Homelessness and mental health in a northern English Steel City (Sheffield)

Integrated Services and Housing: OECD Conference Centre, Paris 8th and 9th November, 2012

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Thanks:

- To the late Sean Spence, who undertook much of the audit work presented here, and published in the psychiatric bulletin

What I do

- Consultant psychiatrist for homeless people in Sheffield
- Executive Medical Director, Sheffield mental health and social care (medical and pharmacy, strategy, research, governance/effectiveness)
- Director National Collaborating Centre for Mental Health
  - National guideline development (for NICE)
  - International guideline development (Turkey, Georgia, Holland)
### NCCMH: mental health NICE guidelines

<table>
<thead>
<tr>
<th>Condition</th>
<th>Date</th>
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<tr>
<td>Schizophrenia*</td>
<td>Dec 2002</td>
<td>ADHD*</td>
<td>Sept 2008</td>
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<td>Eating disorders</td>
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<td>Antisocial personality disorder</td>
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<td>Self-harm*</td>
<td>July 2004</td>
<td>Borderline personality disorder*</td>
<td>Jan 2009</td>
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<td>Depression*</td>
<td>Dec 2004</td>
<td>Schizophrenia (update)*</td>
<td>March 2009</td>
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<td>Post-traumatic stress disorder</td>
<td>July 2005</td>
<td>Depression with Chronic Health Problems</td>
<td>Oct 2009</td>
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<td>Depression in children*</td>
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<td>Depression in Adults</td>
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<td>Obsessive-compulsive disorder*</td>
<td>Oct 2005</td>
<td>Anxiety (partial update)*</td>
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<td>Bipolar disorder</td>
<td>July 2006</td>
<td>Alcohol dependence</td>
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<td>Dementia*</td>
<td>Nov 2006</td>
<td>Psychosis with Substance Misuse*</td>
<td>March 2011</td>
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<td>Ante- and postnatal mental health</td>
<td>Feb 2007</td>
<td>Common Mental Health Disorders</td>
<td>May 2011</td>
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<tr>
<td>Drug misuse – detoxification</td>
<td>July 2007</td>
<td>Improving Service User Experience in adult mental health*</td>
<td>Jan 2012</td>
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Guidelines under development

- Autism in Adults (with Netherlands)  
  June 2012
- Psychosis & Schizophrenia in Children & Young People*  
  March 2013
- Conduct Disorders (with SCIE)  
  February 2013
- Social Anxiety Disorder  
  July 2013
- Autism in Children & Young People (with SCIE)*  
  November 2013
- Schizophrenia in Adults (Update)*  
  March 2014
- Bipolar (Update) (with Netherlands)*  
  July 2014
Homelessness and mental health

- In London: 20% chronic/severe, 80% have significant mental illness???
- In Sheffield: 10% chronic/severe, 50% significant mental illness???
  - Schizophrenia
  - Bipolar disorder
  - Personality disorder
  - Substance misuse (alcohol and drugs)
  - Depression
  - PTSD
Guidelines relevant to homelessness

- Psychosis and Schizophrenia in adults
- Psychosis and schizophrenia in children and young people
- Bipolar disorder
- Psychosis and coexisting substance misuse
- Borderline personality disorder
- Antisocial personality disorder
- Alcohol and substance misuse
- Depression and other common mental health problems
- PTSD
Integrated services for homeless people

• Mental health and social care in one, integrated community team
• Operate on assertive outreach principles and...
• Intensive case management (<20 patients per worker)

• i.e. ACT/Intensive case management

• BUT: UK data suggest no reduction in hospital use for ACT/ICM but still keeps people in touch with services
Sheffield

- Steel city
- 550,000 population
- North of England
- Ethnicity similar to other UK cities
Employment

• Two large universities with 60,000 students and large employers
• Council large employer
• Three hospital trusts
  – Physical health (£850 Million)
  – Children’s health (£130 Million)
  – Mental health and social care (£120 million)
• No coal
• Steel automated
• Service industries
Homes and homelessness in Sheffield

- 238,400 homes in Sheffield
- 75% of homes are privately owned
- 19% (37,392) experience fuel poverty (13% England)
- East of Sheffield is one of most deprived areas in England

- Estimated 3,000 per year become homeless (2008) [ie 0.5% of population]
- 100 become roofless each year
Mental health services in Sheffield

- Old Asylum closed in the 1980’s – everyone found a home
- Now: one large Mental Health and Social Care trust
  - 190 psychiatric beds (total for acute, PICU, psychiatric rehab, drug rehab and dementia)
  - Range of specialist services, including substance misuse, dementia, APMH
  - CMHTs, EIS, CRHTs, Crisis house, community respite
  - ACT team for most unwell (200) with rehab ward (20)
  - Homeless Assessment and Support Team
Homeless Assessment and Support Team

- Part time consultant psychiatrist (1 day per week)
- Full time community psychiatric Nurse
- 1.5 Full time social workers
- Part time secretary/admin
- Managed as part of ACT team, but operates separately
- Based in primary care setting
Referrals

• 300 homeless/roofless referred each year (10% of homeless population)
• 100 caseload at any one time
Referred from I

- Local authority housing officer
- Hostels and housing associations
- Interim accommodation
- Bed and Breakfast hotels
- Drop-in centres
Referred from II

- GPs (family doctors)
- Health visitors
- Local substance misuse services
- Probation
- Relatives of the ‘missing’
- Rough sleepers (‘trawl’ by homeless team)
Diagnosis

- 50% psychosis with/without substance misuse
- 35% alcohol with/without mental health problem (depression or PD)
- 10% Learning disability or autism/aspergers
- 5% Organic
  - Korsakoffs
  - Huntingtons Chorea
  - Dementia
Gender and age

- Over 80% male
- Median age 35 years
History

- Grew up in state care - common
- Went to special schools - common
- Childhood sexual abuse – very common
- Domestic violence very common – very common
- Unhappiness in childhood – all!
- No father at home (only 5% grew up with a father)
  - Paternal abandonment
  - Imprisonment
  - Divorce
  - Death
Psychiatric history

- 70-90% seen psychiatric services before being homeless
- 40-70% psychiatric hospital in the past
- 20-30% been detained under mental health act
- 25-30% history of being violent
- 25-30% self harmed
- 25-30% prison
Our performance

- Most are seen for 6 weeks to 6 months
- DNA rate 20%
- Lost to follow up 25% (mainly out of city)
Where do we see people?

- Primary care
- Hostels
- Women’s refuge
- Public houses
- Cathedral/churches
- Graveyards
- Parks
- Alleyways, stairwells, railway sidings, wrecked cars
Why do we see people?

• Because they attract attention:
  – Disturbed behaviour
  – Suicidal acts/plans
  – Stopped eating
  – Gross neglect
  – Binge drinking
  – Confused speech/memory problems

• Asking for help!

• What about the quietly mentally ill? In London, maybe 80% of homeless mentally ill? Less than 50% in Sheffield?
Key steps in management

- Engagement is key, especially for roofless i.e. ‘Assertive outreach’
- If roofless, find a home/hostel
- Maintain contact/engagement: case management and a warm, engaging approach
- Then prioritise carefully to create care plan
Care plan

- Physical health often poor (refer to GP/primary care)
- Alcohol and substance misuse
- Find a stable home/supported accommodation
- Safeguarding/exploitation
- Treatment: drugs, psychological treatment
- Benefits and money
- Exercise, diet,
- Offending behaviour
- Work, education, occupation
- Family contact?
- When to transfer to standard community services
Important factors to consider

- Hope and optimism
- Respect and empathy
- Take time, listen and understand – interested in their ‘inner world’
- Touch (eg shake hands)
- Explain who you are and what you can do
- Explain treatments and give time for questions
- Outreach often necessary
- Joint clinical decision making wherever possible
What do we need for chronic homeless?

- Good supply of housing suited to individual need
- Good community treatment (Health, housing & SC) ACT/homeless team to pick up homeless people
- Community teams for long term health and social care with access to psychosocial interventions and ‘environmental interventions’
- Crisis services based in community (crisis houses, crisis/home treatment, respite) backed up by inpatient treatment