1262 - SSM1-DR J O'NEILL.

HOMELESSNESS AND HEALTH IN CHESTER

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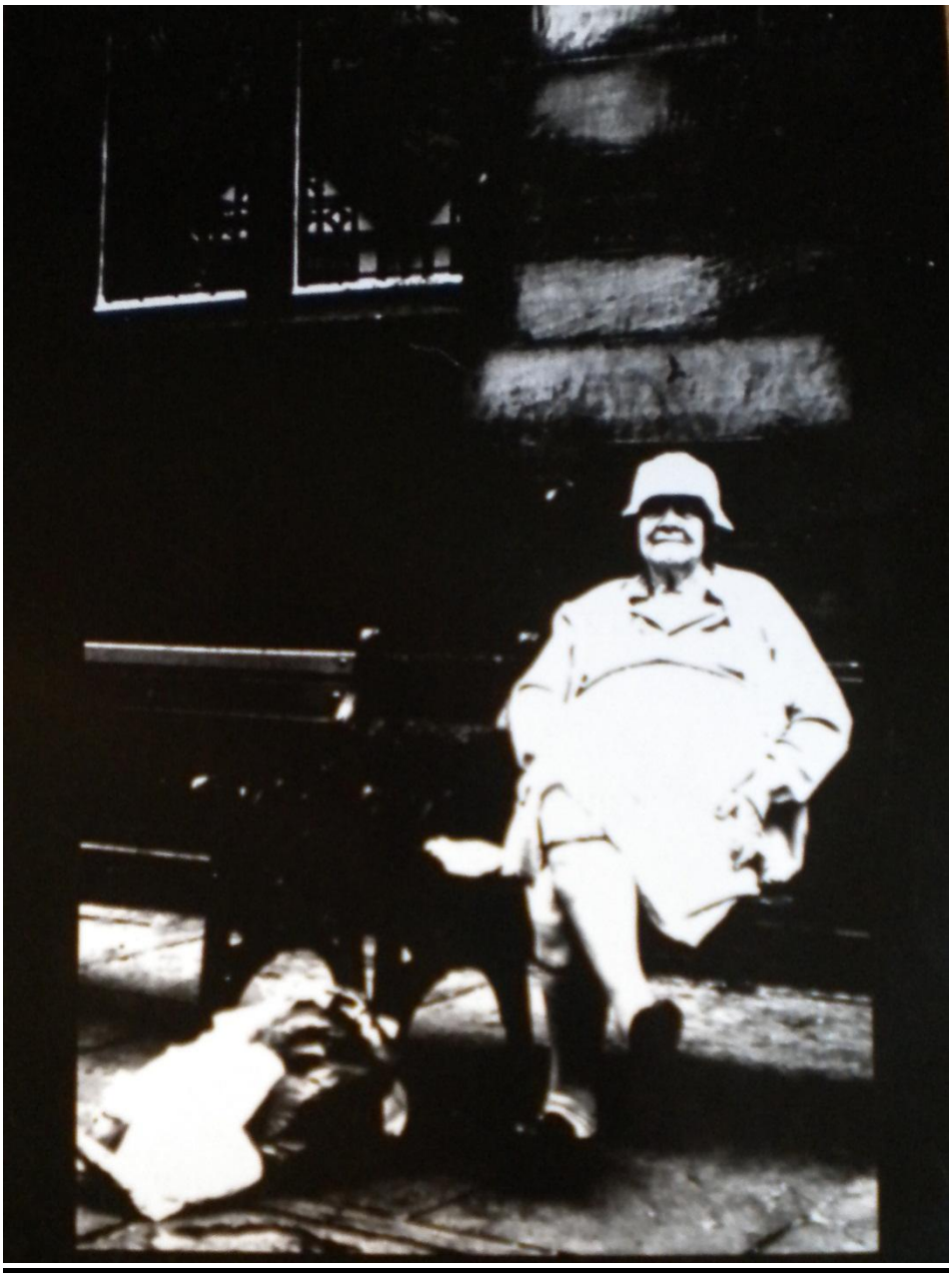

"To simply sit and listen, a reward it may bring,

Without lifting a finger one can hear her sing."

An extract from a poem by Martin Coyle, a homeless client, with permission from Chester Aid for The Homeless.

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Abstract

Background

Poor mental health can catalyse the onset of homelessness. On the contrary, homelessness can have negative effects on mental health. The case histories taken on a three day placement in Chester exposed some of the types of mental illness suffered by the homeless population and the effect it had on their lives.

Aim

The aims of this SSM are to investigate the effects of homelessness on mental health and explore further the associations between personality disorders and drug abuse amongst the homeless.

Method

A three day placement in a general practise that specialised in the care of homeless people was undertaken. From this, case histories were taken that have contributed to the formulation of a question for a systematic review. The databases used to search for articles and studies were: PubMed (1990-present), Medline (1990-present), Cochrane Library (1990-present) and the University of Liverpool library database DISCOVER (1990-present). The keywords used in the search were 'homelessness', 'personality disorder' and 'drug abuse'. Other information was found through websites by searching Google and Google scholar.

Results

Two studies were found to be suitable for the systematic review. Both studies found associations between personality disorders and drug abuse amongst the homeless. The strengths and weaknesses of each study were taken into consideration when drawing conclusions from the data. The two studies used both suggested that more research needs to be done in this field.

Conclusion

Homelessness can have detrimental effects on the mental health of individuals. There are associations between homelessness, personality disorders and drug abuse. When

dealing with homeless patients who are mentally ill, doctors must abide by the GMC duties of a doctor and respect the ethical principles in order to provide effective care.

Learning Objectives

- To learn about the issue of homelessness, the reasons behind it and any topical issues surrounding homelessness at the current time.
- To explore the effects of homelessness on the mental health of an individual.
- To carry out a systematic review that evaluates studies about a topic of interest that is to do with homelessness.

Introduction

What is homelessness?

The term homelessness is used to describe the different living circumstances of individuals. It does not just include living on the streets. An individual can be classed as homeless for a variety of reasons such as:

- Not having permission to continue living where you are (squatter)
- Cannot stay at home due to violence or being locked out
- Living in a movable structure such as a mobile home or boat and having nowhere to park it
- Having nowhere to live in the UK and the world
- If an individual is likely to lose your home in the next 28 days [1]

The 1996 Housing Act states the legal definition of homelessness as:

- There is 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]

According to Crisis website there are four types of homeless individuals:

- Legal homelessness (as described above)
- Statutory homelessness are households that are classed as a priority by the Housing authorities, qualify for assistance and are unintentionally homeless
- Hidden homeless are households who are currently not entitled to accommodation; they either have or haven't applied for assistance. According to crisis there are approximately 400,000 individuals in this position at any one time
- Officially Recognised as Homeless are households that are homeless legally and have applied to be classed as homeless by the state. [1]

Definitions

Term used	Definition of term
Health	"Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity" [3]
Human Rights	Text from Human Rights Act 1998. "anyone who is in the UK for any reason has fundamental rights which the government and public authorities are legally obliged to respect". There are definitive rights which can never be over-ridden and rights that have limitations. [4]
Inverse Care Law	Julian Hart in 1971 described inverse care law as "the availability of good medical care tends to vary inversely with the need for it in the population served." [5] Those who need the services less tend to use healthcare services more often and effectively than those whose need for services is greater. [6]
Health Inequalities	WHO definitions states: "Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups". "Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned." [7]
Poverty	"the state of having little or no money and few or no material possessions". [8]
Rough Sleeper	"People sleeping rough on the streets." [9]

Term used	Definition of term
Depression	"Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration". [10]
Post-traumatic Stress Disorder	"Post-traumatic stress disorder; an anxiety disorder associated with serious traumatic events and characterized by such symptoms as survivor guilt, reliving the trauma in dreams, numbness and lack of involvement with reality, or recurrent thoughts and images". [11]
Substance Misuse/Abuse	Stated by Wikipedia. "Although the term substance can refer to any physical matter, substance abuse has come to refer to the overindulgence in and dependence of a drug or other chemical leading to effects that are detrimental to the individual's physical and mental health, or the welfare of others." [12]
Mental Health	Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community." [13]
Diagnostic and Statistical Manual of Mental Disorders Criteria	This is a standard criteria that is used by clinicians, health insurance companies, researchers, policy makers and pharmaceutical policies for the classification of mental disorders. Includes Axis I and Axis II disorders.[14]
Axis I	"Clinical disorders, including major mental

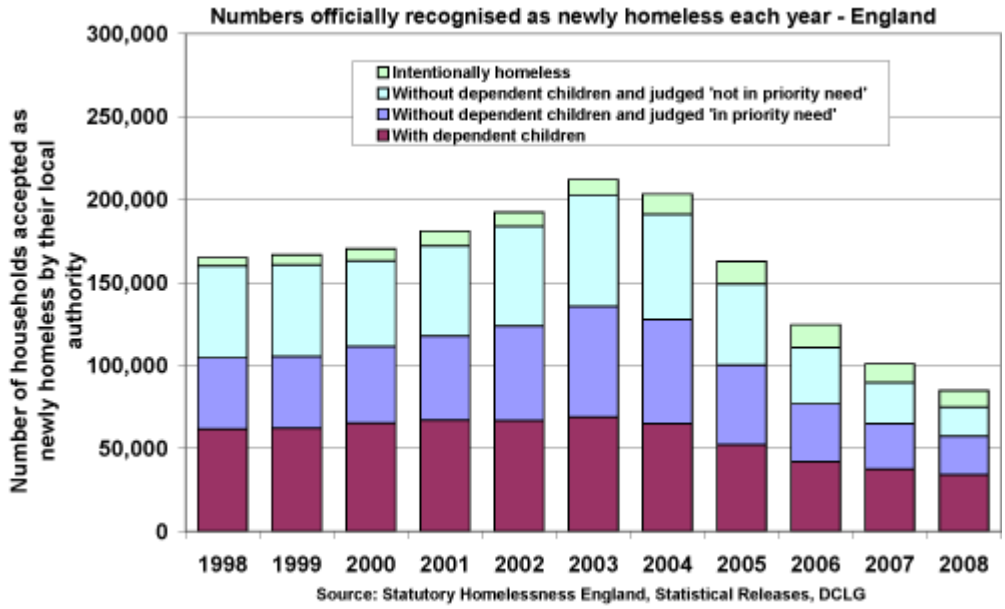
	disorders, and learning disorders".[14]
Axis II	"Personality disorders and mental retardation".[14]

Prevalence of Homelessness in the UK

Homelessness statistics show the number of newly homeless households as recognised by authorities and the prevalence of homelessness in the UK.

In 2008, 85,000 households in England were officially classed as newly homeless by their local authorities. The number of new homeless households per annum rose between 2002 and 2003 but then fell by two thirds between 2004 and 2008. The number of newly homeless households in 2008 is significantly lower than the numbers in the late 1990's. The following statistics are shown on the table below. [15]

Figure 1[15]



Prevalence of Mental Illness in Housing Applications

Decisions were made by local housing authorities between January and March 2010 on 21,410 applications for housing assistance under the Housing Act 1996 homelessness legislation. Of these applicants 45% were found to be unintentionally homeless and were in priority need and were therefore accepted. Of those in priority need 8% suffered from some form of mental illness which qualified them for priority need. [16]

Statistics on the number of people who are homeless are achieved by information provided by the housing authority, the census and sometimes charities that state the number of individuals in hostels or sleeping rough. However, because of the method of the data collection and the nature of the investigation, all statistics should be treated with caution.

Types of Mental Illness Suffered by Homeless People

Mental illness if not managed effectively can lead to homelessness. However, the stress of being homeless can have detrimental effects on mental health. Consequently mental health is prevalent amongst homeless individuals.

The following information has been taken from an article in the British Journal of General Practise by Nat Wright which gives an overview on the common mental illnesses suffered by the homeless. The article lists them as: schizophrenia, depression and other affective disorders, psychosis, anxiety states, personality disorder, earlier onset of drug misuse and severity of alcohol use. [17]

A study was conducted in 1998 on 132 homeless adults which provided information on the health characteristics of the individuals. The study compared the health of those people living in shelters against those who did not live in shelters. The average age of the group studied was mid-thirties and the majority were male. The study showed that the most common mental health issue was depression and the most common fear amongst the individuals was loneliness. This study suggests that there may be an association between the feeling of isolation and depression amongst the homeless. [18]

The Media and Homelessness

Due to the current economic climate, the topic of homelessness features often in the newspapers and websites. On yahoo news an article which was written 6 February 2011 describes the results of a recent survey that took place in Ireland. The survey results show that 1 in 10 people are afraid of becoming homeless in their lives. The survey was undertaken by a homeless charity called Focus Ireland which has announced a new campaign that will increase awareness of homelessness and put the issue on the government priority list. The advertising slogan being used is "While Politicians Canvas Door to Door - Some People Have to Sleep in Them". The charity blames the results of the survey on the recession which has caused many people to fear for their future living situations. The charity hopes that the slogan will shock politicians into moving the issue of homelessness to the top of the political agenda.[19]

Another recent article was found on the BBC News website that discussed the issue of homelessness and mental health. The article was written 4 April 2009. Comparable to the article above, this article mentions how the recession may lead to a rise in homeless people. The article discusses the results of a survey that states 1 in 3 people in a hostel suffer from severe mental health problems, such as personality disorders. Also when depression and anxiety are also taken into consideration, 8 in 10 people are affected by poor mental health. The charities for homelessness have said that the majority of rough sleepers and people living in hostels receive no help for their poor mental health. Because of these results, charities have campaigned for more services to be made available and discussions with NHS experts and other homeless services were to take place soon after the article was written.[20]

The two articles above demonstrate how homelessness is a topic of much discussion and debate both on a national, political and local scale.

Case Histories

Below are the two case histories taken from a three day placement of the author in Chester. The accounts are described by homeless people that visited the GP surgery where the placement was undertaken. It is called St Werburghs Medical Practise and is a specialist GP surgery for the homeless and specifically referred violent patients.

Case History 1

Gender: Male

Age: 25

The male interviewee was born into a middle class family and was diagnosed with Antisocial Personality Disorder aged 12. His parents chose not to help him get help and support for his condition, instead they were ashamed. It reached a point where he was picking fights at school on a daily basis. He started shoplifting and having outbursts of violent behaviour towards other pupils which lead to his exclusion from three schools. He left school aged 16 with minimal qualifications. After a particularly extreme spell of violence towards someone he used to know at school, his parents threw him out onto the street. He managed to live in a friends flat for three years and got an apprenticeship with a carpenter. These were described as the happiest years of his life. Another man moved into the flat with him and his friend. The man smoked cannabis and snorted cocaine and threw wild parties. Eventually he and his friend got degenerated into this behaviour. Cannabis seemed to make his condition worse and eventually his lack of motivation to go to work and verbal aggression towards his boss caused him to lose his job. After that he stayed in all day taking various drugs, he started receiving benefits and spent it all on drugs and alcohol. The friend he was living with allowed his girlfriend move in and subsequently threw him out. Since then he has been in and out of various hostels each time getting thrown out for violence. Since visiting St Werburghs two years ago he has regular counselling sessions which he finds very productive and feels much calmer and more in control of his condition. He is currently staying in Roodie house, a hostel in Chester. He tries to avoid befriending the other people living there as he is not using drugs as frequently and says he has stopped drinking altogether.

Case History 2

Gender: Male

Age: 46

The male interviewee was born into a family of seven, who were always extremely poor. His mother and father rowed constantly during his childhood because of his father's drinking problem. His mother tragically died of a heart attack when he was 14 years old. He chose not to live with his father and moved in with his uncle. He completed school and began work at a pub and eventually became the landlord aged 28. He married and had two children. When he was 32 he had a mental breakdown due to the stress he was under at work. He resigned from his job and sold the pub. His wife was supportive but he was depressed and spent three years being unemployed. His wife eventually left him and moved to Spain with a new partner. His two children went with her. After this he started using heroin after being encouraged to use it by a friend. Heroin completely took over his life and resulted in him being unable to pay his mortgage and having his house repossessed. Since that incident 5 years ago he has been homeless. He now has counselling for his depression and is on methadone to help him become less dependent on heroin. He has received treatment at Aqua House drug clinic. However since moving into a hostel he has started using heroin more often due to the influence of others. He hates having to go out onto the streets to get drugs and is constantly in fear of being mugged. He had a facial injury due to a fight with another inhabitant at the hostel. Despite this he is trying to stay positive and looks forward to the future where he hopes to stop using drugs and see his children whom he hasn't seen since becoming homeless. He is satisfied with the services in Chester and feels that when he begins counselling at St Werburghs (within the next month) he will know how to handle his depression more effectively.

Systematic Review

What is it?

The purpose of a systematic review is to:

- Identify studies and research evidence surrounding a topic of interest
- Assess the quality of each study depending on the type of study, the data collection methods and the baseline characteristics of the participants included in the study
- Summarise the findings of each study in an unbiased manner
- Interpret the findings taking any possible errors in the results or data collection methods into consideration
- Compare the results of each study

A systematic review that examines both quantitative and qualitative data is called a mixed-method systematic review.

The purpose of a systematic review is that it brings together the research evidence of a certain issue and enables it to be more effectively analysed and provides a basis for further investigation. There may be hundreds or even thousands of published studies surrounding a topic and it can be very difficult to gain any real insight into the subject by examining each article individually. Therefore a systematic review can produce a better image of the results.[21]

In order to decide which studies to include, a Critical Appraisal Framework is to be used. This will exclude any poor quality studies and therefore will lead to more reliable results being produced.

The topic chosen for investigation was personality disorders amongst the homeless and whether there is a relationship between having a personality disorder and drug abuse amongst the homeless.

Objectives

The accounts given in the case histories above illustrate how personality disorders and homelessness can lead to drug abuse. Also having a duel diagnosis of a personality disorder and drug addiction can result in the individual becoming homeless. The systematic review therefore will investigate the interactions between these three factors. The question being investigated is 'What is the relationship between personality disorder and drug abuse among homeless people?'

Method

The following databases were searched: PubMed (1990-present), Medline (1990-present), Cochrane Library (1990-present) and the University of Liverpool library database DISCOVER (1990-present).

Limits	Reason for limit
Study 1990-present	To ensure study results are up to date
English Language	To ensure can be read and understood
Abstract	Only abstract read at first to see if paper was relevant to topic
Full Text (after abstract)	Full version read if abstract relevant.

When an article or study was chosen that could possibly be used in the investigation, the Critical Appraisal Skills Programme for Qualitative Research[22] was used to check the study was trustworthy and not of poor quality. Two articles were selected, both studies about the link between personality disorder and drug abuse among the homeless. These studies were selected because the content was relevant to the investigation.

Results

These are the search results for each term searched. The term 'mental health' was later changed to personality disorder so the search was more specific.

	Homelessness	Homelessness AND mental health	Homelessness AND personality disorder	Homeless AND personality disorders AND drug abuse
PubMed	1836	613	50	25
Cochrane Library				
Medline	50	44	9	9
DISCOVER	34,882	5764	286	145

Two studies were found that were suitable to the review.

Study 1 title was 'Impact of personality disorders in a sample of 212 homeless drug users'. The authors were Combaluzier S, Gouvernet B, and Bernoussi A, from the University de Rouen, France 2009.[23]

Study 2 title was 'Substance abuse and personality disorders in homeless drop-in centre clients: symptom severity and psychotherapy retention in a randomized clinical trial' The authors were Samuel A. Ball, Patricia Cobb-Richardson, Adrian J. Connolly, Cesar T. Bujosa and Thomas W. O'Neall, from Yale University School of Medicine.[24]

These are the results when the study was reviewed using the Critical Appraisal Skills Programme for Qualitative Data[22:]

	Study 1	Study 2	
Questions	yes or no	yes or no	Comments
Was there a clear statement of the aims of the research?	Yes	Yes	

Is a qualitative methodology appropriate?	Yes	Yes	
Was the research design appropriate to address the aims of the research?	Yes	Yes	Study 1-Clinical interviews to collect data Study 2-Clinical interviews to collect data RCT
Was the recruitment strategy appropriate to the aims of the research?	No	Yes	Study 1 did not state how participants were selected. However those selected were suitable for the study (homeless, drug abuse).
Were the data collected in a way that addressed the research issue?	-	Yes	Study 1 details how interviews were conducted, however why that method was chosen was not specified. Study 2 each participant had two interviews and completed 3 questionnaires.
Has the relationship between researcher and participants been adequately considered?	No	yes	Study 2 the researcher identified possible bias and explained how research questions were formulated and data collected in sufficient detail.
Have ethical issues been taken into consideration?	No	No	Study 1 and 2 showed no evidence of this.

Was the data analysis sufficiently rigorous?	Yes	yes	Study 1 does not explain how data collected selected from sample to demonstrate the process of analysis. Neither Study 1 nor 2 had critical analysis of researchers own role.
Is there a clear statement of findings?	Yes	yes	
How valuable is the research?	-	-	Both studies explain their contribution to the topic and both suggest more research needed.

Discussion

Study 1

The participants in the study were 226 drug users, 999 homeless people and 212 of these were drug users. The geographic origin of the populations was the Mediterranean basin. The mean age of the groups was 27 years old the drug used was heroin and whether this was used alongside others was not specified. The aim of the investigation was to study the interaction between personality disorder, drug abuse and homelessness. Personality disorders can lead to drug abuse, which can lead to homelessness. However drug abuse and personality disorders can also develop as a result of homelessness. The study evaluated the effects of two of the factors on each other using multiplicative interaction which is basically a measure of association. The multiplicative interaction can also give the etiological fraction which is the number of cases where the exposure was causal of the outcome.

The data was collected from the population by clinical interviews and the analysis followed the Diagnostic and Statistical Manual of Mental Disorders criteria. The personality disorder distribution among the homeless did differ significantly from that of the homeless drug abuser group. However, the link is not strong as personality disorders are much more prevalent among the homeless then the general population (80% compared with 10%). According to the study having a personality disorder and abusing drugs multiplies the risk of becoming homeless by seven and 46% of the homeless drug abusers were made homeless because of this reason. The results of the study also displayed that having a personality disorder and being homeless increases the risk of drug abuse by 13 times. It explained why 75% of drug abuse among the homeless with personality disorders.

The results produced illustrate that the development of personality disorders are not influenced by the association of drug abuse and homelessness. However these may have an impact on personality disorders. The results did show that having a personality disorder and being homeless is a risk factor for drug abuse. Also having a personality disorder and abusing drugs can increase the risk of becoming homeless.

Strengths and Weaknesses of Study 1

The study did abide by the criteria for the majority of the requirements. However, it did not answer the question 'Was the recruitment strategy appropriate to the aims of the research?' effectively. There was no explanation as to how the participants for the study had been selected. There was also was little information about the participants apart from the mean age (28) and the drug used (heroin). This means that an interpreter of the results does not know if the participants had similar characteristics and backgrounds, for example gender, ethnicity and employment history. The lack of information regarding the characteristics of the participants is a major flaw as an interpreter would not know if there was an equal amount of men, women and ethnicity groups. If the proportions of each were unequal then biased results could have been produced. Also, although the mean age is stated, the standard deviation from the mean is not. Without knowledge of how large or small the standard deviation from the mean is, it is difficult to assess the validity of the data. It is important that the background of a participant is known because a previous event could have contributed to the homelessness of that person rather than the factors being studied. The study did not answer the question in the criteria 'Have ethical issues been taken into consideration?' as there was no evidence of whether the participants discussed issues around the study such as consent and confidentiality and whether approval was sought from the ethics committee is unknown. This lack of information regarding ethics is a major weakness.

Another weakness of the study was that the type personality disorder of the relevant participants were not specified and neither was the axis that the personality disorders belonged too in the Diagnostic and Statistical Manual of Mental Disorders criteria. The study did mention that the criteria were used to diagnose the participants during the clinical interviews. However the lack of further detail may mean that the conclusion is invalid.

The method of data collection was through a series of clinical interviews that sought to discover the prevalence of personality disorder amongst the groups. One weakness with this was that there were no details of what the interview entailed, such as what questions were asked in the study and what answers were given. Therefore someone interpreting the study cannot tell if the questions were appropriate for the study and

whether the answers given were sufficient to draw conclusions from. The nature of an interview itself presents limitations such as biased answers from the participants and interpretation by the interviewer. The study design used was a cross-sectional study. The study cannot demonstrate a causal relationship, and in addition being qualitative it is even more difficult to show an association between variables.

Despite the criticisms mentioned above, the study did exhibit strengths. The purpose and outcomes of the study were clearly stated and explained and the need for more research into the topic was suggested. The study abided by the majority of the critical appraisal criteria which assesses the validity of data. One major strength of the study is that the sample size was large, 999 homeless people in total were participants. It is well known that the larger the sample size the more representative the results are of the population which enables valid conclusions to be drawn. Another advantage of using this study in the review is that it was conducted very recently (2009), and the results therefore are more likely to still apply to the homeless population today. However the study took place in France so it is questionable whether the conclusions drawn can be applied to the homeless population of the UK.

Study 2

There were 52 participants in the study all seeking services at a homeless drop in centre. The participants were mostly men (94%), African American (49%), White (23%) and Hispanic (26%). The mean age was 38.3 with a standard deviation of 10.4 and range 19-57. The inclusion criteria was for all participants to have been diagnosed with a personality disorder but without severe mental illness, over 18 years old, drug or alcohol use in the past thirty days and the ability to read write and being capable of completing the questionnaires/interviews/self-assessment reports required for the investigation.

The aim of the investigation was to analyse the prevalence of certain types of personality disorders (Axis II includes: paranoid personality disorder, schizoid personality disorder, borderline personality disorder, antisocial personality disorder and borderline personality disorder, antisocial personality disorder) psychosocial problems and treatment response of people receiving services at a homeless drop in centre that had personality disorders and were substance abusers. In the first part of the study each participant had to attend two interviews in order to diagnose the personality disorder and find out the impairments that the drug addiction has on daily life. The participants also had to answer 3 questionnaires two of which were self-assessment reports. The second part of the study was a Randomised Clinical Trial as each participant was randomly assigned to a certain type of treatment. The treatment was either individual psychotherapy (focused on personality disorder) and substance abuse relapse prevention or standard substance abuse counselling.

However due to the sheer size of the investigation, this review will focus on the first part of the investigation which was to find out the types of personality disorders among the participants.

The results of the study with regards to drug abuse were that 50% of the sample identified illicit drugs (heroin 14%, cocaine 50% and marijuana 14%) as their primary substance of choice. The mean age for starting to abuse drugs was 21.

The results with regards to personality disorders were as follows: 88% had a Cluster A diagnosis with the most common being paranoid personality disorder (74%), second Schizotypal (56%) and third schizoid (42%). Cluster B disorders normally develop due to drug dependence and 74% of the participants had a diagnosis; borderline (51%), antisocial (47%),histrionic (23%) and narcissistic (35%). Other conditions were depression (87%), cognition (64%) and anxiety (81%). These were not a direct result of substance abuse which means they may have developed as a result of being homeless.

The prevalence in the participants of borderline, anti-social, dependant and avoidant personality disorders were similar to those that are found in drug dependant samples of inpatients in hospitals. In order to be diagnosed with a personality disorder there must be evidence of traits early on in life. However, the study describes how Cluster A personality disorders may have developed as a consequence of living rough on the streets and this conclusion cannot be ruled out. Therefore being homeless may have contributed to the development of a personality disorder. The study is one of few that investigated Axis II personality disorders so more research is needed in this area before reliable conclusions can be drawn.

Strengths and Weaknesses of Study 2

The results of Study 2 are perhaps more valid than Study 1 as Study 2 answers all of the questions in the criteria accept for the question about ethics. The method, description of data analysis and results were all described in more detail in Study 2 than Study 1. Study 2 showed many strengths, for example the characteristics and background of the participants were stated, such as gender, ethnicity, past and current employment (if any) and marital status. By knowing these details an interpreter of this investigation can decide if the results are representative of a population. Study 2 also gave more details about the recruitment strategy for the participants by listing an inclusion and exclusion criteria than Study 1 and the interviews and questionnaires that the participants had to undertake were described more effectively. This is evidence that the results of Study 2 may be more valid than Study 1.

Another advantage of Study 2 is that the type of personality disorder being investigated is stated. Also the prevalence of each type of personality disorder is given in percentages which enable an interpreter of the data to see what personality disorder is most common/least common etc. Like Study 1, Study 2 was also carried out within the past ten years (2005) and the more recently a study is carried out, the more likely it is that the results can still be applied to the current time.

However Study 2 did have several weaknesses. The sample size for Study 2 was quite small (52 participants). A small sample size is a major weakness because there is less chance that the participants will be representative of the rest of the population they have come from. Also the study did not answer the question in the criteria 'Have ethical issues been taken into consideration?' as there was no evidence of approval from the ethics committee or details of how confidentiality and consent were dealt with. This is a weakness as ethical issues are very important and need to be taken into consideration in a study.

Another disadvantage of Study 2 is that the results of the half of the study that was the Randomised Clinical Trial were not relevant to this review as the treatment for personality disorder and drug abuse were not being investigated.

Both studies show that there is a relationship between personality disorders and drug abuse amongst the homeless. Study 1 suggests that while there is an association between these three factors, personality disorders combined with another factor tend to be a catalyst for homelessness or drug abuse. Study 2 on the other hand focuses more on what type of personality disorder homeless drug abusers have developed and suggests that some personality disorders can develop as a result of homelessness.

Study 1 and Study 2 both suggest that more research needs to be done in this area so more details about the associations between the three factors can be produced. These two studies were the only ones in the search that were considered suitable for use in this review. Therefore in order to draw more valid conclusions, more research needs to be done.

Conclusion

- Homelessness does not just mean living on the streets. There are several categories of homelessness which apply to different living situations of individuals. Homelessness can have a negative effect on the mental health of an individual; however poor mental health can lead to an individual becoming homeless in the first place.
- The case histories show that homelessness can have a poor effect on mental health, with depression being the most common mental illness. The homeless individuals that were spoken to in Chester were satisfied with the services that were provided to help deal with poor mental health.
- Personality Disorders are prevalent among the homeless population. Whether homelessness and drug abuse lead to the development of a personality disorder, or if having a personality disorder and a drug problem can lead to homelessness is a topic of debate. In order to assess the link between these three factors effectively, more research needs to be done.

Reflection

Looking back over the course of this SSM, I realise that I have thoroughly enjoyed completing it. I have learnt a vast amount about the issue of homelessness and have seen the detrimental effects that it can have on an individual's health first hand. The placement I undertook in Chester really opened my eyes to an issue I previously had little knowledge about. One of the most important things I felt I learnt on placement was that the preconceptions I used to have about homeless people and why they were homeless, were very judgemental and usually wrong. This taught me about stigmatisation. I believe this SSM gave me an insight into the health issues surrounding a topic that I will have little opportunity to explore further during my undergraduate course. For that reason I am glad I chose to study this particular SSM.

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Appendix 1

Ethics

Due to the nature of mental illness, sometimes patients may not be competent in making their own decisions regarding their own healthcare. Homeless people are also less likely to have a stable network of support from family and friends. Taking this into consideration, a healthcare professional will have to abide by the four ethical principles when treating homeless patients.

The four ethical principles according to Beauchamp and Childress taken from the UK Clinical Ethics website[25]:

Respect for autonomy: respecting the decision-making capacities of autonomous persons; enabling individuals to make reasoned informed choices.

Beneficence: this considers the balancing of benefits of treatment against the risks and costs; the healthcare professional should act in a way that benefits the patient

Non maleficence: avoiding the causation of harm; the healthcare professional should not harm the patient. All treatment involves some harm, even if minimal, but the harm should not be disproportionate to the benefits of treatment.

Justice: distributing benefits, risks and costs fairly; the notion that patients in similar positions should be treated in a similar manner.

Appendix 2

Good Medical Practice: Duties of a Doctor[26]

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.

Appendix 3

Timetable

Date	Work
19/01/11	Compulsory lecture in Duncan Building about the write up and presentation of SSM. Lecture on writing a systematic review.
21/01/11	Compulsory lecture in Sherrington Building about the use of the library for journals and books. There was also information about searching journals online.
24/01/11	Met Dr O'Neill at Ellesmere Port for an introductory talk. We were informed of our placements.
25/01/11	Went to Chester and spent the day at St Werburghs. Met some of the patients and obtained a case history from one patient. In the afternoon, I visited a hostel called Roodie House and found out more about the services available there.
26/01/11	Returned to St Werburghs and sat in the morning clinic. Met more patients and took another case history from one patient. In the afternoon I visited the Harold Tomlin Day Centre and found out what the purpose of the day centre was and what activities they held.
27/01/11	Returned to Chester for final day of placement. Visited Aqua House Drug & Alcohol Clinic and spoke to the manager about the purpose of Aqua House. In the

	afternoon I visited Crispin night shelter and learnt about the services available there.
28/01/11	Met Dr O'Neill again and we were given several talks by different people who worked with the homeless. The purpose of the day was to find out about the homeless services in Liverpool and the experiences that the employees had had. Started reviewing journals and articles to include in SSM
29/01/11-03/01/11	Began planning what studies and articles to include in SSM and began writing up SSM
04/01/11	Returned to Ellesmere Port and listened to a talk about systematic reviewing and how to apply it to this SSM. I then presented a PowerPoint presentation about a study I had looked at and explained it to a small audience. Continued writing SSM.
11/01/11	Submitted SSM.

Appendix 4

Contact List

1. Dr Joseph O'Neill, Gneral Practitioner with special interest
   Addaction
   83-93 Stonebridge Lane
   Croxteth
   L11 4SJ
   0151 546 1141

2. Siobhan Harkin, Secretary to Dr O'Neill
   0151 355 4008
   07551596968

3. Dr Julie Reid, General Practitioner with special interest
   St Werburghs Medical Practise
   2a George Street
   Chester
   CH1 3EQ
   01244 665834

4. Pete Melvin
   St Werburghs Medical Practise
   2a George Street
   Chester
   CH1 3EQ
   07775537259

5. Pauline Finlay
   St Werburghs Medical Practise
   2a George Street
   Chester

CH1 3EQ
07521309514

6. Val Casey
   St Werburghs Medical Practise
   2a George Street
   Chester
   CH1 3EQ
   007765243523

7. Dr Martin Dennis
   St Werburghs Medical Practise
   2a George Street
   Chester
   CH1 3EQ
   01244 665834

8. (Ask for manager)
   Drug & Alcohol Service
   Aqua House
   Broughton
   Chester
   Cheshire
   CH3 5AF
   01244 344 999
   01244 347 087

9. Harold Tomlins Day Centre
   24 Grosvenor Street
   Chester
   Janet.rennie@cath.org.uk

Amy Reynolds

Appendix 5

Authors PowerPoint Presentation

Homelessness and Mental Health

By Amy Reynolds and Poppy Jackson

Impact of personality disorders in a sample of 212 homeless drug users

2009 Oct;35(5):448-53. Epub 2008 Oct 1

Introduction

- During our placement in Chester the issue of drug misuse was particularly prevalent among the homeless population
- One of our case history participants suffered from a personality disorder and we decided to choose a study that discovered a link between drug abuse and personality disorders
- A study done in France 2009 investigated this link.

Objectives

- To study the interactions between drug abuse, personality disorders and homelessness.
- Personality disorders can lead to drug abuse, which can lead to homelessness
- Drug abuse and personality disorders can also develop as a result of homelessness

Procedures and methods

- Evaluating the effects of the two factors on each other by studying multiplicative interaction (measure of association) and etiological fraction (causality measure) linked to interaction.
- Studied a group of homeless people (999) and the drug abusers amongst this group (212)
- Data collected through clinical interviews with the participants following the Diagnostic and Statistical Manual of Mental Disorders.

Outcomes and results

- The distribution of personality disorders between the two groups (homeless, homeless drug abusers) did not vary to a large degree. Therefore intensity of the link was low because there was a high prevalence of personality disorders amongst both groups.
- "led to the conclusion that PD are not influenced by the association homelessness/DA"
- We interpreted this as meaning that there is no significant difference between personality disorders in the homeless and homeless drug abusers as the prevalence of personality disorder is high in both groups.

Conclusion

- The study explained that both a personality disorder and being homeless are a risk factor for drug abuse.
- However abusing drugs and having a personality disorder can also lead to homelessness.