What Health Problems do Homeless Street Sex Workers Face and what can be done to Improve their Situation?

“I tell a woman
what work I do for money
Don’t you ever feel afraid?
She asks, staring into the headlights
through a curtain of long, brown hair
which obscures half her face
like Veronica Lake
Yes, I’m afraid
Sometimes I try not to feel afraid
Four months ago I was raped
I was afraid of being tortured or killed
I answer, driving my dark green Vega
Wearing a turquoise angora sweater
dark red lipstick, new hairdo, good pants
I’m stronger, won’t quit
and they’re not going to stop me
She laughs and pushes the hair behind her ear
Bars of light drift upward, over our eyes”

Rhiannon Beynon
SSM 4: Homelessness and Health
September 2010
Abstract

Background

Of the 80,000 sex workers estimated to be working in the UK, the most visible representatives are the women who work on the streets. This causes a number of problems for these women as they have to deal with the abuse from people who are against their work. On top of this, many are homeless and have drug addictions, causing a lot of health and social problems for them.

Aims and Objectives

To look into the issues facing homeless persons and street sex workers in the UK and to look into what services are available to them, and explore how the situation may be improved.

Method

Databases; BNI, CINAHL, EMBASE, MEDLINE, PsychINFO were searched for relevant papers on street sex workers for a critical appraisal. Local services targeted at homeless persons and street sex workers in Liverpool were visited to discover what services are available in the area. Lastly, street sex workers were interviewed and issues surrounding their cases discussed with the outreach workers to get case histories to be discussed.

Results

Street sex workers in the UK face many problems, from drug addictions to violence. Many are also homeless and therefore face all the problems associated with this as well. The current legislation surrounding street sex work makes it impossible for sex workers to take necessary precautions to protect themselves.

Conclusion

The current situation for street sex workers in the UK is not acceptable. A change from the current laws that force the women into dangerous situations and do nothing to support women in exiting prostitution should be replaced by the development of managed zones in which the women are safer and can be easily targeted by support groups to help them overcome their drug problems, find suitable housing and exit sex work.
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Aims and Objectives

Learning Objectives:

1. To develop an understanding of the causes and consequences associated with homelessness and street sex work, using up to date literature on the subject.
2. To understand the clinical and social problems associated with homelessness and street sex workers.
3. To explore current services available to homeless people and street sex workers and look into how these services can be provided sustainably to the clients.

Core Learning Activities:

1. Service learning visits
2. Case histories
3. Article presentation
Acknowledgements

Firstly I would like to thank Dr O’Neill for running the course and allowing me the chance to explore this area of healthcare, which I have found thoroughly interesting.

I would also like to thank Siobhan Harkin for organising all the placements at the different organisations, as without these arrangements I would not have had the chance to gain the same insight into the subject.

I would also like to thanks Julie Hughes for all her help and guidance about different aspects of sex work.

I would also like to thank everyone at the following organisations for allowing me to visit and gain an insight into your work: Basement drop-in centre, Sisters of Charity, Big Issue, Surestart, Stoak Lodge and Addaction.

Lastly I would like to thank Mandy and Julie from the Armistead Centre for allowing me the experience of joining them on the outreach project to the street sex workers in Liverpool.
Introduction

Many street sex workers in the UK are homeless; due to their chaotic lifestyle and laws surrounding sex work, they are a relatively hard population to access and therefore rarely receive the services they need. Also due to stigma towards them, they are quite often excluded from society and also face a large amount of abuse and violence towards them. As housing state alone is a major determinant of health and there is also a very high prevalence of illicit drug use, there health should be of great concern and appropriate measures should be taken to address these issues and improve street sex workers wellbeing. This SSM will focus on these issues, look at the services available and look for appropriate ways to improve the situation in the UK.

Definitions

‘Homelessness’ can mean different things to different people and may cover a wide variety of housing situations, as shown in box 1:

<table>
<thead>
<tr>
<th>Box 1</th>
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<tbody>
<tr>
<td>• ‘rooflessness’: those without any kind of shelter, i.e. rough sleepers</td>
</tr>
<tr>
<td>• ‘houselessness’: includes those living in temporary accommodation such as shelters and those living in long-term institutions</td>
</tr>
<tr>
<td>• those with temporary tenures, for example staying with relatives or with an eviction notice and squatters.</td>
</tr>
<tr>
<td>• those in ‘intolerable’ housing circumstances, for example where there are threats to the personal or psychological wellbeing of the person</td>
</tr>
<tr>
<td>• ‘concealed households’: those who are involuntarily sharing accommodation on a long-term basis.</td>
</tr>
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</table>

For the purpose of this essay, all the above situations will be accepted as homelessness.

The following definitions are also relevant to the topic and important to reflect upon in relation to homelessness and street sex work (see box 2):

<table>
<thead>
<tr>
<th>Box 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”</td>
</tr>
<tr>
<td>• Human Rights: “rights and freedoms that belong to all individuals regardless of their nationality and citizenship. They are fundamentally important in maintaining a fair and civilised society.”</td>
</tr>
<tr>
<td>• Health Inequalities: “differences in health status or in the distribution of health determinants between different population groups”</td>
</tr>
<tr>
<td>• Poverty: “the state of having little or no money and few or no material possessions”</td>
</tr>
</tbody>
</table>
Statistics

The average number of households recognised as being homeless between 2006 and 2008 in Liverpool was 1402, which is 0.74% of the total number of households.7

In the UK there are estimated to be 80,000 people involved in sex work.8 This however includes not only street sex workers but also the indoor sex industry. The number of women street sex workers in a particular area may vary from night to night. Statistics for street sex workers can therefore be misleading, for example “in Stoke-on-Trent in January 2008, police claimed there were only 45 street sex workers.....while an agency supporting sex workers simultaneously stated they had seen 130 women in the previous nine months”.9

Media Portrayal

The media often portray homeless persons as the vulnerable population they are, and a lot of work is done by homeless charities to raise awareness. An example of this was an advertising campaign done last year “to raise awareness of the fragile housing situation in the UK in the current economic climate.”10 There are also regular news stories covering aspects of homelessness, most of which taking a sympathetic angle on the issue.

The subject of street sex work is also quite commonly seen in the media, but with more mixed messages than the subject of homelessness. A lot of it relates to violence and sometimes murders of female street sex workers, such as the recent murders in Bradford. There is also some attention on the issue of legalising street sex work, with differences of opinions on the matter. A recent story also reported that six street sex workers had been ‘named and shamed’ on a police website, despite not being convicted of any crime.11

Working with the homeless and street sex workers

The GMC duties of being a doctor (see appendix 1) state that you must “work in partnership with patients”12, one aspect of this is to “support patients in caring for themselves to improve and maintain their health”12. This is very important when working with anyone with a drug problem, as they may sacrifice one aspect of their health by putting their addiction first. You must also “listen to patients and respond to their concerns and preferences”12, as these may differ from your own and they must be taken into account.

All patients must also be treated in an ethical way, taking into account Beauchamp and Childress 4 principles of medical ethics (see appendix 2). In people with drug addictions, this may be difficult; whereas the doctor may see a treatment to enable the patient to stop taking heroine as beneficence, the patient may not want to rush the process, in which case the patient’s autonomy must be respected. It is also important for the doctor to consider the principle of justice when dealing with drug users and homeless persons; these people should not be discriminated against and should be treated in the same way as any other patient.

For homeless drug users, total abstinence from drugs may initially be a too optimistic goal, therefore the theory of ‘Harm minimisation’ should be applied. This is the theory that “though the ill-effects of drugs cannot be eradicated by professional input, the harm that they
cause can be minimised.... A harm minimisation approach to homeless substance misusers, as well as addressing their health needs, maximises health gain, as it helps to stabilise their chaotic social situation.”\(^2\) The three aspects of harm minimisation are safer injecting, safer use of illicit drugs and safer sex.\(^2\)

The inverse care law must also be considered in relation to this population. This theory described by Julian Tudor Hart in 1971 states that “the most deprived communities (i.e. those with the highest health morbidity and mortality) were those most in need of quality health care. However, such communities were the least likely to receive such healthcare.”\(^2\) This is important to consider with homeless populations and those doing street sex works, as these are some of the most deprived populations in the country.

**Law**

The current laws and regulations on street sex work are a major factor affecting the health and well-being of the sex workers; “although prostitution may not be illegal, it is impossible for female sex workers to work without breaking a number of laws in the performance of their work.”\(^13\)

There is also the problem that issuing sex workers with a fine often simply forces them back onto the streets to work to earn the money to pay off the fine, resulting in a vicious cycle. Issues surrounding possible solutions to these problems will be explored in later sections.

**Method**

**Searches**

A literature search was also carried out using the FADE library search engine, which included the following databases:

- BNI
- CINAHL
- EMBASE
- MEDLINE
- PsychINFO

Search terms used were “homelessness” and “street sex worker” and the search was limited to studies carried out in the UK. This however was too limiting as no relevant studies were identified, “homelessness” was therefore removed from the search.

The University of Liverpool libraries and the FADE library were also searched for further literature relevant to the subject and grey literature was also used.

**Services**
In order to explore and understand the services available to homeless people in Liverpool, research was done into charities working with homeless people in the area. The Basement Drop-in Centre, Sisters of Charity, Addaction and The Armistead Centre were also visited to gain further insight into their work.

Cases

Whilst on outreach with the Armistead Centre I had the opportunity to talk to some of the sex workers about their experiences and the difficulties they faced in getting into stable housing and to the outreach workers about issues surrounding the cases.

Results and Discussion

Literature Review

Street sex work and Homelessness

Due to the chaotic lifestyle of many street sex workers, they often find themselves in and out of temporary housing and hostels. This can put the women in a difficult situation and cause many problems on top of those faced by any other homeless person in general.

The fact that many street sex workers are homeless poses great risks when finding somewhere to do business with a client. “Some street sex workers used to take their clients to their own or to friends’, where there would be someone to help if there was trouble, but now many are homeless, few have access to indoor premises and those who do risk eviction if they use their homes for business”. The women are therefore forced to do business in places such as alleyways, derelict buildings or out in the countryside, where they will not be seen. The alternative to this is to go to the client’s house, which is equally as dangerous.

There are also aspects of health which are related to homelessness in general. For example there is a linear relationship between ascending housing wealth and years of life expectancy.

Due to these problems associated with homelessness among street sex workers, it can be suggested that efforts need to be made for these women to be able to find accommodation more easily, for example by offering support and advice from local services.

Street sex work and drugs

There is a very strong link between street sex work and illicit drug use, with the need for money to finance their addiction being the main reason most of the women turned to street sex work. Indeed, it has been found that “Often women reported that they prostituted to finance not just their drug habit but that of their partner as well”. This was partly due to the greater income available from selling sex compared to petty theft and also due to the fact that with theft there is the risk of going to prison, whereas selling sex will only result in a fine.
Many street sex workers reported an escalation in their drug use after starting working, reporting that they “used as much money as they had available on drugs”. Many also stated that “if they had been able to overcome their drug dependence they would immediately cease working”. It also reported that more pressure was put on the women to continue working due to dealers offering them drugs on credit. The drug dealers themselves are often an integral part of the area in which the women work, meaning that as soon as they’d earned enough the dealers could sell them the drugs. This would therefore make it very hard to cut down, when the drugs can be acquired so easily and quickly.

There are a number of complications associated with illicit drug use, especially if the person is injecting the drugs (see box 3):

<table>
<thead>
<tr>
<th>Box 3</th>
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<tbody>
<tr>
<td>• Overdose</td>
</tr>
<tr>
<td>• Toxicity from impurities</td>
</tr>
<tr>
<td>• Skin abscess/cellulitis at injection sites</td>
</tr>
<tr>
<td>• DVT or PE</td>
</tr>
<tr>
<td>• Blood borne viruses e.g. Hepatitis B/C, HIV, due to sharing of injecting equipment</td>
</tr>
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</table>

Drug use must therefore be considered as a key aspect of tackling street sex work, not only as it is so often the driving force behind it, but also because of the many health risks associated with it. This has of course been considered as “The Home Office strategy to eliminate street work foregrounds the importance of addressing sex workers’ drug problems”.

**Street sex work, violence and ‘zoning’**

One of the major problems street sex workers face is violence. By getting into a car with a client and going somewhere out of sight of anyone who may be able to help in a bad situation, they are putting themselves in a potentially very dangerous situation.

Whilst many people may have objections to sex workers in general, it is often the women on the streets who are most vulnerable to these people: “women who work the streets are the most visible representatives of the trade and so also are they the easiest targets for some people’s prurient fascinations or loathing or aggression”. Although this violence towards sex workers is quite common, the women rarely report it to the police, unless it is very severe, due to the belief that the men will not be prosecuted for it. This highlights the need for a change in attitudes amongst people; street sex workers should have the same rights as everyone else and men should be prosecuted for attacks against them.

A number of precautions can be taken by street sex workers to decrease the risk of becoming victim to violence (see box 4):
Box 4

- Work in pairs, with one recording the car registration number of the other’s client
- Use visual clues to decide if a client is safe
- Agreeing with the client on the price, service and location before getting into the car
- Letting a friend know where she is going with the client
- Going with the client somewhere where she can easily call for help if needed

However, “zero tolerance undermines all these meagre safety strategies: traditional, close-knit and geographically limited soliciting areas have been broken up, with sex workers dispersed over much wider areas and rarely working within sight of each other” 9. This again highlights the need for change, as the current situation forces the women into an even more vulnerable position.

There are a number of different models suggested for managing street sex work as an alternative to zero tolerance. The outlines of these models are shown in box 513:

Box 5

- ‘managed area’
  - permit street soliciting
  - actively manage street sex work in a particular non-residential area at certain times
  - Health and social services available on site
  - Police focus on safety of street sex workers
- ‘unofficial street walking zone’
  - agencies work together to manage and geographically ‘contain’ street sex work
  - may be some elements of an official street walking zone in place, but it is not declared official or written in official policies
- ‘toleration zone’
  - street sex work is unofficially tolerated by the police who conduct a no prosecution policy

Zones such as those described above have been set up in various places both inside and outside of the UK. Some have been very successful and others not so, but a lot can be learnt from them all.

The first zone to have the ‘whole package’ was set up in Utrecht in Holland. It consisted of: an official zone outside residential areas; a ‘living room’, which is a shelter
in the official zone where prostitutes can go for a break and support between clients; and
a ‘working area’ 1km from the official zone where women could go with clients,
meaning they were safer and staying out of residential areas\textsuperscript{13}. There were no violent
attacks against street sex workers within the zone and women commented on feeling
safer\textsuperscript{13}. “zoning is also seen to provide a context in which health, social care, drugs and
exit interventions could be more accessible and effectively delivered”\textsuperscript{13}. There were
however complaints about the areas being too small causing competition\textsuperscript{13}. This may
cause problems as the women are forced to work outside the zone. Also some zones were
too far from the city centre meaning they had to pay a lot for a taxi or walk through
dangerous areas to get to and from the area\textsuperscript{13}. The position of the zone is also important
to consider; it must be away from a residential area, but close enough to be safely
accessible for the women\textsuperscript{13}. Overregulation can also be a problem as some women may
choose not to work there or may not be allowed\textsuperscript{13}. Although there have been a number of
other arguments made against zoning, such as ‘men would not go into the zone’ and ‘the
zone would attract pimping, drug dealing and other crime’, these have not been identified
as problems in already existing zones\textsuperscript{13}.

One example of an arrangement similar to this in the UK was set up in Glasgow in
1998 after a number of murders of street sex workers; a safety zone was established where
sex workers were not arrested if they stayed in the area covered by CCTV. Following this
there were no more murders on street sex workers in the area for 7 years by which time the
policy had been abandoned\textsuperscript{9}. A managed area was suggested in Liverpool, similar to the
model used in Utrecht and most people seemed to have a positive opinion towards it\textsuperscript{13}. However, it never came to action due do disagreements from residents nearby to the proposed
area.

**Critical Appraisal**

The literature search alone highlighted the lack of research done in this area; there
were no studies relating specifically to homelessness among street sex workers and limited
recent studies on sex workers in general in the UK. The most relevant paper; “Can a targeted
GP-led clinic improve outcomes for street sex workers who use heroin?” by J Litchfield, A
Maronge, T Rigg, et al\textsuperscript{15}, was chosen to be analysed for the purpose of this project.

This paper looked at a drug treatment service with a clinic targeted directly at street
sex workers. The theory behind it being, that once initial treatment had started for the
patients’ drug addictions, other services would also be available for them within the same
centre to help improve both their general health and their social situation, hence improving
their quality of life, as well as getting them off heroin and removing the drive to prostitution.
The study had three outcome measures; Christo score (for measuring quality of life in drug users), self-reported involvement in sex work and urine samples for heroin use. “The mean Christo score reduced from 12.05 at entry to 8.97 at 1 year”\(^{15}\), showing an increase in quality of life of the patients. This supports the hypothesis of the study that “the clinic and its access to targeted primary care services was effective in significantly improving the health and wellbeing of the sample”\(^{15}\). It also reported that “Of 34 women who were sex workers at the beginning of the study, only 11 (33%) reported being involved at 1 year”\(^{15}\). Lastly, “Of 30 urine samples nearest to entry, 26 (87%) were positive for heroin compared with 21 out of 29 (72%) at 1 year”\(^{15}\). These results all show very positive outcomes, suggesting that the model being used in the study is very effective.

The main strength of this paper included the call back of 100\(^{15}\), which was very impressive given the chaotic lifestyles of the population. The paper also, however, had a number of weaknesses. Firstly the sample size was very small, with only 34 participants\(^{15}\). Whereas this was probably the largest sample available from the clinic being studied, the sample size could have been increased by using patients from other centres in the UK running a similar system. This would also have the advantage of giving a more nation-wide perspective on the situation, as although the system appears to work from the study, it was only done in one geographical area; Derby, therefore the same theory may not be effectively applied to other cities in the UK. The study also relied largely on self reporting. However, given the nature of the data being collected, there is no realistic alternative.

Overall, although the sample size was small, the strong positive results suggest that the model being tested does work and gives sufficient evidence to support the idea of larger studies being carried out applying the same model to a number of different locations around the UK.

Services

There are a number of different services available to homeless people in Liverpool. For example the Basement drop-in centre is open in evenings and provides somewhere for homeless people to go for a few hours to get off the streets, socialise and receive support from the people working there. There is also Sisters of Charity, which provides the homeless with food every evening, which is donated by local bakeries. They also have a small number of beds available. There are also a number of hostels available in Liverpool, including the Whitechapel Centre and Loango.

The service most specific to street sex workers is the Armistead Centre which has an outreach project to street sex workers. The women are offered free condoms and injecting equipment and also receive support from the outreach workers on housing and other social aspects. There are also a number of hostels in Liverpool specifically for women including, the Anne Fowler Hostel and Geneva Road.
Cases

Below are a few of the case histories, from the outreach team at the Armistead Centre (see box 6):

**Box 6**

BM is a 32 year old street sex worker who has never had her own property; she and her partner have always stayed with friends. Her partner works a bit and they receive no benefits, so almost all their income is from her sex work, most of which is spent on feeding her heroine addiction. BM became pregnant and was due for a late termination at 24 weeks. However, she then acquired a chest infection so the termination could not go ahead and she gave birth in June. She already had three other children who were all in the care of her mother. Following a child protection conference, BM was allowed to keep the baby with the condition that she found stable accommodation. After staying off the drugs for 12 weeks she managed to secure a rented flat, however problems with the landlord not paying the mortgage on the flat has resulted in them receiving an eviction notice. BM is now in the position where she must find a new place to live otherwise she will lose the baby to social services. However she has no internet access, making looking for a new flat a lot harder.

This case highlights how hard it can be for someone in BM’s situation to find suitable accommodation; despite managing to overcome her addiction and find herself a suitable flat, factors beyond her control have left her homeless again. It is also important to note how disadvantaged she is by not having access to the internet; this means she is not on property pool, which makes it very hard to find accommodation.

Below is another case which highlights different issues regarding homelessness among sex workers (see box 7):

**Box 7**

SA has been living with 4 men for the past 3 years, acting as the carer for one who is disabled and unable get out of bed on his own. She has a chair and a pillow instead of a bed and she is only allowed to stay there by funding all their drug habits on top of her own, which she does by sex working. 2 weeks before Christmas last year she was sorted out with a fully furnished 2 bedroom flat and, although still using heroine on the side, was stable on her methadone prescription. However, after just 1 week in the new flat she had moved out and was back living with the 4 men again.

This case shows how other factors as well as suitable housing are very important when attempting to rehouse people in this situation. The timing of the moving into the new flat, as well as the fact that she was moving from a very social situation with the 4 men to living alone meant that, although the flat seemed to have everything she needed and seemed much better than her previous situation, it was not at all right for her. It highlights the importance of
a holistic approach to rehousing people, taking into account their social situation and the impact such a big change from what someone is used to may have on them. In this case, for example, a hostel may have been more appropriate due to the social aspect of it.

The last case history shows yet another aspect of homelessness among street sex workers (see box 8):

<table>
<thead>
<tr>
<th>Box 8</th>
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| BH is in her early 30’s and has been homeless for the last 5 years, in and out of accommodation. She is a poly-drug user and has a mental disorder. 8 weeks ago she was 30 weeks pregnant and in need of somewhere to stay. A hostel was contacted for her and despite a GP confirming her pregnancy she was refused a place as an error in their system led them to believe she couldn’t be pregnant and as she had left their hostel to live with her partner at the time, they claimed she was ‘intentionally homeless’.

This case shows obvious flaws in the admittance process for hostels; despite confirmation from a GP that BH was 30 weeks pregnant she was refused entry to a hostel. This put BH in a very dangerous situation for her and her baby as they had nowhere to sleep. Another aspect to point out is the fact they described her as ‘intentionally homeless’, because she had left the hostel a few months before. This situation is typical of street sex workers due to their chaotic lifestyle, it should therefore be taken into consideration when providing a service to this population.

**Conclusions and Recommendations**

In conclusion, there are a number of problems that street sex workers face in relation to their health and wellbeing. Firstly, many street sex workers are in unstable accommodation, as noted throughout the literature and seen in the case histories. This has a huge impact on the health and safety of the women. Drug use is also very prevalent among street sex workers and is indeed often the drive to start and/or the drive to continue doing street sex work, despite the associated risks. The close association between drug use and street sex work means it is hard to get out of one without stopping the other first causing a viscous cycle. Violence is also a major factor affecting the health and wellbeing of street sex workers, as they are the visible representatives and easiest targets of the sex trade and current legislation forces many of the women into dangerous situations.

There are a number of support services available to street sex workers such as those provided by the Armistead Centre and by hostels in the area. Little progress however can be made with the current legal situation, which often forces the women into more dangerous situations and also makes it harder for support services to access the women.
A solution therefore needs to be developed to improve the situation. Zones have been tried and tested in a number of different places in the past and the positive and negative aspects of these zones should be considered carefully before implementing them in the UK: they must have enough regulation to make it safe, but not so much that sex workers are discouraged from working there; they must be close to the city centre and safe to travel to, but out of any residential areas; and they must be large enough for the population of street sex workers in the area. However, the success of these zones must rely on a change in attitudes to a more accepting view of street sex workers and trust must be built up between street sex workers and the police. Social and medical support is also important in improving the situation for the women.
Bibliography

Three most useful books:

- Sex Work Now, edited by Rosie Campbell and Maggie O’Neil
- Sex Work on the Streets: Prostitutes and their Clients, by Neil McKeeganey and Marina Barnard
- Violence and Sex Work in Britain, by Hilary Kinnel
References

Reflection

Before starting this SSM, I had little knowledge of street sex workers and had not honestly given much thought to the subject. Reading over the topic, however, and having the opportunity to meet and talk to both street sex workers in Liverpool and those who work in services to support them has really opened my eyes to the shocking reality of it. I have found the whole experience very inspiring and would definitely recommend this SSM to others.
Appendices

Appendix 1 : GMC Duties of Being a Doctor

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 2: Beauchamp and Childress 4 Principles of Medical Ethics

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>Respect for autonomy</strong></td>
<td>respecting the decision-making capacities of autonomous persons; enabling individuals to make reasoned informed choices.</td>
</tr>
<tr>
<td><strong>Beneficence</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Non maleficence</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Justice</strong></td>
<td>distributing benefits, risks and costs fairly; the notion that patients in similar positions should be treated in a similar manner.</td>
</tr>
</tbody>
</table>
## Appendix 3: Timetable

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>31/8</td>
<td>Met with Dr O’Neil, introduction to course, visits to Surestart and Stoak Lodge.</td>
</tr>
<tr>
<td>1/9</td>
<td>Addaction, Fleet street; met with Julie Hughes and Dr Greenshaw</td>
</tr>
<tr>
<td>2/9</td>
<td>Big Issue, Mount Pleasant; Dr O’Neil’s Clinic. Fade library.</td>
</tr>
<tr>
<td>3/9</td>
<td>Addaction, Croxteth; Dr O’Neil’s Clinic. Visit to Basement drop-in centre and Sisters of Charity.</td>
</tr>
<tr>
<td>4/9</td>
<td>Literature search</td>
</tr>
<tr>
<td>5/9</td>
<td>Read through articles and homelessness book.</td>
</tr>
<tr>
<td>6/9</td>
<td>Started plan for essay.</td>
</tr>
<tr>
<td>7/9</td>
<td>Addaction, Croxteth.</td>
</tr>
<tr>
<td>8/9</td>
<td>Went to university library, made notes on books.</td>
</tr>
<tr>
<td>9/9</td>
<td>Met with Julie Hughes, Armistead centre.</td>
</tr>
<tr>
<td>10/9</td>
<td>Started critical appraisal of article</td>
</tr>
<tr>
<td>11/9</td>
<td>Finished critical appraisal. Started presentation</td>
</tr>
<tr>
<td>12/9</td>
<td>Finished presentation</td>
</tr>
<tr>
<td>13/9</td>
<td>Presentation</td>
</tr>
<tr>
<td>14/9</td>
<td>Wrote up notes from books</td>
</tr>
<tr>
<td>15/9</td>
<td>Wrote up notes from books</td>
</tr>
<tr>
<td>16/9</td>
<td>Wrote essay</td>
</tr>
<tr>
<td>17/9</td>
<td>Wrote essay</td>
</tr>
<tr>
<td>18/9</td>
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</tr>
<tr>
<td>19/9</td>
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</tr>
<tr>
<td>20/9</td>
<td>Outreach with Armistead centre</td>
</tr>
<tr>
<td>21/9</td>
<td>Wrote up case histories</td>
</tr>
<tr>
<td>22/9</td>
<td>Finished essay</td>
</tr>
<tr>
<td>23/9</td>
<td>Checked over essay</td>
</tr>
<tr>
<td>24/9</td>
<td>Submitted essay</td>
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