Diabetic foot disease among rough sleepers in central London

Abdulkadir Abdul

Article points

1. Rough sleepers have a range of significant health burdens and often experience difficulties in accessing health services.
2. The author undertook a placement with the podiatry team at a multidisciplinary health service for rough sleepers in central London.
3. Two case studies involving people with diabetic foot disease – one a rough sleeper, the other a recently housed ex-rough sleeper – are reported.
4. The author's experiences in this placement highlight the high level of vulnerability and individuality of this patient population.

Keywords

- Challenging patient population
- Rough sleeper
- Student podiatry placement

In August, 2010 the author undertook a voluntary placement at Central London Community Healthcare, which provides a range of healthcare services for rough sleepers in central London – including podiatry care. Here, the author reports his experiences during the placement and two case studies.

Capturing a single definition of homelessness or rough sleeping is a challenge. For the purposes of rough sleeping counts and estimates, the Department of Communities and Local Government (2012) define rough sleepers as "people sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments) and people in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or 'bashes')."

Likewise, ascertaining precise figures for the rough sleeping population is notoriously difficult. The Department of Communities and Local Government (2012) published figures on 17 February 2011 showing that there are some 1768 people sleeping rough across England on any given night. It is known that London (and specifically central London) has more rough sleepers than anywhere else in England (perhaps due to the increased opportunities for casual work and because it is a transport hub). Data for London come from 13 outreach teams, who enter the details of rough sleepers in the Combined Homeless and Information Network (CHAIN) database, which is commissioned and funded by the government and managed by the homeless charity Broadway (www.broadwaylondon.org).

Data from CHAIN show that the number of people found rough sleeping was 1850 in 1998 compared with 483 in 2008. Although the number of rough sleepers has reduced in the past decade, data also reveal a steep increase in the proportion of rough sleepers from Poland, who now account for around one in 10 first-time rough sleepers. The share of homeless people from Central and Eastern European states, excluding Poland, stood at around five per cent of all first-time rough sleepers in London between 2006/07 and 2007/08 (Cebulla et al, 2009).

Within the rough sleeper population there are a number of significant health burdens, commonly drug, alcohol and mental health problems; just under three-quarters (74%) of rough sleepers on CHAIN (during the period 2001/02–2007/08) had one or more support need relating to drugs, alcohol or mental health. Relatedly, morbidity and mortality are higher among rough sleepers than the general population, with a survey completed by the charity Crisis in 1991/92 showing the life expectancy of rough sleepers to be 42 years, almost half that of the national average

Abdulkadir Abdul is a Podiatry Student at the University of Southampton, Southampton.

"My ideas about rough sleepers were challenged the moment I stepped into West London Day Centre on the first day of my placement ..."

at the time (74 for men and 79 for women; Grenier, 1992). Despite these data being now quite old, they demonstrate that living on the streets has a marked effect on health status and life expectancy.

Providing health care for rough sleepers in central London

Central London Community Healthcare (CLCH) has recognised the need for a specialist approach to providing healthcare for rough sleepers, who have multiple, complex health needs. CLCH funds the Homeless Health Team (HHT), which comprises specialist nurses and GPs, counsellors, psychiatrists, drug and alcohol workers, a podiatrist and a dentist among others. Medical services are provided at three of the largest charity-run day centres for homeless people in Westminster: the Passage Day Centre, Victoria; Connection, St Martin-in-the-Field; West London Day Centre, Marylebone.

There are also two GP practices for homeless people in Westminster: the Great Chapel Street Medical Centre, Soho; the Dr Hickey Practice, Victoria. The general services provided by the day centres include food, legal, social and benefit advice, and washing and laundry facilities. This "one-stop shop" approach to services means homeless people are more likely to access the care and support that they need.

Experience on the ground

My ideas about rough sleepers were challenged the moment I stepped into West London Day Centre on the first day of my placement with Alison Gardiner, Specialist Podiatrist for Homeless and Vulnerable People, Central London Community Healthcare. After being greeted by the friendly volunteers at reception, I was asked to wait for Alison in the foyer and took the opportunity to look around at my surroundings and the service users. The room was full of people talking to one another and eating canteen food; the atmosphere was calm and friendly, which is not what I had expected of people whose lives – based on my preconceptions – centred around drugs.

When I met with Alison, she showed me around the day centre and described the services provided. I asked what happens when a new service user walks in the door for the first time. Alison told me that the specialist workers and volunteers talk to the person to find out what assistance they might require. This could include food, washing or medical care. They might also advise on accommodation, welfare, benefit and employment options. If they need to see the doctor, nurse or podiatrist, they are advised to put their name on a list held at reception. Some will do this without prompting as they come in, and others, often the more vulnerable (e.g. due to mental health issues), will not do so and do not ask for help. It is these individuals that Alison reminds the volunteers to approach, particularly as they need more encouragement to use the services.

As well as participating in clinics with Alison, I also spent one evening (7pm to midnight) on the streets with the outreach team from Connection at St Martin-in-the-Field. After I went home, the dedicated team continued until 3 am – which they do usually 6 days a week. Adrian Purchase (a member of the outreach team) explained; "When the outreach team meets a rough sleeper they quickly try to build rapport by introducing themselves and the type of work they do in order to avoid confrontation. They then ask about the person's general health and wellbeing. They will be assigned a duty worker who will risk assess their situation and provide assistance according to their needs."

Diabetic foot disease among rough sleepers

Rough sleepers with diabetes are, of course, among those who podiatrists working in this area are keen to ensure have good foot care. The effects of rough sleeping on the condition of the feet of these individuals can be very serious indeed. Here, I report two cases of diabetic foot disease in rough sleepers I saw during my placement.

Case 1: Mr M

On my first week of placement I met 60-year-old Mr M who has type 2 diabetes and had been sleeping rough for approximately 9 months. Mr M was a visa over-stayer who arrived from India approximately 40 years ago. He had most recently been working as a chef but after that employment ended Mr M was unable to pay for the room he was renting and so started sleeping rough. Alison said that at first he avoided talking about employment and how he came to be homeless. This case is an example of service users who withhold information about their personal history, often because they believe that their true circumstances may exclude them from accessing the services they desperately need.

Mr M was well known to the day centre's staff and his medical records showed that he had been accessing the service since 2003. He had hypertension, hypercholesterolaemia and angina (for which he had undergone a coronary artery stent procedure). He was receiving irbesartan and bisoprolol, warfarin, aspirin, clopidogrel, rosuvatatin, gliclazide and metformin.

Mr M's foot health was poor, with significant neurological deficit and some vascular impairment, a prior amputation of the right hallux in 2010 due to recurrent ulceration and infection, and Charcot also in the right foot. At the time I met Mr M, he had been coming to the clinic daily for dressing changes for an apical ulcer on the right second toe. On examination that day, there was a significant dressing strike-through and the ulcer was deteriorating with maceration of the surrounding skin (*Figure 1*).

The deterioration was thought to be due to walking longer distances as he reported that his GP had classed him "fit for work", meaning all benefit payments had ceased and he was having to walk to all appointments as he could not afford the bus fare. He was clearly distressed by his GP's actions and complained to Alison and me about his frustrations.

Due to his poor health and the risk of the ulcer becoming infected, a place in the night shelter at Connection at St Martin-in-the-Field was made available for Mr M. Given that Mr M was still under the care of a specialist podiatrist in outer London, Alison encouraged him to continue to attend these appointments and Mr M was given bus fare to do so.

Mr M did attend his specialist podiatry follow-up appointment. Wound swab revealed moderate growth of meticillin-resistant *Staphylococcus aureus* and antibiotics (flucloxacillin 500 mgs four times a day; ampicillin 500 mgs four times a day; both for a week) were prescribed. X-rays ruled out bone infection.

"Mr M's foot health was poor, with significant neurological deficit and some vascular impairment [and] a prior amputation of the right hallux in 2010 due to recurrent ulceration and infection ..."

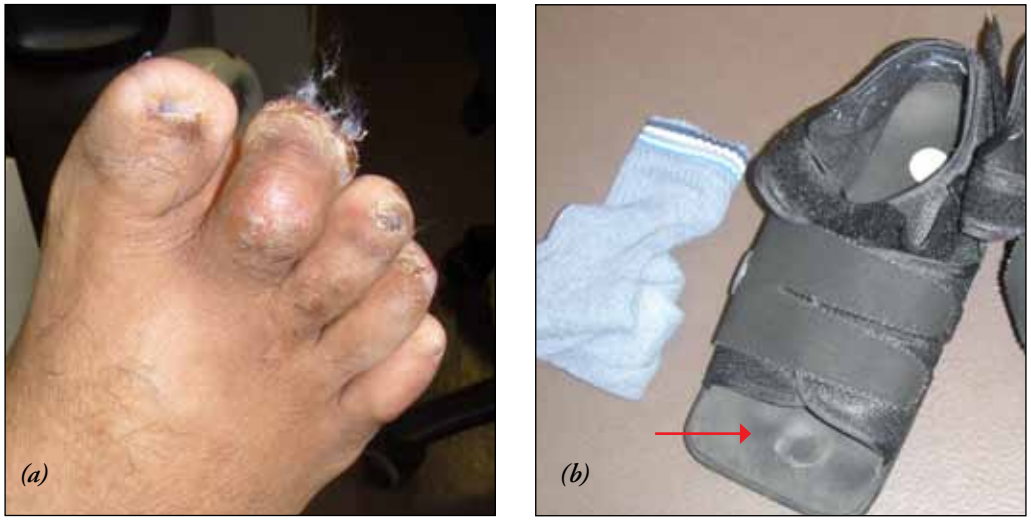

Figure 1. (a) Mr M's right foot. The ulcer on the apex of the right second toe was deteriorating when Mr M presented to the day centre. Note Mr M's prior hallux amputation. (b) Mr M's footwear. Note the strike through marked by the red arrow.

"Mr J [was] alone outside the day centre in a wheelchair and ... reported that he had returned to London from Ireland 2 weeks previously, where he had undergone a left below-knee amputation after which he had discharged himself."

Case 2: Mr J

This case illustrates the difficulty of reintroducing former rough sleepers to mainstream health care services. Mr J, a 64-year-old man with type 1 diabetes, was no longer homeless at the time of presentation to the day centre, sharing a second-floor flat in south London with his 19-year-old son. Due to his being in permanent accommodation and being under the care of his local GP he had been banned from using the day centre and encouraged to use mainstream services, but he remained vulnerable and struggled to make this transition.

Alison found Mr J alone outside the day centre in a wheelchair and, not knowing that he had been banned from the day centre, we brought him into the clinic. Mr J reported that he had returned to London from Ireland 2 weeks previously, where he had undergone a left below-knee amputation after which he had discharged himself. That morning he had got himself onto the bus in his wheelchair to attend the day clinic because he was unable to use his bath at home and, due to living on the second floor, had been forced to crawl up and down the stairs following his amputation.

Mr J was a poor historian and it was difficult to get an accurate history of his state of health. However, Alison managed to ascertain that Mr J was alcohol dependent, a heavy smoker with cardiovascular disease ("heart problems", had experienced mini-strokes). In the management of his type 1 diabetes he reported that he took his insulin every now and then when he felt like it. He was receiving ramipril, aspirin, water tablets and insulin. His record with the HHT went back to at least 2004.

Examination of his right foot revealed that he was wearing a trainer with self-made lateral cut-outs (*Figure 2a*). The removal of his sock revealed a blister on the apex of the second toe and a recently dressed first toe. Mr J then revealed that he had attended his local specialist podiatrist the previous day. The decision was made to remove the dressing in the day clinic and check his foot in view of his high level of vulnerability (*Figure 2b*). Both the ulcer and blister were irrigated and redressed. Mr J was issued with a post-operative sandal and a clean sock.

Mr J's specialist podiatrist was called to inform her that he had attended and what treatment had been given. He was well known to that service and apparently he had left the UK unannounced several weeks previously with a necrotic left heel (which ended in amputation in Ireland). His specialist podiatrist also said that he had presented on his own in his wheelchair at their clinic the day before and a follow-up appointment had been made for the following week. Mr J was reminded of this and encouraged to attend.

The day centre health worker contacted Mr J's GP who was unaware of his recent amputation. The GP was advised by the

Figure 2. (a) Mr J's footwear at presentation. Note the self-made lateral cut-outs of the trainer. (b) Mr J's foot and stump at presentation. Note the ulceration to the first and second toes.

healthcare worker of the patient's difficulty managing at home and an appointment to discuss suitable ground-floor accommodation and other necessary support was made for the same day.

This case illustrates the difficulties ex-homeless people often have in moving back into mainstream healthcare services, and that transitional support is needed to move them away from the services that they become familiar with when homeless.

Conclusion

The experience of assisting in the provision of foot care for rough sleepers in central London has taught me a lot of things over and above those that I had anticipated. During the placement I learnt a lot about myself, and the profession that I have chosen. I have learnt that no two patients are the same, even if they present with apparent similarities or have similar backgrounds. Ultimately, this experience has taught me to treat each patient holistically and as an individual, taking into account their wider circumstances in order to diagnose and manage their condition appropriately. ■

Cebulla A, Rice B, Tomaszewski W, Hough J (2009) *Profiling London's Rough Sleepers: A Longitudinal Analysis of CHAIN Data*. National Centre for Social Research and Broadway Homelessness and Support, London

Department of Communities and Local Government (2012) *Homelessness and Rough Sleeping*. Available from: http://www.communities.gov.uk/housing/homelessness/ (accessed 12.03.2012)

Grenier P (1992) *Still Dying for a Home: An Update of Crisis' Investigation Into the Links Between Homelessness, Health and Mortality*. Crisis, London.

Acknowledgements

I would like to express my sincere gratitude to Alison Gardiner and the Homeless Health Team for allowing me to work alongside them and benefit from their wisdom and experience. I would also like to thank my tutor, Ivan Bristow (Lecturer in Podiatry, University of Southampton), for his support and encouragement.

If you would like to help, whether financially or by volunteering your time, any of the charities mentioned in this report, their websites are listed below:

- **Connection at St Martin-in-the-Field** www.connection-at-stmartins.org.uk
- **Crisis** www.crisis.org.uk
- **The Passage Day Centre** www.passage.org.uk
- **West London Day Centre** www.wlm.org.uk

I would also like to thank Cosyfeet for giving me the opportunity to develop my skills. The Cosyfeet Podiatry Award (£1000) assisted me with my travel costs and living expenses during my voluntary work. To find out more about the Cosyfeet Podiatry Award please email prof@cosyfeet.co.uk

"... this experience has taught me to treat each patient holistically and as an individual, taking into account their wider circumstances in order to diagnose and manage their condition appropriately."