Practicalities of working with homeless people with diabetes in an inner-London borough

Martin Jones, David Gable

Homelessness can be classified as either "street homelessness" or "hidden homelessness". This population is a heterogeneous mixture of ethnicities and cultures, and is accompanied by a range of physical and mental health issues. The presence of diabetes is often a significant additional challenge for this group but, with the correct support, individuals from this group can manage their diabetes effectively. The healthcare professional working with homeless people with diabetes should be able to understand the needs of each individual and needs to develop a unique skill set of communication skills and problem solving skills in order to give each individual effective support.

Online learning opportunity

See page 419 for details.

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Article points

1. The presence of diabetes is often a significant additional challenge for homeless people, but with the correct support, individuals from this group can manage their diabetes effectively.
2. Homeless people often present with complex health and social problems, which present barriers in engaging with medical services through conventional routes.
3. This article describes a proactive engagement programme in Westminster. This programme aims to support homeless people with diabetes access specialist diabetes services easily.

Key words

- Diabetes
- Homeless people

Authors

For authors' details, see the end of the article.

Central London Community Healthcare NHS Trust works in collaboration with Imperial College Healthcare NHS Trust to deliver community-based specialist diabetes services right in the centre of London. The service provides consultant-delivered, multidisciplinary diabetes services that include diabetes nursing, dietitians, podiatry and clinical psychology.

In 2009, the service was commissioned to develop new and innovative pathways to overcome health inequalities in the local area by improving access to high-quality specialist diabetes care for certain groups. This included homeless people who do not traditionally access clinic-based services.

The first year of the service development was spent seeking out and learning about established services for homeless people, including a well-established homeless health team, dedicated primary care and the third sector. This partnership working proved to be the basis of the service design and the development of effective care for this group.

Homelessness in Westminster

Homeless people can be split into two categories: "street homeless", including those who are rough sleeping in shop doorways and parks; and the "hidden homeless". The hidden homeless are those who may have a roof over their head but do not have access to secure housing and includes those temporarily staying with friends or family; staying in a hostel or night shelter; those living in very overcrowded conditions; those at risk of violence or abuse in the home; and those living in poor conditions that affect health (Reeve, 2011). There are also people who repeatedly transit between street homelessness and hidden homelessness.

Westminster, as the most central part of London, has a disproportionate homeless population compared to other parts of the country (*Figure 1*).

Challenges of engagement with the homeless population

Homeless people often present with complex health and social problems, which are barriers

to engaging with medical services through conventional routes.

Rees (2009) found there is a disproportionate prevalence of mental health problems within this population. This literature review found that homeless people are twice as likely to present with a mental health problem, and 4–15 times more likely to experience psychosis than the general population. Drug and alcohol use are also common and they also can present with a number of complex social issues, such as abuse by partner or within the family.

The result of these complex factors is that many homeless people have poor access to healthcare; for example, homeless veterans in the US are 5 times more likely to use emergency services compared to the general population and were less likely to utilise primary care services (O'Toole et al, 2011) and this can lead to significantly reduced life expectancy (Thomas, 2012). Unfortunately, data describing the characteristics of the diabetes population in the UK is limited, which is why we are reporting data from the US; this would be an interesting and necessary area for future study.

Homeless people also face logistical difficulties with both self-care and access to support (Hwang and Bugeja, 2000). Food availability and meal timings can be difficult. While those living in hostels tend to have access to food, it will often contain a large amount of starchy carbohydrates and saturated fat, as it is, by design, required to deliver a very high calorie load in order to maintain energy levels (Luder et al, 1990). This is because homeless individuals may be malnourished due to drug or alcohol misuse.

Medication storage can be complex. Some hostels will not allow needles on the premises, and the secure storage of insulin might not be always guaranteed. Street homeless people with diabetes walking the streets in hot weather may compromise the efficacy of the current insulin pen they are carrying, and there is also the issue of safe sharps disposal.

Homeless people with diabetes are often walking long distances each day and, combined with poor footwear and limited access to regular foot checks, may result in the development of serious, but preventable, foot complications.

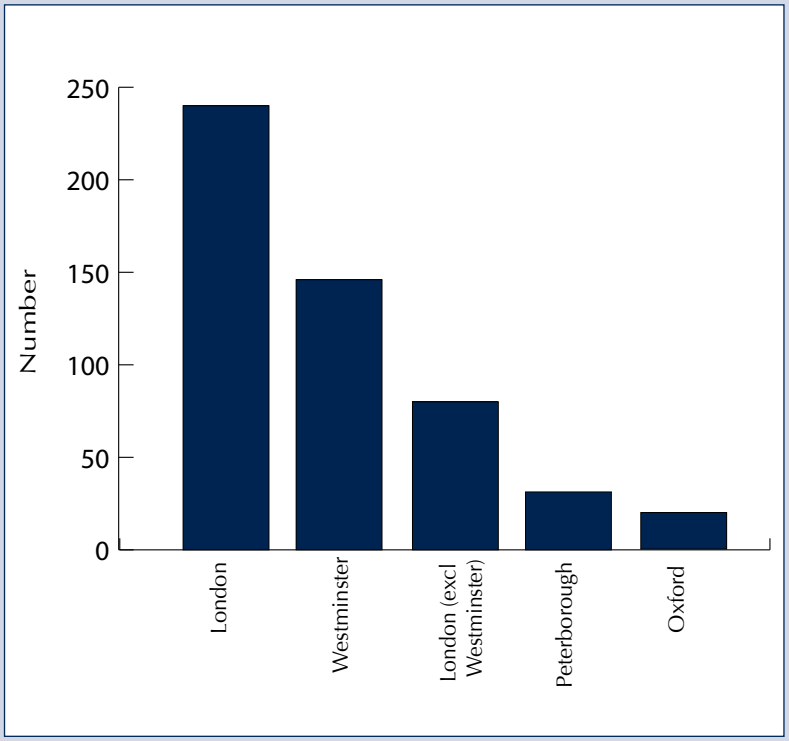

Figure 1. Local Authority Statutory Street Count (Department of Communities and Local Government, 2010).

Prevalence and characteristics of diabetes in the homeless population

Little is known about the prevalence and characteristics of diabetes in the homeless in the UK. Two populations are described by research, both identified during a screening programme, either for diabetes (Arnaud, 2009) or cardiovascular risk (McCary, 2005). These screening programmes measured body weight and height, arterial blood pressure and glucose levels. Participants were then given a detailed questionnaire on socio-demographic characteristics, lifestyle and self-reported health. *Table 1* (overleaf) illustrates what is known about these groups.

The prevalence of diabetes in homeless people is not too dissimilar to that of the general diabetes population but may be slightly higher (6.2% in Paris compared with 4.2% in the general population; Arnaud, 2009); although, glucose levels may be considerably higher in homeless people due to several reasons including medication discordance, irregular medication review and the high carbohydrate content of their diet (McCary, 2005).

Table 1. Two studies illustrating the prevalence and characteristics of diabetes in the homeless population.

	Paris (Arnaud, 2009)	Toronto (McCary, 2005)
Recruitment	9 shelters	12 shelters
Study type	Diabetes screening	Full cardiovascular assessment
Prevalence of diabetes	35/488 (6.2%)	14/202 (7%)
Gender	80% male	89% male
Glucose control (HbA_{1c})	72% > 48 mmol/mol (6.5 %) 16% > 64 mmol/mol (8.0%)	43% > 68 mmol/mol (8.4%)
Treatment	29% insulin 51% antidiabetes medications 3% Both	
Other	46% had severe hypoglycaemic episodes 32% had retinopathy 25% had macrovascular disease 42% had neuropathy	78% smokers 35% hypertensive

Westminster co-ordinated homeless primary care

In Westminster, we developed a proactive engagement programme, with the aim of supporting homeless people with diabetes to access specialist diabetes services easily when required. The process is outlined in *Figure 2*.

On triage, the referral will flag up if it has originated from a referee working for a homeless organisation or it is from a known hostel. The individual will then be allocated a case manager, who will be a member of the diabetes multidisciplinary team. The case manager's role is to proactively engage with the individual to encourage attendance at conventional specialist diabetes services. Usually identifying and working with the individual's key support worker is the most effective way of achieving better attendance.

Multi-agency working is the basis of successful engagement. Initially, it is important to work with the referee to obtain more information about the individual, such as details of their key worker, if allocated, or which day centres they frequent. Once these facts are established, the programme works with the homeless person and very often the key worker to encourage attendance at clinics.

We also work with third sector organisations and the local dedicated homeless person primary care units to put in support to encourage attendance if required. This could include asking the person to attend clinic alongside someone from these organisations, or allowing the homeless person to use the organisation's office as an address.

A recent local audit found that, using this approach, 95% of hidden homeless and 50% of street homeless were able to attend their first appointment with the diabetes team. Once the individual has attended the clinic, they then need a different type of consultation to ensure that they stay in contact with the service and this should be tailored carefully to the individual. As with all people with diabetes, a patient-focused approach to care is essential, although it is of particular importance for homeless people. For example, it may be the case that the homeless person has had negative experiences with "authority figures", so it may be necessary to spend additional time building a relationship and trust with the individual. Furthermore, more patience may be required and the individual may need more encouragement to set personalised goals.

Homeless people with diabetes will often need help to navigate the NHS. Our programme has improved retinal screening rates from 5% to 50% by helping them access the booking centre for the screening provider.

It is important to note that the advice delivered to the homeless person must be meaningful to their life experience, practical and realistically achievable. The healthcare professional needs a good understanding of their barriers to better diabetes care and a sound knowledge of the network of services that might help the individual overcome these barriers.

Professional psychological support may also

be required, so referral to clinical psychology colleagues may be necessary.

A case study: The referral pathway in action.

A 65-year-old Russian gentleman was referred to our programme for review. He was living on the street and had type 2 diabetes, which he managed with insulin. He was accessing primary care at one of the dedicated homeless person surgeries. His glucose levels were high (his HbA_{1c} averaged 67 mmol/mol [8.3%]) and had recently had a toe amputated due to his diabetes. He was triaged and discussed at our multidisciplinary team meeting, where a case manager was appointed. The case manager, using multi-agency collaboration skills, was able to establish who his key worker was, and which day centre he used. An appointment letter was sent to both his GP and key worker, as well as to the day centre that he attended.

We were able to build a trusting and working relationship with the gentleman. Lack of housing was an immediate issue and was impacting on his ability to control his diabetes. The case manager had to advocate on the gentleman's behalf with local government housing departments and charitable organisations.

The result of this work led to the individual being housed and he was subsequently able to control his glucose levels more effectively. His overall quality of life has improved and he has been motivated to improve his English language skills. More recently he has obtained a part-time job and he continues to manage his diabetes well.

"Professional psychological support may also be required, so referral to clinical psychology colleagues may be necessary."

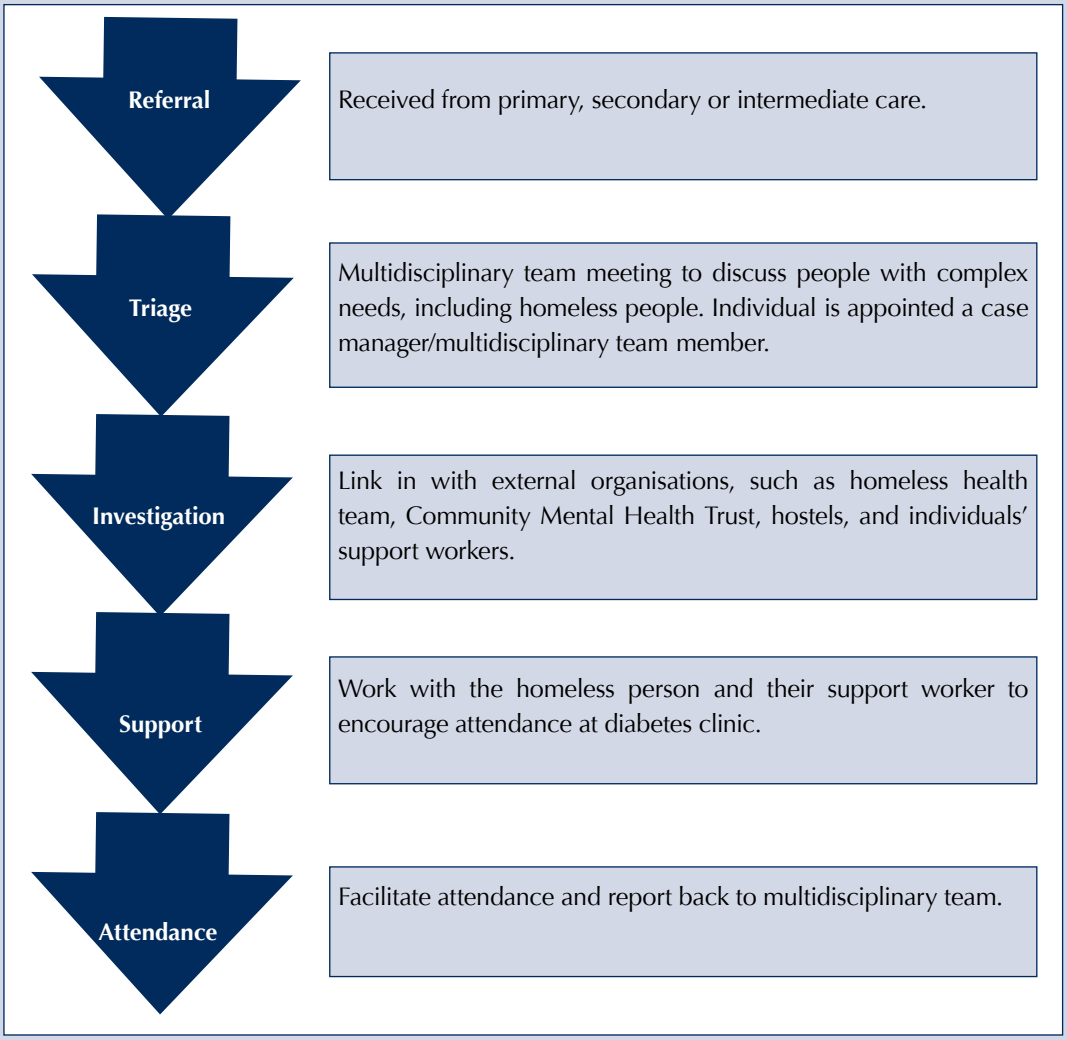

Figure 2. Homeless people with diabetes referral pathway, Westminster.

Page points

1. Be ultra-practical in the advice given to homeless people; set achievable goals and be resourceful – know your providers in the local area who can help.
2. Learn to be pragmatic in treatment plans agreed; it is a priority to ensure that the person keeps in contact with the team.
3. Provision of food is a significant issue, It is useful to know who and where your free food providers are located, and what times they provide meals.

Authors

Martin Jones is Diabetes Dietitian, Central London Community Healthcare NHS Trust; David Gable is Consultant Diabetologist, Central London Community Healthcare NHS Trust and Imperial College Healthcare NHS Trust

Tips for healthcare professionals working with homeless people

1. Be very practical in the advice given to homeless people; set achievable goals and be resourceful – know your providers in the local area who can help. You do not need to be alone when treating the individual. Try to establish which social and third-sector organisations are available to help address the present barriers to lower glucose levels and better diabetes care.
2. Learn to be pragmatic in treatment plans agreed; it is a priority to ensure that the person keeps in contact with the team. While you may not be able to achieve optimal control, remember that even small reductions in glucose levels increase the chance of a healthy future.
3. Be willing to network with multiple agencies by attending their case conferences or study days. This helps you keep updated with services in your area and the people who might require your support. We have developed excellent links with our Community Mental Health Team and often have representatives present at our multidisciplinary team meeting and vice versa.
4. Provision of food is a significant issue. It is useful to know who and where your free food providers are located, and what times they provide meals. The best way to obtain updated lists is to contact *The Pavement*, which is a magazine for homeless people in the UK. For those who live in hostels, where food can be high in fat and with large amounts of starchy carbohydrate portions, people can be advised to ask for more vegetables on their plate and fewer starchy carbohydrates. They can also choose leaner protein sources where available.
5. Do not make assumptions; street homeless persons often have a mobile phone and can be keen to attend clinic appointments if details of the date and time get to them. Homeless people with diabetes often need help navigating the system and you can make a significant difference if you help them with this.

Conclusion

Homelessness is a major social problem and nationwide there is also a significantly under-recognised population of hidden homeless. With homelessness comes a set of challenging social problems and comorbidities, but there is no need for the individuals or the healthcare teams to be overwhelmed by them.

In many areas there is already infrastructure to deliver services and a specialist diabetes team can use this to ensure access to their services. Using a patient-centred approach is key to working with this client group.

As a healthcare provider providing specialist diabetes care you will be required to overcome barriers that may not be within your usual areas of expertise and you will need to help the individual navigate what can be a confusing array of services.

Thinking laterally and being resourceful is very important. Using resources such as the mental health service and the third sector can help people overcome their barriers to better diabetes care. This is a real test of your communications skills and ability to build a partnership with your patient.

Our experience shows success is possible and often better diabetes care is only part of the journey back from the edges to a more conventional place in society. ■

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Online CPD activity

Visit www.diabetesonthenet.com/cpd to record your answers and gain a certificate of participation

Participants should read the preceding article before answering the multiple choice questions below. There is ONE correct answer to each question. After submitting your answers online, you will be immediately notified of your score. A pass mark of 70% is required to obtain a certificate of successful participation; however, it is possible to take the test a maximum of three times. A short explanation of the correct answer is provided. Before accessing your certificate, you will be given the opportunity to evaluate the activity and reflect on the module, stating how you will use what you have learnt in practice. The CPD centre keeps a record of your CPD activities and provides the option to add items to an action plan, which will help you to collate evidence for your annual appraisal.

1. The term "hidden homeless" can be used to describe those who are: Select ONE option only.

A. Living in hostel accommodation
B. Sofa surfing
C. Rough sleeping in areas where rough sleeping teams have not identified
D. All of the above

2. UK prevalence data for diabetes in the homeless population are lacking. Based on data for other countries, what percentage of homeless people in the UK would you expect to have diabetes? Select ONE option only.

A. 5%
B. 7%
C. 12%
D. 30%

3. By how many times is a homeless person more likely to experience mental health issues, compared to the general population? Select ONE option only.

A. 2 times
B. 4 times
C. 5 times
D. 6 times

4. High blood glucose levels in a homeless person may be due to which of the following factors? Select ONE option only.

A. Inappropriate storage and administration of diabetes medication
B. Poor diet, high in refined and starchy carbohydrates
C. Poor access to diabetes appointments
D. All of the above

5. A 63-year-old homeless man with a HbA_{1c} of 72 mmol/mol (8.7%) is chaotic and lives on the street. He attends clinic. What is his target HbA_{1c}? Select ONE option only.

A. 48 mmol/mol (6.5%)
B. 53 mmol/mol (7%)
C. 62 mmol/mol (7.8%)
D. 72 mmol/mol (8.7%)

6. As a DSN, you receive a referral from a GP for an annual review. You note that the person has not had retinal screening for a few years and retinal screening is provided by a private provider. What is the best course of action?: Select ONE option only.

A. Ask the patient to contact the retinal screening service
B. Ask the patient to make an appointment with you next week, when you can give him some more time
C. Call the retinal screening programme while the patient is with you and book appointment. Emphasise the importance of retinal screening
D. Document that the patient has not received retinal screening and ask him to look out for the next appointment letter

7. Which of the following best describes the proactive engagement process used in Westminster? Select ONE option only.

A. Receive GP referral, triage and send out appointment letter
B. Receive GP referral, triage and discuss at multidisciplinary meeting. Allocate case manager
C. Receive GP referral, triage and contact the GP for more information
D. Receive GP referral, triage, and ask the administration to encourage patient attendance

8. When educating a street homeless person about appropriate foot care, what would be the least practical suggestion? Select ONE option only.

A. Always wear socks with footwear
B. Encourage good foot hygiene, and regular engagement with the GP surgery or podiatry services
C. Provide details of local shops providing cheap footwear
D. Where possible, especially if walking long distances, trainers are the best footwear

9. O'Toole (2010) found that homeless people were high users of emergency services. By a factor of how many? Select ONE option only.

A. 3
B. 4
C. 5
D. 7

10. A homeless patient does not attend an appointment. Surgery policy is to discharge all patients back to the referee. What is the least appropriate course of action? Select ONE option only.

A. Investigate further to understand why the patient did not attend
B. Discharge back to the referee
C. Discuss the person at your next multidisciplinary meeting with a view to considering the next steps in this patient's care
D. Attempt to call the patient