Do the homeless have equitable access to healthcare?

Jesal Gohil

“Yes I am homeless, but not hopeless.
I am needy, but not greedy
As I stand alone, I hear your whisper,
But it is not in kindness.
And as I stand alone, you avoid me like a plague.
But as I stand alone your prejudice is everlasting
I will not cry, I will not hate
As I talk to god, I ask for strength in this cruel and wicked world.
And this I concentrate on as I stand alone”

August Mmallory. As I stand alone in Street Verses by Street Sense
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Learning objectives

1. To understand the causes of homelessness and the consequences this brings and also to review the current literature available.
2. To understand the main clinical problems among the homeless, with particular attention to mental health, substance misuse and hepatitis C.
3. To explore ways of distributing health services to the homeless in an effective manner.
4. To be aware of substance misuse by medical students and doctors, and finding ways of managing stress and preventing burnout.

Acknowledgement

It has been a privilege to be part of this course and I would like to thank Dr O’Neill and Dr Dillon for compiling an excellent SSM. Also I would like to extend my gratitude to the numerous organisations that gave us the opportunity to visit. Finally, thank you to Charles Flood for his passionate dedication to this project.
ABSTRACT

Background
Homelessness is a local, national and global issue. The homeless experience “physical, mental and social” problems and many are deeply involved with substance misuse. Despite the aims of the NHS to supply “good health care to all”, the homeless find difficulty in accessing health services.

Aim
Do the homeless have equitable access to health care?

Method
Review of white literature by searching MEDLINE, CINAHL, PsychINFO, EMBASE using the keywords homelessness, ‘and’ equity, ‘and’ primary care, ‘and’ stigma. The internet was searched using the same keywords. Grey literature recommended by Dr J O’Neill and librarians was also reviewed. Service learning visits to organisations in Liverpool, Chester, Birkenhead and St. Helens. An ex service user was interviewed informally, in order to gain a case history.

Results
The homeless face numerous barriers in accessing healthcare. Stigma, complex health problems and no address are just a few reasons for the low levels of registration at GP surgeries. Additionally, other needs such as food and warmth take a higher priority than confronting poor health. Despite this, progress has been made in primary care with more mainstream general practises caring for homeless patients, and the installation of general practices dedicated only to homeless healthcare. Homeless outreach programs targeting severe mental illness are effective, yet are excluding individuals experiencing anxiety and depression. It is evident the inverse care law continues to exist.

Conclusions
The homeless exhibit complex medical problems which are not being resolved. The barriers preventing equitable access needs to be addressed. Doctors must be urged to maintain professionalism and not act on stereotypical impulses. Furthermore, a greater emphasis in “multi-agency cooperation” is required, to ensure the full health potential of a patient is maximised.
INTRODUCTION

In the third quarter of 2008, 14,340 people were confirmed to be homeless in England. A common issue surrounding the accuracy of homeless data, is determining what can be defined as homelessness? The RCGP identified three categories:

1. “Statutorily accepted homeless people - mainly families with children or pregnant women”.
2. “Rough sleepers and hostel dwellers. This group is excluded from government statistics”.
3. “All other groups in housing need”.

However, many of these homeless individuals find difficulty in accessing health care, despite exhibiting poor health.

There are two types of access. On the one hand there is the theoretical ideal set by the NHS which seeks to “provide health care for all”. Whilst on the other, there is the inequitable reality faced by a majority of the homeless. The GMC stresses the need for doctors to “treat patients with respect” and not allow their views regarding “age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social status”, affect their medical practice. However, many homeless individuals fall victim to discrimination in primary and secondary care. This has led to a loss of faith in the health care system, and many homeless remain untreated.

The NHS was founded on the idea of providing good “healthcare for all”. Yet 60 years on, what we find is a nation that struggles to “meet the needs of everyone” and has resulted to health inequalities. The World Health Organisation defines health inequalities as

“differences in health status or in the distribution of health determinants between different population groups.”

Despite guidance from Beauchamp and Childress’s four principles of medical ethics, the principle of justice is failing to be met. Justice has been defined as:

“treating equals equally and unequals unequally but in proportion to their relative differences”.
Distributive justice has been defined as:

“The justified distribution of benefits and burdens in society”

Health resources in the UK are distributed according to need. As Goodwin claimed, “equity in healthcare is centred upon need.” The homeless present great need, but are failing to be provided with adequate health services. This approach sharply contrasts with the free market model implemented by the USA, where people purchase “services by means of wealth acquired through their own legitimate efforts.” However, this approach places the homeless population at a high risk of jeopardy due to difficulties in obtaining finances and health insurance.
METHOD

The method I used is described below:

Review of white literature by searching MEDLINE, CINAHL, PsychINFO, EMBASE using the keywords homelessness, ‘and’ equity, ‘and’ primary care, ‘and’ stigma. The internet was also searched using the same keywords. Grey literature recommended by Dr J O’Neil and librarians was also reviewed. Service learning visits to organisations in Liverpool, Chester, Birkenhead and ST Helens were conducted. Finally an ex service user was interviewed informally, in order to gain a case history.
RESULTS

The Inverse Care Law

A core principle of the NHS is to supply good health care on the “basis of clinical need”\(^2\). The communities in the UK which experience poverty have a strong need to receive healthcare. Poverty has been defined as

“\begin{quote}
The lack of resources to obtain the types of diet, participate in the activities and have the living conditions and amenities which are customary, or at least widely encouraged or approved, in the society to which they belong\end{quote}\(^{13}\)

However in 1971, Julian Tudor Hart published an article which claimed the existence of an inverse care law. He described how “the availability of good medical care tends to vary inversely with the need of the population served”\(^{14}\). As the results of the Joseph Rowntree foundation highlighted, there is a low number of doctors and other professionals working in deprived areas\(^{15}\). The outcome is that there is poor access to quality health services, a theory which applies to the homeless. Nat Wright suggests they experience a higher rate of mortality and premature morbidity in comparison to the general population\(^{16}\). From a group of 388 individuals, an average age of death of 44.5 was found in a German study\(^{16}\). People with less need are accessing health services more, rather than the homeless and others with a greater need.
Primary care barriers

In 1981, Sir Donald Acheson published a report which not only highlighted health inequalities, but also provided an insight into primary care. The report indicated that homeless people were finding it hard to register with a GP. Tom Mason described the following reasons which had been given by GPs:

• "Lengthy consultations"  
• "Need to establish a relationship built on trust"  
• Difficulty in obtaining medical records 
• "Heartsink consultations" that offer doctors a challenge, which they feel is beyond their skills. 
• "Disruption to the efficiency of the general practice, from homeless patients missing appointments"  
• "Concern for the feelings of other patients towards the homeless" 
• No permanent address.

A GP is the epicentre for "effective primary health care service". As Nat Wright suggests, registration to a GP "is more than a piece of paper", it is a ticket to the "referral to other professionals and agencies". However, as Hinton’s study demonstrates, many homeless individuals remain unregistered, where only 60 percent of the homeless population in London are registered, compared to a staggering 99 percent registration rate concerning the mainstream population.

One explanation for this is that the homeless fall victim to discrimination by health professionals. The GMC frowns upon doctors that "unfairly discriminate" but instead, strides to offer a service which treats "patients with respect whatever their life and beliefs" may be. Rather than this being upheld, what we find is medical staff acting on stereotypical impulses, and therefore standing as a stubborn barrier to achieving "health care for all". This stigma stems by the belief that they are "violent, antisocial or undeserving". A study conducted by Shinner and Leddington found that many homeless people felt they were receiving the "cold shoulder" from medical staff. This barrier not only violates Article 14 of the Human Rights act which prohibits discrimination, but will ultimately lead to a loss of faith in the health care system, and as Fisher and Collins described, a cycle of reluctance. In this cycle, the “GPs unwillingness to offer care is coupled by the homeless individuals expectation of being refused”. An implication of this cycle is that health care will only be sought when the condition has become far worse. Furthermore the homeless will utilise accident and emergency departments as their first point of call. However, discrimination can sometimes still be present here.
Other barriers

Staff from hostels I spoke to criticised the discharge policies at hospitals. The policy treats the general and homeless populations the same. The major concern is that the environment the homeless return to, increases the risk of gaining an infection to a wound. Also, with no permanent housing, further care from a district nurse is prevented.

The agenda of health is not a priority to many homeless individuals. Even being diagnosed with hepatitis C, the unsettled nature of Mr X’s (appendix 1) life meant engaging in a treatment plan could never take a high enough priority, over his immediate needs. The struggling aspects a homeless lifestyle brings means their “basic needs” must be satisfied before the “medical needs can be properly addressed”. As Abraham Maslow described in the hierarchy of needs model, without meeting the basic physiological factors such as water, food and for many people, drugs or alcohol, consideration of health and any other higher level need will often be eclipsed.

Many still fear the home office index. The index stored a record of known drug users for the purposes of providing epidemiological data. Continued belief in the index by homeless drug users can be seen to play a pivotal role in the failure to utilise services, despite the abolishment of the index in 1997.

Primary Care Provision

Despite these barriers, the RCGP has urged its “members to practise equity in its registration policy”, and different models have been implemented, in order to deliver health care to the homeless population. The first model aims to integrate homeless care into a mainstream setting. This has been achieved through GP surgeries dealing with both the homeless and mainstream populations. The second approach involves GP surgeries which only register the homeless. A study conducted by Doering and Hermes in Hannover, Germany found a decrease in admission rates to homeless since the introduction of primary care models.
Mental health and the outreach team

Many homeless individuals suffer from mental illness. As Nat Wright notes, only one third of them will receive treatment. To tackle this issue, homeless outreach teams have been employed to seek individuals who experience a severe mental health problem. Individuals suffering from psychosis, schizophrenia and dual diagnosis are mainly targeted. A benefit of this approach is that it not only brings health services to the homeless, but also aims to integrate care within a mainstream setting. Despite this, the approach excludes people suffering from depression and anxiety, who will continue to remain untreated.

Health promotion

Accident and emergency departments are the first point of call for many homeless individuals. As a consequence, these individuals are missing health promotion provided by primary care. However, there are interventions available. The prevention of disease among homeless drug users is a key target. Programs such as need exchange and rapid vaccinations schedules have been implemented. Death caused by drugs is a major problem and Mr X himself overdoses three times. There is strong appeal for the introduction of medically supervised injecting centres, to decrease the number of deaths caused by “drug related deaths”. The results of a study from Frankfurt found that a “drug user who overdoses on the street is 10 times more likely to stay in hospital” than an individual who “overdoes in a safer injecting centre.”

It must be understood that the needs of the homeless is not universal. It is therefore necessary to develop effective health promotion strategies, which target a range of needs. As Nat Wright argues, the needs of a “young man sleeping on the streets differ from those of a single mother”.

DISCUSSION

The main source of the problem appears to be the barriers present at primary care. Mr X’s successful treatment of hepatitis C illustrates the importance of a GP, as a “gate keeper” to secondary and specialist care. However, discrimination is a major barrier that is preventing this. It appears the drunken, violent image commonly depicted in the media is dominating many health professionals perspectives. Mr X’s story further emphasises how key GMC guidelines are not being upheld, where his experience of being neglected from a nurse, exacerbated his feeling of social exclusion. These are the factors which are contributing to the continuing existence of the inverse care law.
During a visit to Hatton and St Helens GP surgery, Dr Sutton highlighted the importance of professionalism. Many homeless experience low self worth, yet by being respectful and polite, we can show these individuals that they are worth something, and provide the initiative for them to change for the better. It is these simple gestures that can prevent the inappropriate utilisation of accident and emergency departments, and the condition from getting worse. 

The results indicate there is a lack of awareness by medical staff concerning a homeless individual’s predicament and lifestyle. The hospital discharge polices is a big disadvantage to the homeless. This highlights the pivotal relationship that is needed between organisations and the NHS. As Nat Wright suggests “working with a whole variety of different organisations” is necessary, in order to meet the needs of homeless people. Organisations which offer accommodation can help a patient’s recovery. It is clear receiving health services is only one step of the struggle.

Progress however is being made in primary care. The models implemented within primary care both contain strengths and weaknesses. Nat Wright suggests the general practice which caters for both the homeless and general populations, has the advantage of integrating homeless care within a mainstream setting. However, individuals with complex medical problems could offer a challenge. The custom care available at GP dedicated to the homeless would be more suited to dealing with these patients. However the mainstream setting can produce a climate of competition between the homeless and general population.

Mr X’s story highlights, what Nat Wright describes as “satellite clinics”. Clinics located within a day centre or hostel, such as the Dawn Centre in Leicester, can be an effective way of providing health care. The advantage of providing care at this location is that it offers the homeless an opportunity to access health which is in a comfortable environment, and can even be utilised by individuals such as Mr X, who are reluctant to deal with health problems.

A major consequence of inequitable access to healthcare is that health promotion is not being received. However needle exchange programs and rapid immunisation programs have been implemented. Mr X acquired hepatitis C from a shared needle. This suggests that health education is a key issue which is not being tackled effectively. My visits to a hostel in St. Helens and Chester showed that despite there being health educational posters present, many of these often remained unnoticed. The agenda of health to the homeless is a low priority. This again emphasises the importance of “multi agency cooperation” in order for basic needs to be met and health education to be effective. There is a large emphasis on disease prevention, but because the homeless are a “heterogeneous population”, these interventions do not
cater for everyone’s needs.
However, there are positives which we can draw from this case history. Mr X’s successful hepatitis C treatment shows us that the homeless can access high quality health care. Furthermore rehabilitation programs can be successful. It shows that areas such as Chester GP surgery dedicated to the homeless are attempting to break down these barriers, a shining example for the nation to follow.

**Strengths and Weaknesses of the articles**

The article I chose was ‘how can health services effectively meet the health needs of homeless people’, by Nat Wright. This article is reliable as it has been published in the British Journal of General Practice and is written by Nat Wright, a leading expert in this field of study. Furthermore, it was written in 2005 which suggests it is recent. The article reviews the current interventions which are aimed at the homeless. The merit of this article is its ability to discuss the strengths, but also the weaknesses of the current interventions. Additionally, the writer does not just focus on the UK, but provides an international perspective. Finally, the article is littered with relevant statistics which helps emphasise the effectiveness of the current interventions.

This article just falls short of being flawless. One of the main criticisms of this article is its failure to explore the access of health services by asylum seekers. Also, it does not discuss the availability of health services for the homeless in the developing world. Finally, I felt the article didn’t comment sufficiently on barriers such as discrimination. Despite this, the article was a great source of information for my paper. The article was relevant to me as it discussed an excellent overview of homelessness and health, but also provided a valuable insight into international interventions that are effective in meeting the medical needs of the homeless.

**Conclusion**

In conclusion, it is evident that the NHS is failing to provide equitable access to the homeless. Despite the progress being made in primary care, Hart’s inverse care law continues to exist. The barriers must be addressed. A greater emphasis is required in “multi agency cooperation” in order to meet the health needs of the homeless. Health professionals need to mend broken relationships, and the NHS must uphold Beauchamp’s principle of justice. By doing so, we can re-establish faith into the health care system and prevent further social exclusion of a population who remain taint in the public eye.
Limitations

This paper inevitably contains limitations. Homelessness is a topic which offers a vast amount of relevant information and it became a major challenge to compact as much of this information within the constraints of a 3000 word limit. As a consequence, I was unable to explore the use of health services by asylum seekers. Additionally, discussion regarding access to health care by the rural homeless was also excluded. International statistics regarding homelessness also offered a problem. Many countries didn’t record homeless data and the use of different definitions prevented a comparison.

Areas for further study

It is necessary to conduct research which evaluates the effectiveness of the two main models implemented within primary care. Research evaluating the effectiveness of health promotional strategies must also be conducted. Finally, more research exploring the current extent of the inverse care law is required.

Recommendations

I would encourage the installation of what Nat Wright describes as “satellite clinics” in all hostels and day centres. The convenience of a GP or nurse present within a hostel could provide an incentive for individuals to access health care. Additionally, this offers the opportunity to deliver effective and interesting health promotion rather than relying on health promotion posters, which often remain unnoticed.

A common issue found with the homeless is the difficulty in the continuity of care. The opt in system operating in many GP Surgeries raises a barrier to the homeless, due to the inability to keep appointments. Therefore, open surgeries without the requirement of an appointment should be implemented.

Many homeless individuals are excluded from homeless outreach programs. It is understandable that the team may feel pressure from their current client base, how people that experience depression and anxiety are excluded. It is vital that these individuals receive care.
Robert Maxwell suggested six criteria necessary to supply quality health care to a population. Which are:

- “Efficiency and economy”
- “Effectiveness”
- “Equity”
- “Access to services”
- “Social acceptability”
- “Relevance to need for the whole community”

As Nat Wright explains the criteria function like an abacus. If the access to a service is improved for example, the services efficiency will decrease. The best approach to delivering a quality health service is to try and achieve a balance between each component and not fall into the trap of being flawless in each criteria.

Reflection

This SSM has been a key learning experience which not only allowed me to gain a feel of the struggles and barriers involved in the daily existence of the homeless, but also made me aware of a population so easily forgotten in the public eye. In doing so I have developed my empathy and communication skills and also learnt the importance of maintaining equity in medical practice. Throughout these four weeks, my visits to organizations and hostels has shown how vital each institution plays, towards reaching the shared goal of stability and eventual reintegration of a homeless individual back into mainstream society. It is a great shame that the media doesn’t highlight and celebrate their efforts. It is their dedication which continues to light a beacon of hope for the homeless, and has left me with great admiration and respect towards Britain’s unsung heroes. I hope this SSM continues to flourish in the future and sow the seeds into tomorrow’s doctors, so that one day we can finally achieve “health care for all”.

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20. Homelessness and health: what can be done in general practice? Nat M J Wright, MB MRCGP,¹ Charlotte N E Tompkins, BA PGDip,² Nicola S Oldham, MSc,³ and Debbie J Kay⁴


The three most useful books

1. Homelessness: A primary care response by Nat Wright is an excellent resource which provided a great deal of information on the common health problems faced by the homeless and also reviewed primary care provisions.
2. Stigma and Social exclusion in healthcare by Tom Mason provides a detailed description of major barriers faced by the homeless to accessing health care.
3. Homelessness and Ill Health: Report on a Working Party of the Royal College of Physicians. This book comments extensively on barriers faced by the homeless, and also the major health problems.

The best three references

1. Wright N. How can health services effectively meet the health needs of homeless people. United Kingdom; British Journal of General Practice ;2006 is an excellent source of information regarding health interventions, primary care provisions and international perspectives.
2. Wright NMJ, Tompkins CNE. How can health care system effectively deal with the major health needs of homeless people? Provided an overview of the barriers faced by the homeless in accessing health care and also commented brilliantly on health promotion.
3. The Inverse Care law by Julian Tudor Hart provided an excellent introduction on health inequalities in England.
Appendices

Appendix 1

Case History of Mr X

He was born on the 31st of August 1967 and experienced a difficult Childhood. His father was an alcoholic and his mother left the family for another man. His father later died in 1981, and so he joined his mother and stepfather in Runcorn. However, originally being from a middle class family, moving to a council estate was a culture shock. He became absorbed into the deviant culture present.

His step father was strict in his parenting methods, to the extent of physical violence towards Mr X. The fear factor of his Step Father eventually lead to Mr X running away from home in the year 1983 and thus becoming homeless. In the next years he found himself sofa surfing from one house to another before settling into a hostel. However a breach of the rules resulted in his eviction from the hostel. With no home and qualifications, his self esteem was deeply impacted. He turned to petty crime in order to survive. However in 1985 he received an inheritance of £39,865 from his father. Despite purchasing a flat, he started using drugs such as heroine due to curiosity. Furthermore offences such as fraud and the breach of peace landed him in trouble with the police.

Selling the flat, he travelled the country conducting a scam with his three friends. However a failure to repay the driver in Sheffield resulted to an assault. After being discharged from hospital he returned to his mother in Runcorn. He then visited Denmark in order to revaluate his life. In Denmark heroine could not be purchased and did not have to rely on it anymore.

Returning to England, he decided to attend college and was able to achieve the qualifications necessary to read a degree in sociology combined honours with social policy at Plymouth University. However he relapsed and began using drugs again. At University he was able to complete the first three years of his course yet in the final year, his addiction to drugs took a toll on his life, eventually leading to the failure of the fourth year. Leaving Plymouth he chose to travel to Brighton where he stayed in a hostel for 7 months, until a charity called the Rough Sleepers project provided him with accommodation. He decided to confront his drug addiction and emitted admitted/emitted himself into a rehabilitation program. He followed a treatment called intuitive recovery and had a successful detox. However he also tested positive for hepatitis C.

Despite carrying the virus for three years, the struggling aspects a homeless lifestyle brings meant engaging with a treatment plan never took a high enough priority. However, it was when he arrived in Chester in 2002 that he took advantage of the clinic situated within a day centre. He was referred by the GP to the Countess of Chester Hospital, where a liver biopsy was conducted, and then finally to the Linda McCartney centre at the Royal Liverpool University Hospital. The treatment lasted for 6 months and involved taking ribavirin and interferon alpha anti-viral. There was only one instance of feeling stigmatised by health professionals, where he was left to sit in a wheelchair by a nurse after his biopsy. He was left with the impression that the nurse thought of him as “just a junky”.

During this period, a charity called Chester Aid to the Homeless provided him with accommodation. Charlie has remained in this accommodation since May 2008.
Appendix 2

Time table

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### Appendix 3

**Resource list**

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<tr>
<td>1</td>
<td>Dr Sutton</td>
<td>General Practitioner</td>
<td>Victoria House Holloway, Runcorn, WA7 4TH</td>
<td>01928593600</td>
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<tr>
<td>2</td>
<td>Joe McGovern</td>
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<tr>
<td>3</td>
<td>Charles Flood</td>
<td>Student facilitator</td>
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<tr>
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<td>5</td>
<td>Sue Barwise</td>
<td>Member of H.O.T.</td>
<td>The Infirmary 70 Pembroke Pl, Liverpool, L69</td>
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<td>6</td>
<td>Joe Holman</td>
<td>Manager</td>
<td>Kevin White Unit Kevin White Unit/Smithdown</td>
<td>07813189367</td>
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<td>Health Pk, Smithdown Road Liverpool L15 2HE</td>
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<td>7</td>
<td>Anne Omarah</td>
<td>Manager (arch)</td>
<td>Craven Business Centre Bentinck St, Birkenhead,</td>
<td>01516478633</td>
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<td>8</td>
<td>Mandy Casey</td>
<td>Team leader</td>
<td>2 Crook St Chester, CH1 2BE</td>
<td>01244624088</td>
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<tr>
<td>9</td>
<td>Phil Clarke</td>
<td>Support Worker</td>
<td>The Hope Centre Atherton Street St Helens</td>
<td>01744738835</td>
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<td>WA10 2DT</td>
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</table>
Appendix 4

Ten best websites

1. www.crisis.org.uk/
2. www.shelter.org.uk
3. www.homelesspages.org.uk
4. www.centrepoint.org.uk
5. www.housing.org.uk
6. www.jrf.org.uk
7. www.cih.org
8. www.bigissue.co.uk
9. www.rcgp.org.uk
10. www.alcoholconcern.org.uk