What is the relationship between homelessness and substance abuse?

“There is a lot that happens around the world we cannot control. We cannot stop earthquakes, we cannot prevent droughts, and we cannot prevent all conflict, but when we know where the hungry, the homeless and the sick exist, then we can help.”

Jan Schakowsky

Source: http://www.brainyquote.com/quotes/keywords/homeless.html
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# Abstract

**Background:** Substance abuse is present throughout the UK, spanning all areas of society. However, its prevalence lies mostly where there is deprivation and poverty, making those living in such conditions more likely to succumb to drugs and the detrimental consequences that follow. It has been established that homeless people are more susceptible to ill health than the general public, given the environment and lifestyle in which they live. The use of illicit drugs that is seen in a high percentage of homeless people contributes greatly to this chaotic lifestyle, exacerbating ill health and instigating a life far from that accepted by society.

**Aims:** To explore the abundant problem of substance abuse and its harmful effect on the social, psychological and health aspects of the homeless population. To explore NHS and other services available to homeless people and their effectiveness in managing substance abuse.

**Method:** A database search was conducted to access publications on the subject of homelessness and substance abuse. Databases such as MEDLINE, EMBASE, CINAHL and BNI were used. An internet search was also conducted using key terms related to the area of study. A hands on approach was also taken, consisting of visits to a number of services for the homeless and for substance abusers in the North West.

**Results:** Homeless substance abusers are vulnerable to a wide range of health and social problems, and have support needs that scope way beyond housing and drug support. There are inequalities with regards to the delivery of healthcare, and many homeless people suffer from discrimination by the general public and health professionals alike. Due to the barriers faced when accessing mainstream care, an increasing number of practices are attempting to provide clinics aimed at the homeless population. Drug services available in the North West aim to promote safe use of injecting equipment in a bid to reduce the immediate risks of injecting.

**Conclusion:** Owing to the high levels of support the average homeless person requires, success in managing drug problems and integrating an individual back into society is best achieved when multiple organizations liaise with one another to provide holistic care.
Learning objectives

- To understand the causes and consequences of homelessness, and be up to date with current literature in this area
- To learn about the main clinical problems of homelessness, including substance abuse, mental health and Hepatitis C
- To explore the most effective ways in providing NHS and other services to the homeless population
- To reflect upon substance abuse amongst medical students and doctors, and to consider methods of stress management

Acknowledgements and thanks

I would like to thank Charles Flood; for organising visits to the numerous services we were able to go to. I would also like to thank Dr Joseph O’Neill, for conveying such an insightful SSM. Thank you to all the services that I had the pleasure of visiting; to the staff and service users alike for being most hospitable and welcoming. I would also like to thank the staff at Fade library, as they were incredible helpful and a valuable resource.
Introduction

Whilst it is recognized that homeless people suffer from and present with a vast array of health and social problems, this study concentrates predominantly on substance abuse among the homeless population. Having visited several services in areas of the North West including Liverpool, Birkenhead, St Helens and Chester, it quickly became apparent that homelessness and substance abuse go hand in hand. Previous study suggests that, “the most common health needs of homeless people relate to drug dependence, alcohol dependence or mental ill-health, and dual diagnosis is frequent,” (1) making it clear that the prevalence of substance abuse among homeless people is ripe. Furthermore, such abuse contributes to the poor health of many of the homeless population, and this study aims to investigate the detrimental effects that substance abuse has on this vulnerable portion of society.
**Method**

Searches using the medical databases MEDLINE (1950-present), EMBASE (1980-present), CINAHL (1981-present) and BNI (1985-present) were conducted. Search terms used were “homelessness” AND “substance abuse” AND “health” AND “drugs” AND “alcohol” and other closely related terms. To use the databases:

- Go to the National Library for Health website: [http://www.library.nhs.uk/default.aspx](http://www.library.nhs.uk/default.aspx)
- Login using Athens and click Healthcare Databases Advanced Search
- Choose one of the databases, for example, MEDLINE
- Enter keyword, for example “homelessness,”
- You can then click “map to thesaurus” to expand the term
- Click Search
- If map to thesaurus was chosen, you can then choose a related term such as “homeless persons” and check the “exploded” and “major descriptor” boxes
- Then click Search
- The number of hits (i.e. the number of articles available) will come up, in this case 3683
- Repeat with other key words, for example “substance abuse”
- NB: to search for specific phrases, quotation marks are required
- To combine the searches of the above keywords, click the check boxes beside them and then click the check box “AND”
- Then click combine selected searches
- This comes up with all the articles relating to both homelessness and substance abuse
- Combining searches makes searches more specific and reduces the number of articles
- In this case there are 344 articles relating to homelessness and substance abuse
- To view the articles, click the number of articles available
- This then comes up with a list of all the available articles
- Clicking on the title of the article allows you to view the abstract
Another valuable tool was the search engine Google, with searches being conducted using similar terms to the ones stated above. This led to many websites concerning information on homelessness, health and substance abuse. Care was taken to only use ‘credible’ websites, such as government and specific homelessness sites, to increase the likelihood of information validity. Service learning visits were also attended, during which the opportunity to talk to both staff and service users was available, albeit opportunity to converse with the latter was rare. Visits included various homeless shelters, hostels, drop-in centres and soup kitchens in:

- **Chester** (Chester Aid to the Homeless)
- **Liverpool** (Sisters of Charity)
- **Birkenhead** (Charles Thompson Mission, Ark)
- **St Helens** (103 day centre).

Also visited were drug services in the North West, namely:

- Addaction
- Aquahouse
- the Homeless Outreach Team
- the Kevin White Unit

Visits involved staff giving information on the services provided and detail of who used the services, so that I was able to get an overview of how the system worked. I also had the opportunity to visit Fade library in Liverpool, in which I had access to books that are not available at the University library, due to the specialised nature of the topic.
What is homelessness?

A common misconception of homelessness is that it pertains to only those who we see sleeping on the streets; rough sleepers. The legal definition of homeless, according to the 1996 Housing Act is much broader than this, and is as follows:

Homelessness is when a person has:

- No accommodation that they are entitled to occupy; or
- They have accommodation but it is not reasonable for them to continue to occupy this accommodation (2)

Examples of not being able to continue occupying accommodation would be because of poor housing conditions and violence or abuse

Another definition of homelessness is statutory homelessness:

**Statutory homeless:** “Households that have been found to be eligible for assistance, unintentionally homeless and falling within a priority need group and thus owed a main homelessness duty by a local housing authority.” (3)

If someone finds themselves in a position where they have no home, an application can be made to their local council. Upon receiving this application, the first step the council will take is to assess if the person/household is legally homeless, looking for the following factors:

- “they have no home anywhere in the world where they can live together with their immediate family or
- they can only stay where they are on a very temporary basis or
- it is not reasonable for them to stay in their home because of violence or because of the condition of the property.” (4)

Whilst many people may be classed as statutory homeless and be entitled to help from the council, not everyone will get the desired help. Since everyone who is statutory homeless will fit the legal definition of homelessness, allocation of housing primarily goes on a
‘priority need’ basis, whereby those that are considered most dependent will be more likely to obtain emergency accommodation.

Priority need according to Shelter goes to those who are:

- “pregnant
- 16 and 17 year olds
- Care leavers aged 18-21
- Households with dependent children
- Vulnerable people
- Victims of fire, flood or other natural disaster” (5)

Those who are homeless according to the legal definition but have not applied or are not eligible for accommodation are aptly termed the ‘hidden homeless’ by Crisis; a UK charity for homeless people. Those who apply to this branch of homelessness may be in situations such as:

- Rough Sleeping
- Bed and Breakfast etc
- Hostels, Night Shelters and Refuges
- People due for discharge from institutions
- Overcrowding in Concealed Households
- Owner dissatisfaction in concealed households
- Risk of eviction
- Involuntary Squatting
- People who are living in severe overcrowding (18)

An important point to note is that drug and alcohol addiction is not generally considered as a vulnerability, and so a single adult with such an addiction would not be classed as a ‘priority need’ for housing. Inevitably, this leads to many people being in situations such as those stated above. Many of the above living conditions can induce ill health. This, in my opinion, can elicit vulnerability and I believe that the council should not out rightly dismiss anyone with an addiction.
**Prevalence of homelessness**

Whilst there are statistics on homelessness that are declared by the government on an annual basis, there is no accurate data that suggests the full extent to which homelessness has infiltrated society. This, as Nat Wright correctly states in his book Homelessness: A primary care response, is because:

> “Official government statistics only record those who apply to their local council. Council housing departments also record applicants as ‘households’ rather than record the number of individuals in that household” (6)

Therefore, the government undeniably excludes the portion of homeless people who choose not to apply for housing via their local council, as well as failing to record the exact number of individuals who are homeless. This strongly suggests that many of the individuals classed as ‘hidden homeless’ are not taken into account and are completely occluded from any such data. Crisis estimates that “there are approximately 400,000 hidden homeless people” (2). Some of these will have applied for accommodation and failed, and so this hidden homeless population interlinks with the governments statistics on homelessness, therefore making an accurate representation of the homeless situation in the UK difficult. Other figures that are available, particularly for rough sleepers, also grossly misrepresent the true value. The total number of rough sleepers in England in 2008 was 483. Liverpool came 4th with 13 rough sleepers counted. (7)

When visiting the Homeless Outreach team in Liverpool, I was informed that methods of counting rough sleepers are not consistent across the board, and there are flaws in the system such as:

- Only being able to count those lying down. People slumped over or sleeping sat up are not counted
- For safety reasons, counters are not able to go in dimly lit places, such as car parks. Places that many rough sleepers will sleep for peace and quiet.
**Homelessness and substance abuse**

Substance abuse, as defined by the Oxford Concise Medical Dictionary is: “*the non clinical, or recreational, use of pharmacologically active substances such that continued use results in adverse physiological or psychological effects*”(8)

Substance abuse is prevalent in all areas of our society, and the UK Drug Misuse and Dependence Guidelines state that:

> “The UK has among the highest rates of recorded illegal drug abuse in the western world” and heroin is named as being the main problem among the majority of adult drug users in treatment (9).

More specifically, “levels of drug use amongst homeless people in 5 English cities have been put at between 66 and 76%”(10). Having visited a number of homeless centres and drug services, the drug of most concern appeared to be heroin. Nat Wright raises the issue of “poly drug use” being common among the homeless population (6). This involves the use of more than one drug to achieve the desired effect.

It is almost impossible, without asking individuals, to ascertain whether it was drug addiction that made them homeless or whether homelessness led to drug addiction.

The NFA team in Leeds conducted a study which goes as follows: “A random sample of homeless patients were questioned regarding drug use. Of those taking drugs, 75% stated that their drug use was the cause of them becoming homeless, while only 25% stated that being homeless caused them to take drugs” (6)

This suggests that drug use is a predominant cause of homelessness. Whilst both homelessness and substance abuse contribute separately to poor health and social exclusion, the two together is a lethal combination that can lead to a pathway of crime, begging, promiscuity.
Problems which arise from substance abuse and homelessness

Health, as stated by the World Health Organisation is “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (11)

In this section we will therefore focus individually on the social, psychological and general health problems that arise from homelessness and substance abuse.

Social

It is no secret that homeless people and drug users are often subjected to stigmatization by the general public and even by health care professionals. Appearance alone is enough to instigate prejudice, although unfortunately many homeless drug users resort to crime to fund their habit, and this tarnishes the rest of the homeless population. Aside from individuals avoiding homeless people in the street, there are policies which exist to socially exclude homeless people. For example, in Chester there is apparently a policy whereby homeless people are banned from the town centre. This demonstrates concern for the general public but not for the homeless individuals who, nevertheless, are still part of our society. Evidence for social exclusion on a wider scale is the aforementioned lack of data on homeless people, in particular single homeless people and the “hidden homeless.” The fact that a significant proportion of the homeless population are excluded from national data only serves to accentuate the true social exclusion to which homeless people are subjected to.

Psychological

Mental ill health is a common problem that homeless people present with. Such illnesses include:

- Schizophrenia
- Depression
- Psychosis
- Anxiety states
- Personality disorder (1)
It has been stated that a “dual diagnosis of mental ill health and substance dependence occurs in approximately 20% of homeless people with mental ill health” (1) suggesting that, in a number of cases, drugs can be a trigger for mental health issues to arise.

**General health**

Although any form of substance abuse is a cause for concern, the services I was able to visit were most concerned with injecting drug users, particularly those injecting heroin. Below are the main complications of injecting:

- Blood borne virus infections
- Skin pathogens causing:
  - Septicaemia,
  - Encephalitis,
  - Endocarditis,
  - Cellulitis
  - Abscesses
  - Deep vein thrombosis
  - Tetanus (1)

There is also a high risk of overdose due to the rapidness of the drug entering directly into the bloodstream. Overdosing, particularly on opiates e.g. heroin, is one of the main causes of drug related death:

“The four main causes of drug-related deaths are:
- overdose
- suicide
- accidents
- physical health complications of drug abuse
Rates of recorded drug-related overdose deaths among UK drug abusers are among the highest in Europe.” (10)
Whilst the drug misuse and dependence guidelines state that the UK has one of the highest drug related death rates, the number has been decreasing overall:

<table>
<thead>
<tr>
<th>England</th>
<th>1999</th>
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<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
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<tbody>
<tr>
<td>Males</td>
<td>1,242</td>
<td>1,262</td>
<td>1,237</td>
<td>1,137</td>
<td>911</td>
<td>1,044</td>
</tr>
<tr>
<td>Females</td>
<td>242</td>
<td>303</td>
<td>291</td>
<td>319</td>
<td>270</td>
<td>295</td>
</tr>
<tr>
<td>Totals</td>
<td>1,484</td>
<td>1,565</td>
<td>1,528</td>
<td>1,456</td>
<td>1,181</td>
<td>1,339</td>
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(12) Source: ONS, Health Statistics Quarterly 29, Spring 2005, p7

These results do not, however, show a substantial enough decrease to conclude the effectiveness of drug services or health promotion. Nor do they conclude a decrease in the rate of drug taking.

As well as drug related ill health, homeless people can suffer from a variety of other diseases, many of which are cause by the poor conditions in which they live, lack of hygiene and limited access to healthcare:

- Pneumonia
- Influenza
- Minor upper respiratory tract infections
- Tuberculosis
- Body lice and scabies
- Fungal infections
- Inflammatory skin conditions
- Foot trauma e.g. oedema, frostbite, overgrown toenails (1)
Access to health care

Having highlighted the main health problems that homeless people succumb to, the next logical step is to address the availability and access to health care.

Quite often, health is not the highest priority on the agenda of a homeless drug user, and the problem must have an impact on their daily activities before they present to a professional. A Crisis press release suggests that:

“Mental health and addiction problems can distract them from physical illness; someone with severe mental health problems may continue walking on a broken ankle for weeks rather than seek help” (13)

Leaving problems until they become more severe can cause serious complications that perhaps would not have occurred had they presented earlier.

If we recall the GMC Duties of a Doctor, one of these duties is to “never discriminate unfairly against patients or colleagues” (14) and yet homeless people are often shunned from surgeries. Not many people, health professionals and patients alike, want a homeless person in their waiting room; particularly those on drugs and alcohol who can be volatile, aggressive and have poor hygiene. This invariably links with Beauchamp and Childress’ ethical principle of justice, in that every individual regardless of ethnicity, gender, social class etc, should be entitled to a fair and equal distribution of health resources.

Yet in a study conducted by MORI, “Four out of five GPs interviewed believe it is more difficult for a homeless person to register with a GP than the average person” (13). The reasons for this were thought to be:

- a lack of time or resources on the part of the surgeries
- the attitudes and beliefs of surgery staff
- homeless people’s inability to cope with rigid working practices of GP surgeries
- many surgeries mistakenly believing that without an address, a patient cannot register (but homeless people can be registered using the surgery’s own address) (13)
It would be unfair to suggest, however, that all GP surgeries exude such negativity. Some practices do offer registration to those with no permanent address. Some practices offer a regular drop-in clinic solely for the homeless population. Some GP surgeries are run entirely for homeless people, for example St Werburgh's Medical Practice, Chester. The availability of such services means homeless people in these areas have access to the health care that they deserve, delivered by professionals who are understanding of their lifestyle. This is also a gateway to other forms of care should they so need it in the future.

But even assuming access to a GP can be made easier, is this NHS gateway service suitable for the homeless? Research suggests that, for many, the first point of call when in need of healthcare is A&E.

In a survey of 135 homeless people attending an A&E department, “52.6% of those questioned said they preferred being seen in the A&E department when ill, with 23.7% preferring GP treatment and 10.5% attending community homeless clinics” (15)

When I visited the Homeless Outreach Team at Brownlow practice in Liverpool, it was mentioned that homeless people are less likely to attend their appointments due to the lifestyle in which they lead. This could explain why such a high proportion of the homeless people questioned in the above survey prefer to use A&E; no appointment is necessary and they are able to ‘drop in’ at a time which suits them. To combat this problem of non attendance and low priority health, the Outreach team are regularly out on the streets of Liverpool finding rough sleepers and encouraging them to get the help they need.

Whilst many organisations are putting efforts in to provide healthcare, the difficulty that homeless people face in accessing mainstream healthcare still exists, and very much coincides with an idea presented by Julian Tudor Hart in 1971:

The Inverse Care Law: Those that need medical care the most are the least likely to receive it. (16)

**Drug services for homeless people**
Homeless people who use drugs need the expertise of services specifically dealing with drugs. Nat Wright suggests that many GPs feel there is a lack of training on drug use at undergraduate level (6). The shared care system involves a GP working with a drugs service, and is allocated a member of their staff whose job title is a key worker. This is a Tier 2/3 model of care, dealing with drug users on Class A substances. Together, both the key worker and the GP work with a drug user to devise a care plan which suits them. Initially the key worker will gather information about the individual.

"Treatment for drug abuse should always involve a psychosocial component. Drug abusers often present for drug treatment with a myriad of health and social problems. Psychosocial interventions encompass a wide range of actions from ‘talking therapies’, such as cognitive behavioural or family therapy, to supportive work such as help with benefits." (9)

The above statement suggests that it is not about combating the drug alone, but about tackling the underlying problems that cause a person to begin, and continue to take drugs. I was able to visit one of the main Tier 2/3 services in Chester; Aquahouse. One of the drug services Aquahouse provides is harm reduction. This focuses on health promotion and is responsible for reducing the risks that drug taking poses. A key worker is responsible for the majority of the harm reduction system, and they offer:

- Safer injecting advice
- Needle exchange
- General health checks
- Blood borne virus testing e.g. Hepatitis B/C
- Methadone to replace heroin

The first two aspects can help to reduce the transmission of blood borne viruses by educating about the transmission via sharing injecting equipment. General health checks may also be undertaken:

"The aim of a health assessment is to identify unmet healthcare needs as well as to consider the presenting symptoms and take account of health problems that could interact with drug treatment" (9)

A major part of harm reduction is the substitution of heroin (or other opiates) with methadone. However,
harm reduction poses many an ethical issue in that it is making no attempt to stop drug use, only to control it and make sure it is done safely.

Tier 4 services consist of detox and rehabilitation centres. I was able to visit a detox centre in Liverpool called the Kevin White Unit. The aim of such programmes is to help the individual to become abstinent. Unfortunately, a lot of detox centres are not designed for homeless drug addicts. For example, the policy of the Kevin White unit is that clients must have a home to go to once treatment has finished. Whilst this is a rational idea with regards to stability after detox, it is clearly not plausible for the homeless individual. Homeless people do not have the same support as people who have a home; be it the feeling of safety, or social support provided by family. This policy highlights the holistic care approach that is needed when treating homeless drug abusers;

“Their needs are often complex and services that focus on any one element of their need, be it substance abuse, mental health or housing related support, meet with less success than services that are designed to support all their needs” (17)

The drug service Aquahouse in Chester liaises not only with GPs but with Chester Aid to the Homeless (CATH) to provide support from a number of directions. Below is a plan of care of a homeless drug user, which incorporates getting them rehoused – initially temporarily – and resolving other issues such as unemployment and mental health:
This plan looks at making an attempt to manage the drug problem and reintroduce the individual into society by giving them support in areas such as tenancy and employment. There are, however, a range of other problems that a homeless person may present with that are equally as difficult to resolve as their drug problem and need to be addressed to enable successful integration:

- alcohol problems
- mental health problems, including mental illness and personality disorder
- a combination of mental health, drug and alcohol problems
- experience of physical or sexual abuse
- time in local authority care
- self-harm
- family homelessness
But of course, being integrated into society isn’t the final step. Support needs to be given after being rehoused and becoming abstinent/managing drug taking in order to prevent relapse and other issues.

Problems faced for ex homeless people are:

Feelings of loneliness: particularly with ex drug users, as often their social network consists of their dealer and people who also take drugs, all of whom they should lose contact with to avoid relapse

Having to make social contributions such as council tax, water bills, food bills etc
Effectiveness of drug services

One of the key workers from Aquahouse stated that approximately only 3% of people who enter the drug treatment system became completely drug free afterwards. Whilst this looks poor statistically, these figures only represent full abstinence. A paper on effective services for substance abuse and homelessness in Scotland states that:

“services that are aimed solely at promoting abstinence among homeless people with a substance abuse problem tend to meet with quite limited success” (17).

Abstinence, although ideal for society, is not always achievable and the figure above does not include those who have demonstrated progress within the drug programme. Just because someone is not yet abstinent does not mean they haven’t taken positive steps towards becoming drug free e.g. reducing their drug dose. Drug service success is about the individual.
Limitations and areas of further study

Journal articles obtained from database and website sources vary in age and it was in the best interest of this study to use the most recent articles. The search suggests there is very little literature pertaining to the UK surrounding the issue of homelessness and substance misuse. Getting up to date UK literature proved quite difficult. Other limitations included time. If I were to do this study again I would interview as many homeless substance abusers as possible to gain some recent qualitative information.

Recommendations

- Having visited numerous services provided for both homelessness and drug use alike, there seems to be little emphasis on trying to combat alcohol problems and absolutely no attempt to obliterate addiction to tobacco among homeless people. In a journal written by Nat MJ Wright, it is suggested that “smoking is more common among homeless populations and prevalence may be as high as 80%.”(1) Whilst I understand that illicit drug use is the main focus, as it poses an immediately severe threat to health, social and psychological wellbeing, tobacco addiction is a serious threat to long term general health, particularly to those who live in such poor conditions.

- Another issue raised was that homeless women are very much underrepresented in terms of services. In all the places I was able to visit many provided their services to men only. Although there are more men than women that are homeless (particularly those sleeping rough), this is discrimination. Many of the women became homeless because of violence and abuse, and this to me would incur a vulnerability that makes them of high priority. Therefore, I think there should be more beds available for women in hostels and night shelters throughout the North West.
Conclusion

- One of the major problems in treating drug addiction in the homeless population is that many have other underlying issues and support needs which also need to be taken into account. Given this, it has become evident that a holistic approach is needed when treating people of such a vulnerable nature. Services need to communicate with one another to provide support from every angle necessary.

- Ill health is a major issue among the homeless population, and substance abuse can exacerbate problems. Unfortunately, for many, health is not of high priority. Introducing more drop-in clinics designed specifically for the homeless population increases access to healthcare and will no doubt result in a higher proportion of this transient population seeking help for their health needs.

- Steps have been taken to manage and control drug use amongst the homeless population. Drug services such as harm reduction are effective in managing drug use and initiating safety, but do not eradicate the problem. As long as there are still vulnerable individuals out there, it can never be fully eradicated.
Appendix 1

Reflection

This was my first choice SSM and so I was very keen to get started. Before I began I thought being homeless referred to those sleeping rough. Having finished the SSM it is clear that this is not the case. The most enjoyable part of the SSM was meeting Dr Sutton, who ran a weekly clinic for homeless people. I was able to sit in on two of her patient consultations, which proved to be very interesting. The “hands on” approach was definitely the best option for this SSM. Overall, this was an extremely insightful SSM and I would certainly recommend it to others in the future.
Appendix 2

Literature Review

The paper I have chosen to review is entitled:

“How can health services effectively meet the health needs of homeless people?”

Written by Nat MJ Wright and Charlotte NE Tompkins, this paper discusses the health implications of being homeless. It also discusses the health care services that are available to the homeless population.

Strengths

• This paper is relatively recent, dating April 2006

• This paper is reliable, the source is the British Journal of General Practice

• The paper is readable: The paper flows in a logical manner and the abstract is clear, giving a neat overview of the content of the paper.

• The paper is relevant: Homelessness is a massive issue in society today. An investigation into how health services can effectively meet the needs of homeless people is relevant, particularly because of the problems homeless people face in accessing mainstream healthcare services

Weaknesses

• Literature used was not from the UK alone. Whilst this gives a greater scope of information, it means the information does not solely represent UK health services. This could impair the validity of the results

• Possible bias on the part of the authors as they have written previous work on the subject and they cite this previous work in this article.
Case Study: Mr C

During the first week of this SSM I had the opportunity to talk to Mr C and listen to his story of homelessness and substance misuse. His cascade into drug misuse had started many years earlier. Born into a middle class family, Mr C had no siblings and lived with both his mother and his father up until the age of 9. His father, who was an alcoholic, had a good job as a quantity surveyor, whilst his mother worked as a dinner lady. Mr C was regularly beaten with a belt by his father. When Mr C was 9 years of age, his mother left home to live with another man. At the age of 13, in 1981, Mr C's father died of his alcoholism, and so Mr C went to live with his mother and stepfather on a council estate. Mr C left school and took his first job as a trainee joiner. At some point during this he was given a supervision order by the courts - having been arrested for carrying a stick - which under law is described as an offensive weapon. The first time Mr C became homeless was at just 15 years of age. Parents of his friends allowed him to stay at their houses for a short while, and after this Mr C went into hostel accommodation. However, he was thrown out of this hostel for sneaking a girl into his room, and was consequently roofless once more. He started experimenting with drugs such as cannabis, LSD and speed. In 1985 Mr C lived in a bed and breakfast, and stayed there until he was able to acquire a council flat in 1986. At this point he had now been in trouble with the police further, for acts of fraud, deception and breach of peace. In 1988, aged 21, Mr C inherited £40,000 from his father. He invested in a house in Warrington with his then fiancée, and spent much of the rest of the money on drugs. It was here that Mr C became involved with heroin. £1000 of his inheritance was loaned to a friend to buy drugs, who subsequently made a large profit. Having spent all of his inheritance and now struggling with a heroin addiction, Mr C was having trouble with money. The man who he had initially lent £1000 to lent Mr C money in return. At its highest peak Mr C owed £4000. To earn money, Mr C was involved in a scam which conned shop keepers into giving him more money back than he had given to the shop keeper. This made profit each time. However, this was not enough money to cover the amount he owed, and Mr C was assaulted with a knife by the man he thought to be his friend. After this, Mr C went to live with his mother in Runcorn for a short while, then went on to live with his uncle in Denmark, where he was able to come off the heroin after going ‘cold turkey.’ When he returned from Denmark, Mr C moved back in with his mother and stepfather, then onto a shared house in Widnes, embarking on a college education whereby he obtained a BTEC in Social Care and Caring Strategies. His hard drug use was now a thing of the past, although he still took the occasional ecstasy pill recreationally. He applied and was accepted by Plymouth University, where he started a degree in Sociology combined honours with Social Policy. Whilst studying in Plymouth, Mr
C unintentionally met a drug dealer, who then supplied him with heroin. Back into the depths of a heroin centred lifestyle, Mr C managed to get through the first years of his degree but failed his final year. He stayed in Plymouth – still addicted to heroin – and was able to finish his degree some two years later, having failed the final year once more. After his degree, Mr C went to Brighton, ominously with nowhere to go. He arrived at a hostel and stayed there for many months. In 2001, Mr C went to a rehabilitation centre, and the first time in his life was able to crack the addiction that had possessed his life for many of his early years. And so he came to Chester; where he currently resides. Upon arriving in Chester (a move which was family orientated), Mr C stayed in a night shelter for a week. After this he was able to move to Roodee House accommodation, where he stayed for 12 weeks. As he had had good behaviour and had showed efforts of improvement, Mr C was allocated a Moving On house, in which he stayed for a year. At some time during his injecting years, Mr C had contracted Hepatitis C. This was found out in early 2008, whereby Mr C was able to start Hepatitis C treatment of Ribavirin and Interferon for 6 months. Mr C is thought to be clear of Hepatitis C now, and will have a test at some point this year to confirm this. At the point of interview, Mr C was a 41 year old man living in a flat in Chester, having been abstinent for 15 months and had just found a new job.

Many thanks to Mr C for sharing his story and for allowing it to be used in this paper.
Appendix 4

References


5) http://mobile.shelter.org.uk/get_advice/homelessness/help_from_the_council/what_the_council_will_check/priority_need (accessed 7/2/2009)


16) Inverse Care Law: Available at: http://www.kingsfund.org.uk/publications/articles/inverse_care_law.html


GMC Duties of a Doctor

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
  - Recognize and work within the limits of your competence
  - Work with colleagues in the ways that best serve patients’ interests

- Treat patients as individuals and respect their dignity
  - Treat patients politely and considerately
  - Respect patients’ right to confidentiality

- Work in partnership with patients
  - Listen to patients and respond to their concerns and preferences
  - Give patients the information they want or need in a way they can understand
  - Respect patients’ right to reach decisions with you about their treatment and care
  - Support patients in caring for themselves to improve and maintain their health
Be honest and open and act with integrity

- Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
- Never discriminate unfairly against patients or colleagues
- Never abuse your patients’ trust in you or the public’s trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.
## Appendix 6: Timetable

### Week 1

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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<tbody>
<tr>
<td>Intro to SSM with Lisa Jones. Given a talk from Joe McGovern, a drugs key worker. Also visited Roodee House.</td>
<td>Meeting with Dr O’Neill: Intro to SSM</td>
<td>Case Study</td>
<td>Visited the Fade Library, Liverpool Free afternoon: Decided what topic to write the SSM on</td>
<td>Birkenhead</td>
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### Week 2

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
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<tbody>
<tr>
<td>Brownlow practice, Liverpool: Homeless Outreach Team Helped out in the Sisters of Charity soup kitchen</td>
<td>Aqua House, Chester Journal Club, St Peters Church, Chester</td>
<td>103 Day Centre, St Helens Dr Jean Sutton, GP Practice, Homeless Clinic, St Helens</td>
<td>Free day: Started literature search using databases and the internet</td>
<td>Visited the Kevin White Unit, Liverpool Continued with the literature search</td>
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### Week 3

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<tr>
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<tbody>
<tr>
<td>Attended a course developed by Shelter. The topic was homelessness and asylum seekers. held in the Sherrington lecture theatre. Wrote up the literature review</td>
<td>Wrote the introduction and created a title for the SSM Wrote up the case study</td>
<td>Started to write the abstract. Decided on the structure of the paper Wrote the method.</td>
<td>Finished writing the abstract Started the sections “what is homelessness” and “prevalence of homelessness”</td>
<td>Started to write the substance abuse and drug service sections and continued into the weekend.</td>
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</tbody>
</table>

### Week 4

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<tr>
<th>Monday</th>
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<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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</thead>
<tbody>
<tr>
<td>Finished writing</td>
<td>Finished writing</td>
<td>Wrote the</td>
<td>Meeting with Dr</td>
<td>SSM deadline</td>
</tr>
</tbody>
</table>
main body of the paper.
the conclusion and recommendations
reflection. Checked the finished piece and made an necessary amendments
Dillon to sign contract

| Appendix 7 |
|---|---|---|---|

**Key Sources**

1) Dr Jean Sutton  
   General Practitioner  
   Victoria House  
   Holloway  
   Runcorn  
   WA7 4 TH  
   01928 593600  

2) Joe McGovern  
   Key Worker  
   Aquahouse  

3) Charles Flood  
   Student Facilitator  
   chazfloody@hotmail.co.uk  
   07929732953  

4) Sue Barwise  
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5) Mandy Casey  
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   Chester  
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   01244 624088
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