"And homeless near a thousand homes I stood,
And near a thousand tables pined and wanted food."

William Wordsworth
Abstract

With a lack of accurate statistics it is difficult to assess the true scale of homelessness in the UK, but what is clear is that the homeless are a venerable group and one which is in great need. Substance abuse and morbidity rates were found to be high in the homeless population due to their chaotic lifestyles; this presents a daunting task for health care professionals who face the task of treating the homeless, as a lot of time needs to be invested in them. This can cause difficulty in gaining access to health care.

Introduction

This paper is set out to define homelessness and substance abuse, and explore the services offered to address the health and social issues relating to substance abuse. The paper will focus primarily on the services offered in Chester, Birkenhead, and St. Helens, but will draw on information from national and international studies.

Method

The databases AMED (1985 to 2009), BNI (1985 to 2009), EMBASE (1980 to 2009), MEDLINE (1950 to 2009) and the Cochrane Library were searched using key words relating to homelessness and substance misuse. Grey literature was also accessed from the Fade Library. Information was also gathered through meetings with key workers, services workers, service users, and General Practitioners whose surgeries offered special services to the homeless. The book Homelessness; A Primary Care Response(1), and the Department of health booklet, Drug misuse and dependence; UK guidelines on Clinical management(2), have been used for research. The key article chosen for this paper is “How can health services effectively meet the health needs of homeless people?”(3)

Homelessness

“Being Homeless” has a board meaning, encompassing a wide range of housing situations, in this paper the term homelessness will relate to both statutory and none statutory definitions given. The “Homelessness Task Force” definition of

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homelessness from the Scottish Executive(4) is a statutory definition and should involve those, (see below in figure 1)

- without any accommodation in which they can live with their families;
- who cannot gain access to their accommodation or would risk domestic violence by living there;
- whose accommodation is 'unreasonable', or is overcrowded and a danger to health; and
- whose accommodation is a caravan or boat and they have nowhere to park it.

Non-statutory definitions of homelessness are given by Fitzpatrick et al(1) and includes the housing situations, (see figure 2)

1. “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.
2. “Houselessness”, a wider term that includes those living in emergency and temporary accommodation provided for homeless people; e.g. night shelters, hostels and refuges. This category also covers 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.
3. Those who have insecure or impermanent tenures; e.g. staying with friends or relatives on a temporary basis, tenants under notice to quit and squatters.
4. Those who live in “intolerable” housing circumstances. This includes people in severely crowded or substandard accommodation and also people in situations where there are threats to personal safety or psychological wellbeing
5. “Concealed Households”, where such households are involuntarily sharing accommodation on a long-term basis because they cannot secure separate housing.

Due to the transient nature of the homeless population and their social exclusion it is hard to find accurate statistics on the true number of how many homeless there are in the Britain. The charity shelter estimate that there are “380,000 hidden homeless”(5)

Homelessness and Health
From my own clinical experience on a service learning visit to a GP practice it was clear to see that the homeless suffer from higher rates of morbidity than the general population. This observation is supported by my key article which displays the common “diseases found among homeless people” in the Figure 3 below.
### Figure 3

- **Drug dependence syndrome** — most commonly heroin or cocaine
- **Alcohol dependence syndrome**
- **Mental ill-health**: schizophrenia, depression and other affective disorders, psychosis, anxiety states, personality disorder, earlier onset of drug misuse and severity of alcohol use
- **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
- **Adverse effects of illicit drugs**
  - Heroin-related death secondary to respiratory coma\(^{37-39}\)
  - Cocaine — case reports of toxic inhalation leading to pulmonary inflammation and oedema ("crack lung")\(^{40}\), agitation and paranoia due to acute toxicity and thromboembolic events\(^{37-39}\)
  - Adverse effects of alcohol overuse\(^{37-39}\)
  - Cardiological — cardiomyopathy
  - Neurological — peripheral neuropathy, erectile dysfunction, Wernicke's encephalopathy, Korsakoff's psychosis, amnesic syndrome, cerebellar degeneration, alcohol withdrawal seizures
  - Gastrointestinal and hepatobiliary — hepatitis, liver cirrhosis, pancreatitis, gastritis, peptic ulceration, oesophageal varices, carcinoma of the oesophagus and oropharynx, cardiomypathy
  - Metabolic — vitamin deficiency (particularly thiamine), obesity
  - Psychosocial ill-health — including depression and suicide, sexual dysfunction, alcoholic hallucinosis, marital, family or employment breakdown
- **Complications of injecting illicit drugs**
  - Blood-borne virus infections (see below)
  - Skin commensals or pathogens causing septicaemia, encephalitis, endocarditis, cellulitis and abscesses or deep vein thrombosis (a combination of poor hygiene and repeated skin puncture)
  - Tetanus — possibly secondary to injecting contaminated drugs\(^{37-39}\)
- **Infections**
  - Blood-borne virus — hepatitis B, C or HIV
  - Hepatitis A\(^{40,41}\)
  - Skin infections — cutaneous diphtheria\(^{40}\), impetigo, viral warts
  - Secondary to louse infestations — typhus (caused by *Rickettsia prowazekii*), trench fever (caused by *Bartonella Quintana*) or relapsing fever (caused by *Borrelia recurrentia*)\(^{37,40-42}\)
  - 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 influenzae* b, aspiration of anaerobes or *Pneumocystis carinii* (the latter occurring almost exclusively in immunocompromised patients).
  - Influenza
  - Minor upper respiratory infections
  - Tuberculosis (often latent)
Causes of high morbidity

There are a number of factors which contribute to higher rates of morbidity amongst rough sleepers. Poor nutrition, lack of hygiene, and the complications of illicit drug and alcohol abuse are all given as reasons in the key article(3). Studies have also shown that higher rates of respiratory disease can be attributed to the high prevalence of smoking amongst the homeless which can be as high as 80%(6). Homeless and substance abuse can also drastically reduce life expectancy, a heroin user who regularly take large amounts of different drugs, “face a risk of death which may be 20 to 30 times higher than non-drug users in the same age range”(7)

Factors this paper will focus on

Due to the constraints of word count and time restrictions, this paper will look into drug and alcohol dependence, the services offered to combat these addictions in Chester, Birkenhead and St. Helens.

Substance abuse

The World health Organisation defines substance abuse as,

“Harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs”(8). Taking psychoactive substances such as alcohol and illicit drugs can lead to a dependence syndrome, this is “a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state”(8)

The prevalence of alcohol addiction amongst the homeless is high as high as 48.7%(9). The health risks associated with chronic drinking and illicit drug taking (such as injecting heroin) are shown in the figure 4 below(10).
These are all serious health problems which not only impact the individual but also their society, so it is clear that providing treatment options for a homeless patient’s addiction is necessary and beneficial for a wide variety of people. Primarily it benefits the patient in preventing future morbidity so can improve quality of life. It also benefits the NHS as money which would be spent on the treatment of chronic substance abuse is saved. Effective drug and alcohol treatment has also been show to save society money as it reduces crime rates.

In total “For every £1 spent on drug treatment there is a saving of £9.50 is saved in crime and health costs”.(11)

Treatment for substance abuse and the homeless

The paper has already shown that high rates of morbidity, mortality, and substance abuse exist in homeless communities; however during Service Learning Visits (SLV’s) it became apparent that although there are services which are effective at
dealing with these medical and socially needs, they all seem to be under resources, underfunded. This observation fits in with the inverse care law described by Julian Tudor Hart, the law states that, “The availability of good medical care tends to vary inversely with the need for the population served” (12).

The word “chaotic” was often used to describe the homeless with substance abuse problems during SLV’s. The instability of having no fixed abode, being unsure on where they will steep next and the priority of getting their next hit or drink cause poor compliance to treatments and missed appointments with health care workers. It is partly this chaos surrounding their lives that makes treating any medical or social problem more difficult than an “average” patient. The building of service-patient relationship also seemed more difficult with a drug user; due to a lack of trust extend from the service user, probably caused by the illicit nature of the service user’s activities.

After talking to service users and service providers, it is clear that very often unless the underlying reasons why an individual is substance abusing are addressed, any successes dealing with the addiction are short lived. Such reasons maybe a history of an abuse childhood, avoidance of issues, or mental health problems (dual diagnosis). “Dual Diagnosis describes people who have mental health problems and drug or alcohol problems. The mental health problems may include schizophrenia, depression, bipolar disorder or Personality Disorder”. (13) Therefore it is essential that a combination of treatments should be offered to address fully the complex needs of the patient if treatment is going to effective in the long term. It is also important to offer a patient choice of treatments as stated in the duties of a doctor outlined by the General Medical Council, “Work in partnership with Patients, -Listen to a patients and respond to their concerns and preferences” (see “duties of a doctor” in appendix). It also important to respect the patient’s autonomy, only treat when the patient is ready and is willing to give informed consent. This is important as autonomy is one of four principles of medical ethics (autonomy, beneficence, non-munificence and justice) which help health professionals make decisions when faced with a moral dilemma. The following are all treatment offered for substance abuse.
Heroin

Pharmacological interventions such as prescribed methadone can be used to attempt to stabilise the patient’s lifestyle, drug intake and to avoid the dangerous behaviours of injecting.(2) “Methadone, a synthetic narcotic used to treat opiate addiction, is a long acting opiate that shares most properties of heroin”.(14) Taking methadone has been shown to reduce the harm associated with injecting drug use, (as it is taken orally as a liquid) such as deep vein thromboses, vein damage and the blood viruses HIV, hepatitis B, and Hepatitis C. It was clear from speaking to service users taking methadone was helping their life, for example it made association with drug dealers unnecessary, brought them into contact with other important health and social services, decreased the chance of overdose, and reduced illegal active such as shoplifting to fund their heroin addiction. Once prescribed methadone patients seemed to fall into one of two camps, firstly those who wanted to be maintained on a dose of methadone indefinitely and those who once sable wanted to reduced their dose down with the goal of eventually becoming abstinent from opioid usage. Initially methadone is prescribed at low doses of around 10-30 mg which can be raised until the patient is feeling comfortable and does no longer require illicit heroin.(2) If the patient feels they would ready to become abstinent a detoxification can be organised. Commonly this will be over 12 weeks with a reduction of 5 mg to their daily prescription per week.

Alcohol

On a SLV in St. Helen’s a General Practitioner whose surgery I observed, explained the importance of psychosocial treatments to motivate a patient and help them become successful in their desire to become abstinent from alcohol. The motivational treatments are then continued while the patient goes through a detox. Pharmacological interventions include drugs like acamprosate, which can help prevent relapse and maintain abstinence.
The process of changing behaviour (such as becoming abstinent from an addictive substance) has been split into five stages by Proschaka and DiClemente(1). As shown below in Figure 5.(15)

<table>
<thead>
<tr>
<th>Stages</th>
<th>Characteristics</th>
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<tbody>
<tr>
<td>Precontemplation</td>
<td>Individual does not intend to change behavior in the next six months</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Individual is strongly inclined to change behavior in the next six months</td>
</tr>
<tr>
<td>Preparation</td>
<td>Individual intends to act in a near future (generally next month)</td>
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<tr>
<td>Action</td>
<td>Behavior has already been incorporated for at least six months</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Action already happens for over than six months and the chances to return to old behavior are few</td>
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Moving from one stage to the next takes motivation and support which can be provided through a variety of methods.

Motivational Interviewing
This counselling therapy where the therapist motivates the patient want to change by discussing the benefits of a particular behaviour compared with its unfavourable side. The discussion allows the patient to view their behaviour in a broader light, highlighting the negative aspects for themselves. This can strengthen their will to change a particular behaviour.

Cognitive behavioural therapy
This is another talking therapy that enables patients to think and act in a different way.(16) The theory behind this intervention suggests that thoughts influence outlook, mood, and behaviour. Therefore in practise teaching a patient to have a less negative thought process and to focus on their strengths should cause their behaviour to become more positive. This re-education of thought stood out during SLV’s as a
critical step in allowing a patient see the situation they are in as one in which they can be helped out of, through work done by themselves and substance abuse services.

The twelve step program

Initially used to aid recovery from alcohol addiction, it is now used more broadly in achieving abstinence from alcohol drug abuse, and any other addictive behaviour. As the name suggest it is made up of twelve steps, which are worked through in sequentially, in order to achieve freedom from your addiction. The program lasts around six months to complete and does offer “not merely a way to stop drinking, but they became a guide toward a new way of life”(17). Having spoken with service users, I have found anecdotally that the spiritual nature of the program can be extremely effective for those who find they can accept a power greater than ourselves, but turn away those who do not wish to. The 12 steps are show below in figure 6

<table>
<thead>
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<th>Figure 6</th>
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<tbody>
<tr>
<td><strong>The 12 Steps</strong></td>
</tr>
<tr>
<td><strong>Step 1</strong> - We admitted we were powerless over our addiction - that our lives had become unmanageable</td>
</tr>
<tr>
<td><strong>Step 2</strong> - Came to believe that a Power greater than ourselves could restore us to sanity</td>
</tr>
<tr>
<td><strong>Step 3</strong> - Made a decision to turn our will and our lives over to the care of God as we understood God</td>
</tr>
<tr>
<td><strong>Step 4</strong> - Made a searching and fearless moral inventory of ourselves</td>
</tr>
<tr>
<td><strong>Step 5</strong> - Admitted to God, to ourselves and to another human being the exact nature of our wrongs</td>
</tr>
<tr>
<td><strong>Step 6</strong> - Were entirely ready to have God remove all these defects of character</td>
</tr>
<tr>
<td><strong>Step 7</strong> - Humbly asked God to remove our shortcomings</td>
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<tr>
<td><strong>Step 8</strong> - Made a list of all persons we had harmed, and became willing to make amends to them all</td>
</tr>
<tr>
<td><strong>Step 9</strong> - Made direct amends to such people wherever possible, except when to do so would injure them or others</td>
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<tr>
<td><strong>Step 10</strong> - Continued to take personal inventory and when we were wrong promptly admitted it</td>
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<tr>
<td><strong>Step 11</strong> - Sought through prayer and meditation to improve our conscious contact with God as we understood God, praying only for knowledge of God’s will for us and the power to carry that out</td>
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<tr>
<td><strong>Step 12</strong> - Having had a spiritual awakening as the result of these steps, we tried to carry this message to other addicts, and to practice these principles in all our affairs</td>
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</table>
Comparing services observed during Service Learning Visits

Over the first two weeks of my SSM I enjoyed a busy schedule observing both state led and charity driven services for homeless clients. The areas I compared where Chester, St. Helens, and Birkenhead. Although all areas provided social, housing, and medical help to the homeless, they each offered it via different routes and in quantities. It was clear that all of the services I observed were trying to provide place of stability, support, and nutrition to remove the client from the chaotic street environment.

In Chester the services are mainly charity lead, with “Chester Aid to the Homeless (CATH)” leading the way. This charity provides a day centre, an emergency shelter with eight beds called Crispin House, a twenty two bed hostel called Roodee House, and five move-on homes which have a total of twenty four beds between them. The service works well as it is very accessible, due to the day centre being open seven days a weeks. It was apparent that even the more chaotic homeless and true rough sleepers were more likely to access side services that the day centre made available, such as on sight medical care, than other day centres we visited, I think this was a result of the strong relationships which had build up between the service provides and the service uses. CATH provides a journey from rough sleeping to mainstream housing, but does if in several steps, using their hostels and move on accommodation. There is no set time limit for how long the journey should take as progression is only down readiness of the individual, for some it is a few months and others several years. CATH offers educational course in English, maths, and computing, improving a clients CV so their chances of finding a job and supporting themselves are improved. CATH also has strong links with the drug and alcohol services provided by Addaction, a drug and alcohol treatment charity, and Aqua House where clients can be referred for harm reduction and methadone treatment etc. Chester also has a GP practice specifically for the homeless.

St. Helens currently has a day centre for the homeless offering, educational courses, housing advice, and referral services which are similar to those in Chester. However recent funding cuts to the day centre have reduced it to being open three days a week. Speaking to a long time service user, it was clear that having the day centre closed four days a week was not only preventing access to that particular service but all of
the services which it referred to, in effect closing the door on all services in the process of being housed. St. Helen’s does however poses a GP surgery one afternoon a week which is set aside for homeless patients.

Birkenhead boasts the Charles Thompson Mission, an impressive church lead service, offering bedding, clothes, advice and providing over 20,000 meals per year to the homeless and needy. I also visited The Ark, a church lead hostel, with excellent facilities and similar services and pathways to Chester which were helping the homeless into mainstream housing and treatment plans for their problems.

Out of all of the areas visited on SLV’s, the church lead services in Birkenhead were in my opinion an excellent example of how the issues surrounding homelessness should be dealt with. The Birkenhead services are also a great example of how the voluntary sector can play an important role in service development, as once the voluntary services prove effect they may be taken on by the government and rolled out across the country.

Life history of a service user

Taking a life history of an ex-service user (Mr A) showed me how the effective the current services in Chester, and the surrounding area, are in helping someone transform their life from total drug fuelled chaos in a situation of homelessness, to a stable functioning member of society in mainstream housing.

Although raised in an affluent household, Mr A had a difficult childhood being raised by his father after his parents’ marriage broke down when he was nine. His father was an alcoholic and at the age of thirteen his father died from the effects of the drink. He now went to live with his mother, but rebelled against the strict nature of his stepfather who would respond to unsatisfactory behaviour with physical violence. At fifteen Mr A left school and started training to become a joiner, shortly after he ran away from home and “sofa surfed” between friends. After some minor scrapes with the law and being thrown out of a probation hostel, Mr A lived in a B&B for a few years while become trying out and becoming addicted to more drugs, such as cannabis, speed and LSD. Over the following years Mr A got heavily addicted to hard drugs and injected heroin regularly. Whilst using hard drugs he studied and got a degree from Plymouth University, but became homeless again once he graduated. When homeless Mr A moved around the country and successfully
detoxed from drink and drugs using Subutex before coming to Chester where in 2003 was helped by CATH. After Mr A was finally successfully re-housed in 2008 he completed an Intuitive Recovery course which was suggested by Aqua House. Intuitive Recovery is in Mr A’s words “a re-education, which teaches you to stop choosing to remain addicted”. Intuitive Recovery has been successful for Mr A, and now no longer an addict, he wants to use his degree to get back into work.

Review of Key Article

The key article chosen was “How can health services effectively meet the health needs of homeless people?”(3). Although the article does not directly focus on substance abuse there is a large section on the management to Drug dependence which is highly relevant to this paper. The article also had relevant information on common morbidities faced by the homeless, which I could include in the paper. The paper was set out in a clear and accessible way which made it easy to read, and being from the British Journal of General Practice in 2006 also made the article reliable and recent. My only critic of the article is that considering how common a dual diagnosis is amongst homeless people, not a lot is said about how health services which can effectively meet their needs.

Conclusion

This paper concludes the following

• As homelessness is such a large issue more should be done not only to help prevent homelessness and in re-housing, but in changing the public’s negative perception of the homeless. This may allow the homeless to feel less socially excluded.

• The chaotic nature of the homeless with substance abuse problems put them at most need, but due to nature of their situation it is often difficult for them to comply with medical advice. This problem needs to be addressed and healthcare professionals need to be patient and supportive, toward clients of a service.
• Offering substance abusers a choice of treatment plans and involvement in their treatment is important to the level of success the treatment will yield.

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Acknowledgements

I would like to thank the course convenors Dr O’Neill and Dr Dillon for giving me the opportunity to gain the insight into Homelessness I have received over the past four weeks, and Charles Flood the student facilitator for arranging an interesting and thorough timetable. Thanks must also be paid to the service providers and service users who have given up their time to speak to me about this paper.
Good Medical Practice (2006)

The duties of a doctor registered with the General Medical Council

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

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

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions
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<tr>
<th>Week 1</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
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<th>Friday</th>
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<tbody>
<tr>
<td>A.M.</td>
<td>Meeting with Lisa Jones, introduction to SSM</td>
<td>Meeting with Student Facilitator Charles Flood, and Dr O’Neill the course convenor</td>
<td>Meeting ex-service users in Chester</td>
<td>Introduction to the Fade Library by Kieran Lamb,</td>
<td>Visit to the Charles Thompson Mission and the Ark in Birkenhead.</td>
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<tr>
<td>P.M.</td>
<td>Joe McGovern talk about drug services. Talk by Viv Valente, Deputy Director of CATH</td>
<td>Tour of Crispin House, Roodee House, Harold Tomlins Centre</td>
<td>Visit to Addaction in Chester</td>
<td>Review of SSM with Dr Dillon</td>
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<tr>
<td>Week 2</td>
<td>Free time for Research</td>
<td>Visit to Aqua House in Chester</td>
<td>Visit to St. Helens Day Centre</td>
<td>Research</td>
<td>Visit to the Kevin White Unit, and talk by Joe Holman</td>
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<tr>
<td>A.M.</td>
<td>Free time for Research</td>
<td>Journal Club with Dr O’Neill and review of course</td>
<td>Visit to Dr. Sutton’s GP Practice for homeless</td>
<td>Free time for Research</td>
<td>Free time for Research</td>
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<tr>
<td>P.M.</td>
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<td>Free time for Research</td>
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<td>Writing SSM</td>
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<tr>
<td>Week 3</td>
<td>Free time for Research</td>
<td>Mid Course Evaluation with Dr O’Neill in Chester</td>
<td>Free time for Research</td>
<td>Writing SSM</td>
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<td>Week 4</td>
<td>Writing SSM</td>
<td>Writing SSM</td>
<td>Writing SSM</td>
<td>Final Review of course with Dr Dillon</td>
<td>SSM finished and handed in</td>
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