH or associated offenses, especially those relating to children. Service users are allowed to drink on the premises but drugs are prohibited.

Alcohol Team AddAction, Harm Reduction Service 83-93 Stockbridge Lane Croxteth Merseyside L11 4SJ Tel. 0151 546 1175	This team offers a support and brief interventions service; they have some clients who visit regularly and some emergency attendees as clients. The service is accessed by a self-referral. They help service users access further support to suit their needs and offer advice where required.
Windsor Clinic Hope House 26 Rodney Street Liverpool Merseyside L1 2TQ Tel. 0151 709 0516	This facility provides an in-house alcohol detoxification clinic and a community drug team. The community drugs team consists of a specialist doctor and a number of key workers, focusing on heroin users and mainly monitors their methadone prescriptions and how they are coping.
SureStart Stanney Lane Whitby Lodge Ellesmere Port CH65 6QY Tel. 0151 355 2168	This centre has all the aspects of a typical SureStart centre, which help and support the community of Ellesmere Port. It also has an award winning allotment, run and tended by volunteers, it helps to develop the community and gives some service users an aim for the day, a sense of fulfilment and responsibility.
Needle Exchange Service AddAction, Harm Reduction Service 83-93 Stockbridge Lane, L11 4SJ Tel. 0151 546 1141	This service is based at the AddAction centre in Croxteth, with the aim of reducing harm. Not only do they provide needle exchange kits, but also non-judgemental advice and support for the service users who attend regularly. This service also works on a self-referral system.

Other Services

There are a number of other services, which I came across when talking to service users and service providers but was unfortunately unable to attend to due time constraints. These are included in the table below.

The Basement Liverpool	This service concentrates on advice and advocacy for the homeless in Liverpool. Providing council and helping them access the appropriate services for their needs.
The YMCA Liverpool	A hostel based in Liverpool for the homeless.
Veterans Aid London	A charity run support service for ex-service personnel.
Combat Stress Shropshire	A charity run community support service for ex-service personnel with mental health problems and substance misuse issues.
Gateway Drop-In Centre Liverpool	A fast track community detoxification and access clinic, with signposting into treatment services.

Appendix VII - Special Study Module Time Table

Date	AM	PM
5th July – Monday	Attended introduction, Global Inclusion and visited a Dual Diagnosis Autism Sheltered Accommodation, Ellesmere Port	Visited Stoak Lodge, Ellesmere Port and visited Surestart, Ellesmere Port
6th July – Tuesday	Attended convenor meeting, Dr O'Neill, visited the Needle Exchange service AddAction, Croxteth	Attended a Drug-Misuse Information Presentation, AddAction, Croxteth
7th July – Wednesday	Attended 103 homeless centre, St. Helens	Attended homeless drop-in clinic with Dr Sutton, Cornerstone Practice, St. Helens
8th July – Thursday	Shadowed Alcohol Brief Interventions team AddAction, Croxteth	Shadowed Alcohol Brief Interventions team AddAction, Croxteth
9th July – Friday	Write-Up	Write-Up
12th July – Monday	Shadowed ward based work, Alcohol Specialist Nurses, Aintree	Shadowed ward based work, Alcohol Specialist Nurses, Aintree
13th July – Tuesday	Attended an Alcohol Detoxification Clinic, Alcohol Specialist Nurses, Royal Liverpool Hospital	Background reading and literature research
14th July – Wednesday	Attended Windsor Clinic, Hope Place, Liverpool	Attended Windsor Clinic, Hope Place, Liverpool
15th July – Thursday	Attended an Alcohol Clinic, Alcohol Specialist Nurses, Aintree Hospital	Background reading and literature research

16th July – Friday	Attended convenor meeting, Dr O'Neill, AddAction, Croxteth	
19th July – Monday	Write-Up	Write-Up
20th July – Tuesday	Write-Up	Write-Up
21st July – Wednesday	Write-Up	Write-Up
22nd July – Thursday	Attended a community inclusion session, run by Nikki, Millennium Walk-In centre, St. Helens	Attended convenor meeting and presentation, Dr Sutton, Cornerstone Practice, St. Helens
23rd July – Friday	Attended convenor meeting, Dr O'Neill, Global Inclusion, Ellesmere Port	
26th July – Monday	Visited FADE library	
27th July – Tuesday	Attended clinic with Dr Harding (GPSI in drug misuse) in Morecambe	Attended clinic with Dr Harding (GPSI in drug misuse) in Morecambe
28th July – Wednesday	Write-Up	Write-Up
29th July – Thursday	Write-Up	Write-Up
30th July - Friday	Handed in SSM	