Outcome Study

Outcomes at 1 year of established rough sleepers with mental illness who are admitted to hospital involuntarily

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NHS Foundation Trust

Rough Sleeping

- ‘People sleeping, about to bed down or actually bedded down in the open air’. Includes ‘people in buildings or other places not designed for habitation’.

- 2013- 2,414 people rough sleeping on any one night in England

Homelessness in UK

High levels of physical disorder

High mortality rates

High levels of mental disorder

START Team

- Established in 1991 as “Mental Health Team for Single Homeless People”
- Assertive outreach team for homeless people with mental health problems
- Covers 3 London boroughs - Lambeth, Lewisham and Southwark – with a population of around 800,000 people.
- South London and Maudsley NHS Trust.

Brief History

- Began as a team working mainly in homeless hostels, with some day centre work – grew to 16 full time posts.
- Nurses/SWs/Housing/benefit workers, psychiatrist, psychologist.
- Assertive outreach/slow engagement ethos.
- “Continuous relationship” model of work.
- 5 years ago a re-organisation shrank the team to 8 full-time posts and forced a re-orientation to:
  - Day centre and street work.
  - Focus on assessment and referral

Current Situation

- Work closely and collaboratively with voluntary sector (NGO) street outreach teams, first stage hostels and day centres for homeless people.
- Open referral system.
- Although access has tightened we still have access to some high-quality flats/bedsits run by Thamesreach, an NGO. However, tightened rules mean that clients have to go through a first stage “assessment unit”
- Work alongside primary care outreach teams and hospital discharge teams for homeless people.

Current Situation

- Engagement ethos still strong BUT – we are now seeing a more alienated, socially excluded and severely mentally ill group of people than in the past.
- So – sometimes, in spite of everyone's best efforts, gradual outreach and engagement just doesn't work.

Involuntary admission to hospital – The Mental Health Act Assessment

- The “Intervention of last resort”
- Distressing for patients
- Time consuming
- Costly
- May have to happen out of working hours.
- Often frustrated by lack of in-patient beds – or just by the person not being where you thought they would be.

So – is it worth doing?

We wanted to establish whether, in a naturalistic setting, street assessments leading to an involuntary hospital admission could be effective in helping rough sleepers with mental illness.

Crude proxy outcomes 1 year after discharge from hospital.

- Engagement with team or CMHT
- Medication use
- Accommodation status
- Readmission to hospital
- Engagement in social activities
- Employment: Voluntary/Paid
- GP Registration

Sample

- Paper list of patients referred to START (November 2010-December 2012: 25 months)

- AMHPs within START team keep list of patients they have sectioned (2007-2013)

Information

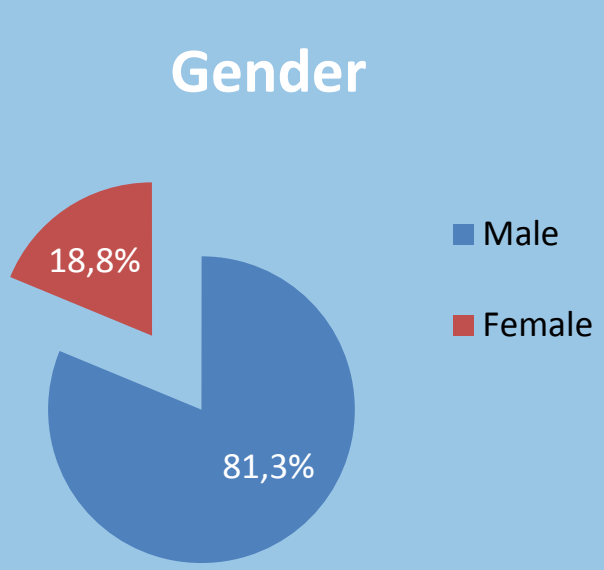
Our trust's electronic record system

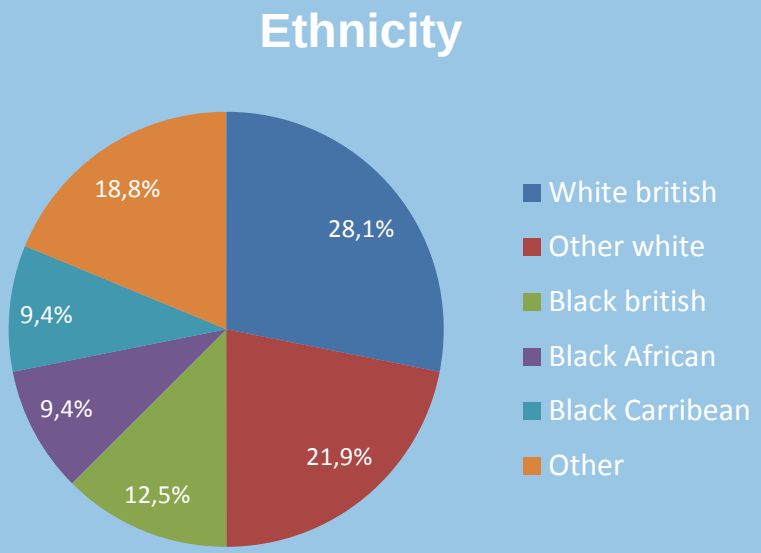
Inclusion Criteria

- Referral to START team
- Established rough sleeper (min 1 month rough sleeping)
- Mental Health Act assessment leading to hospital admission under a section of the MHA
- Discharged from hospital
- Out of hospital for 1 year or more

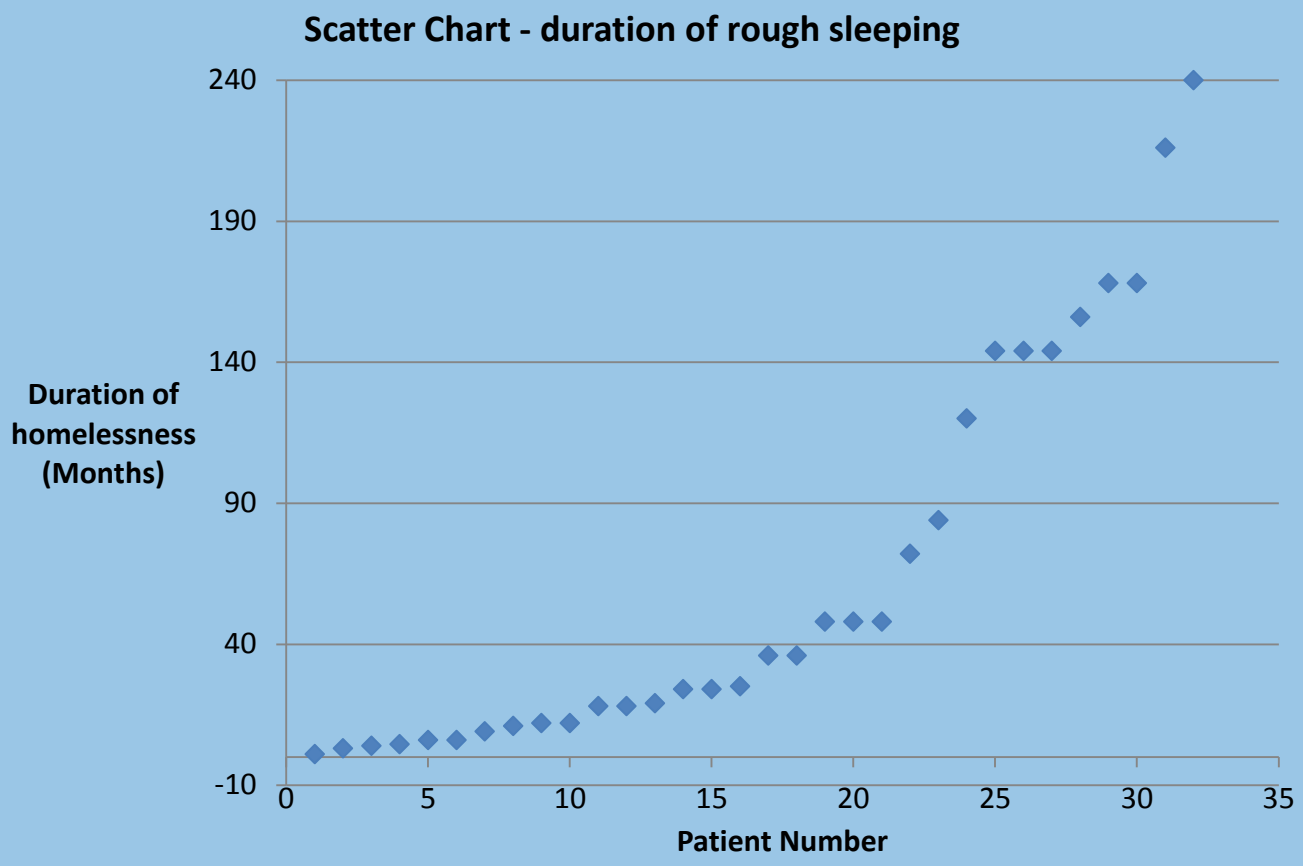
Demographics of Sample

- 32 men and women
- Median age= 44 years (24-84 range)

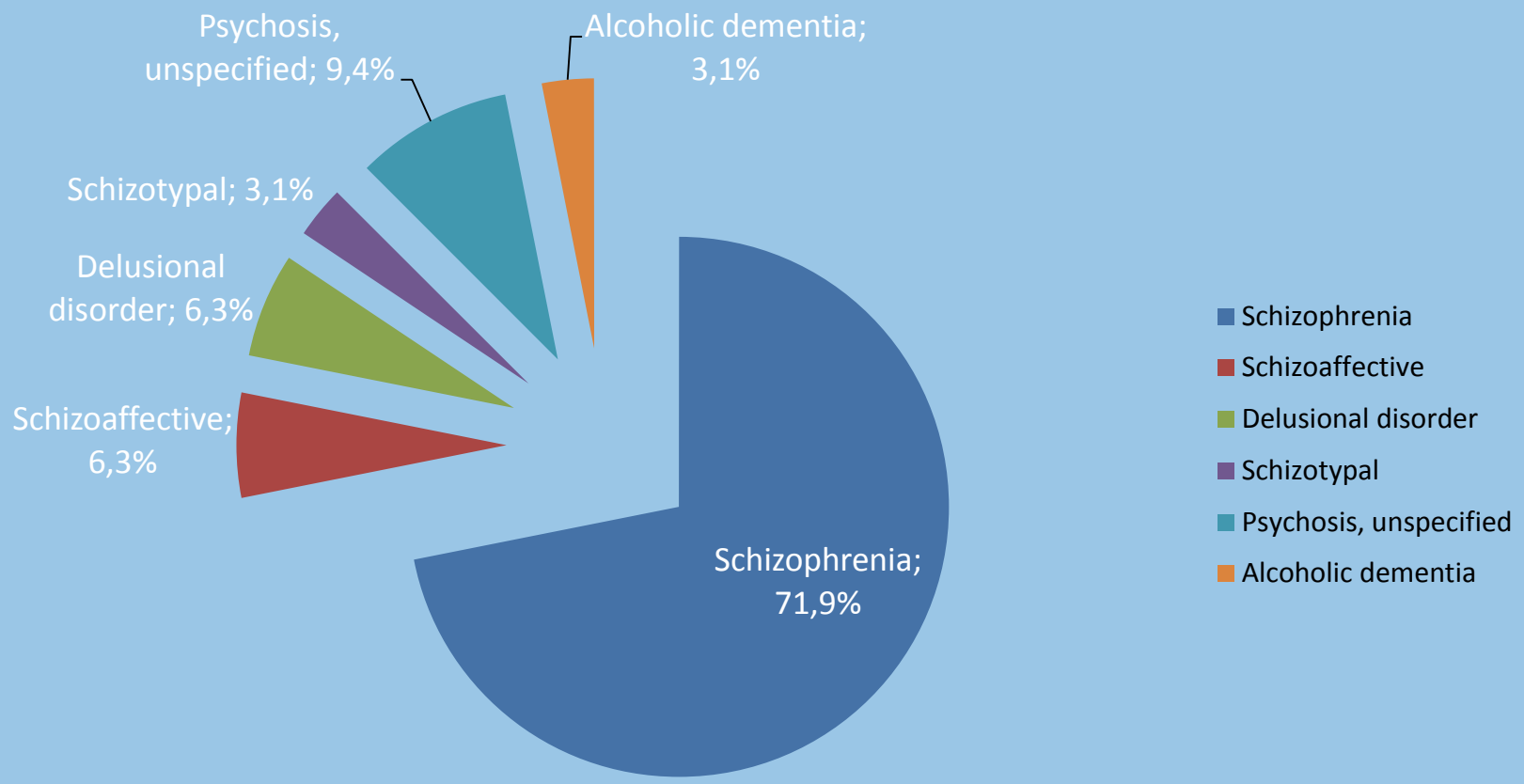




Duration of homelessness

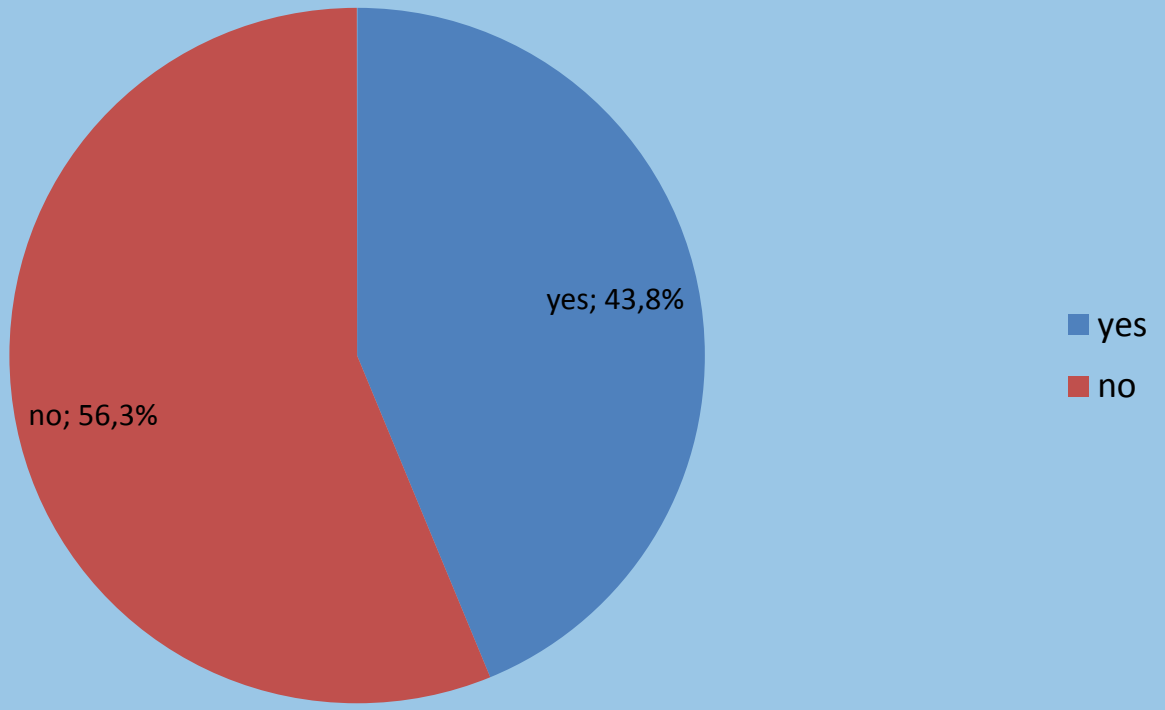


Diagnosis



Concurrent Drug/alcohol misuse: 14/32 (44%)

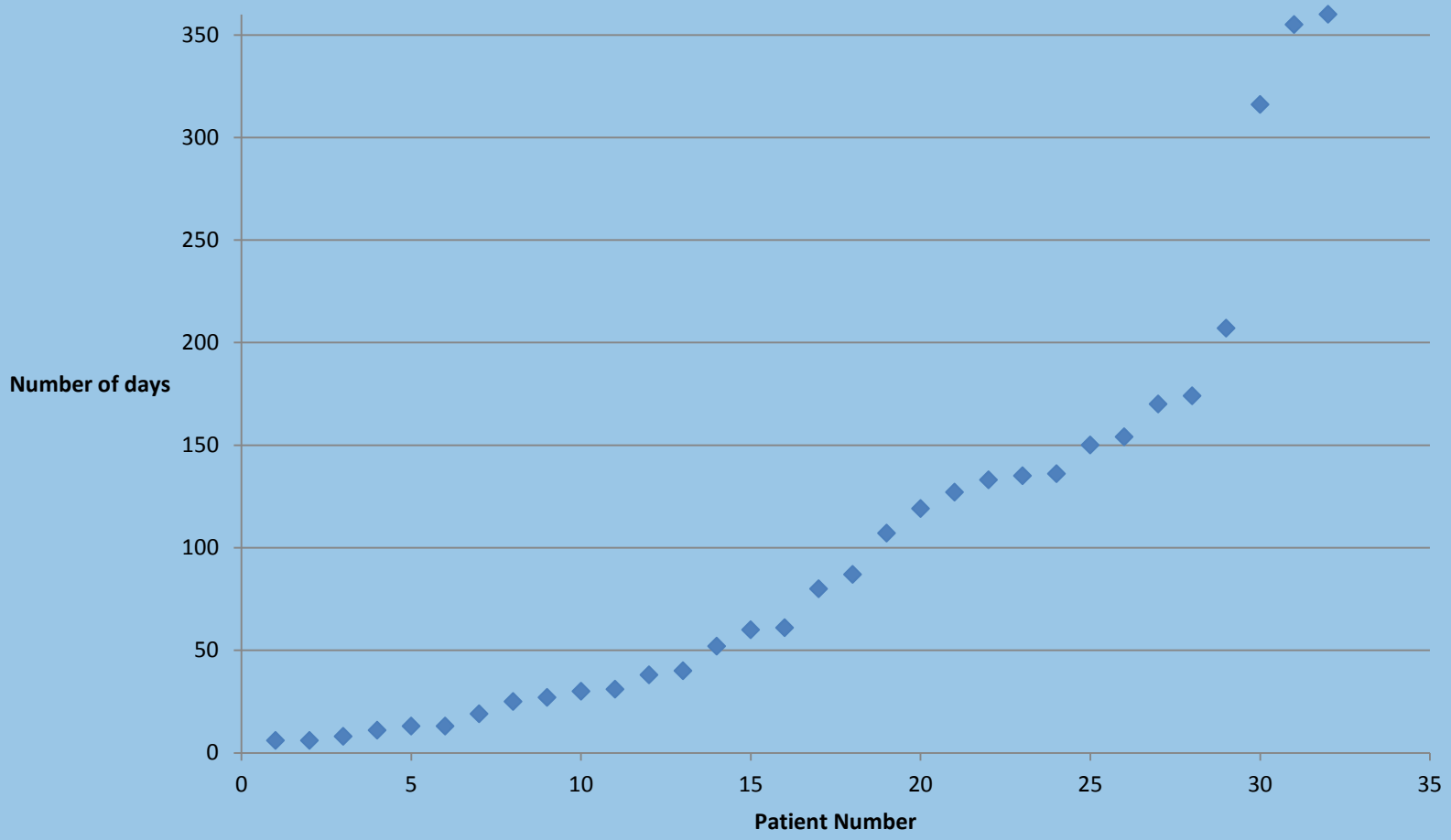
Previous hospital admission(s)?



“Our” Hospital Admission

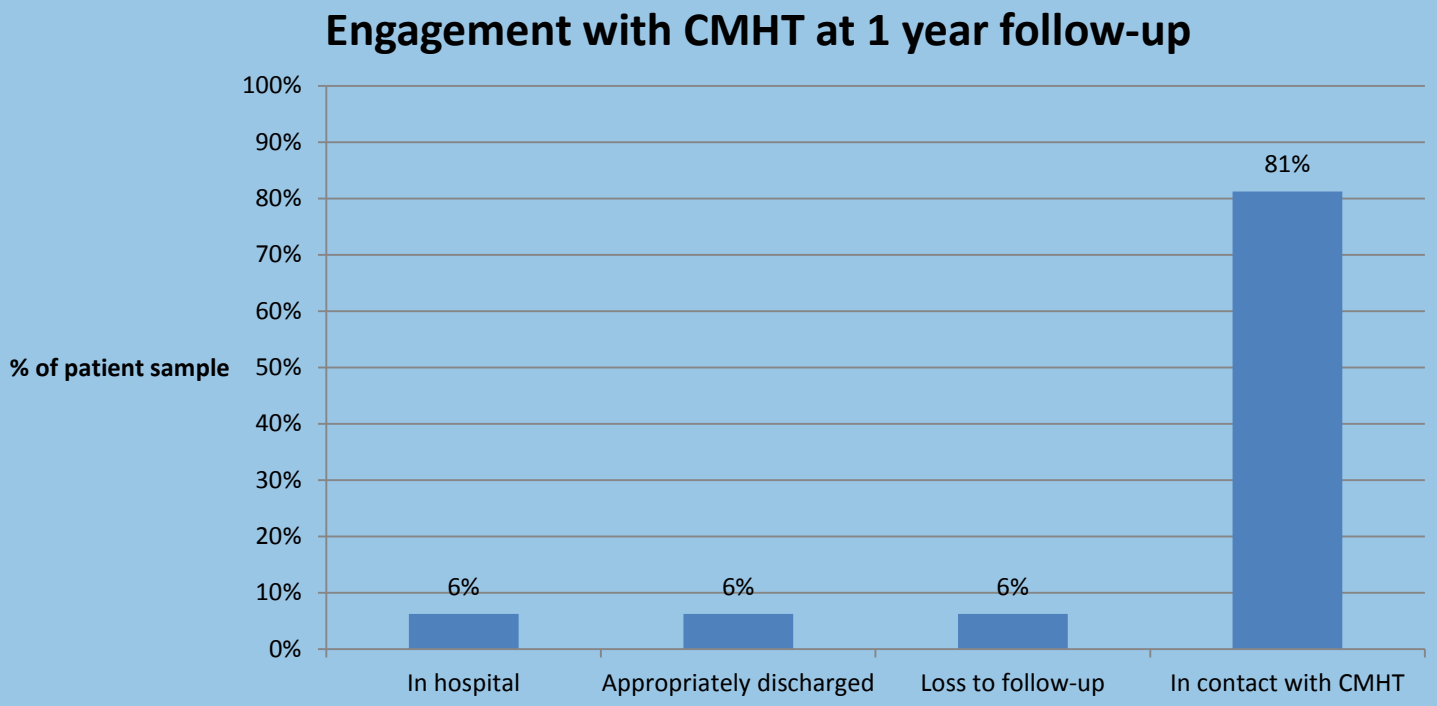
- All 32 were admitted under s2 of the MHA – “for assessment”
- 9/32 (28%) were converted to a s3 “for treatment”

Scatter Chart – Duration of hospital admissions



Outcomes

Outcomes at 1 year follow-up

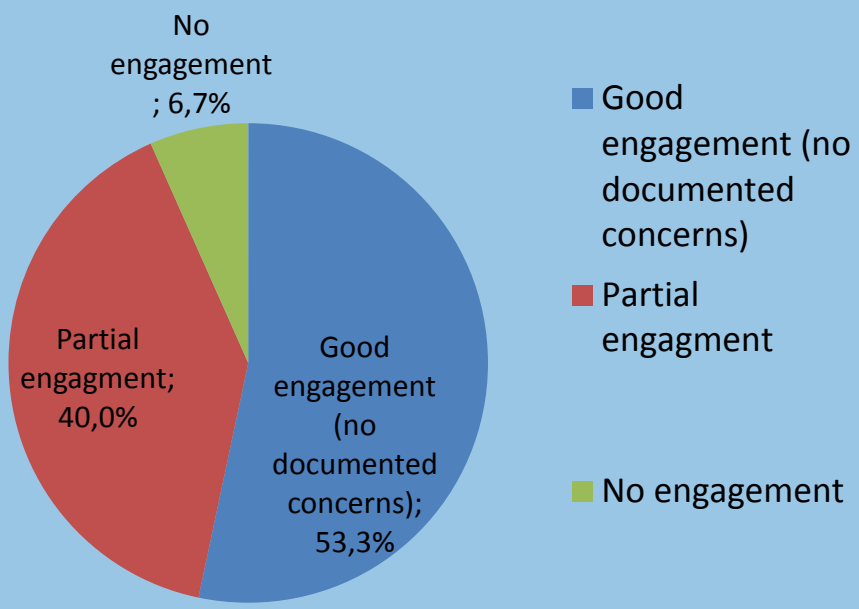


Loss to follow-up

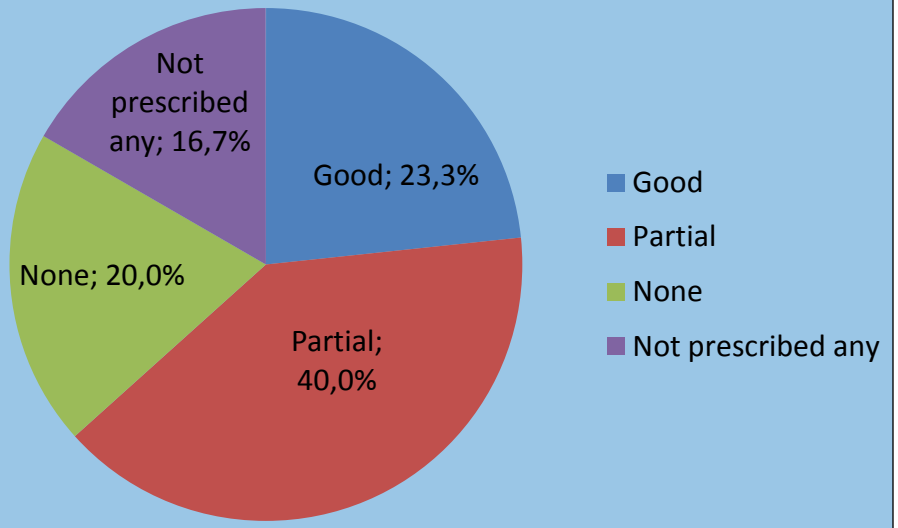
1 patient went AWOL after 6 months

1 patient refused to engage with team and so was discharged after 8 months

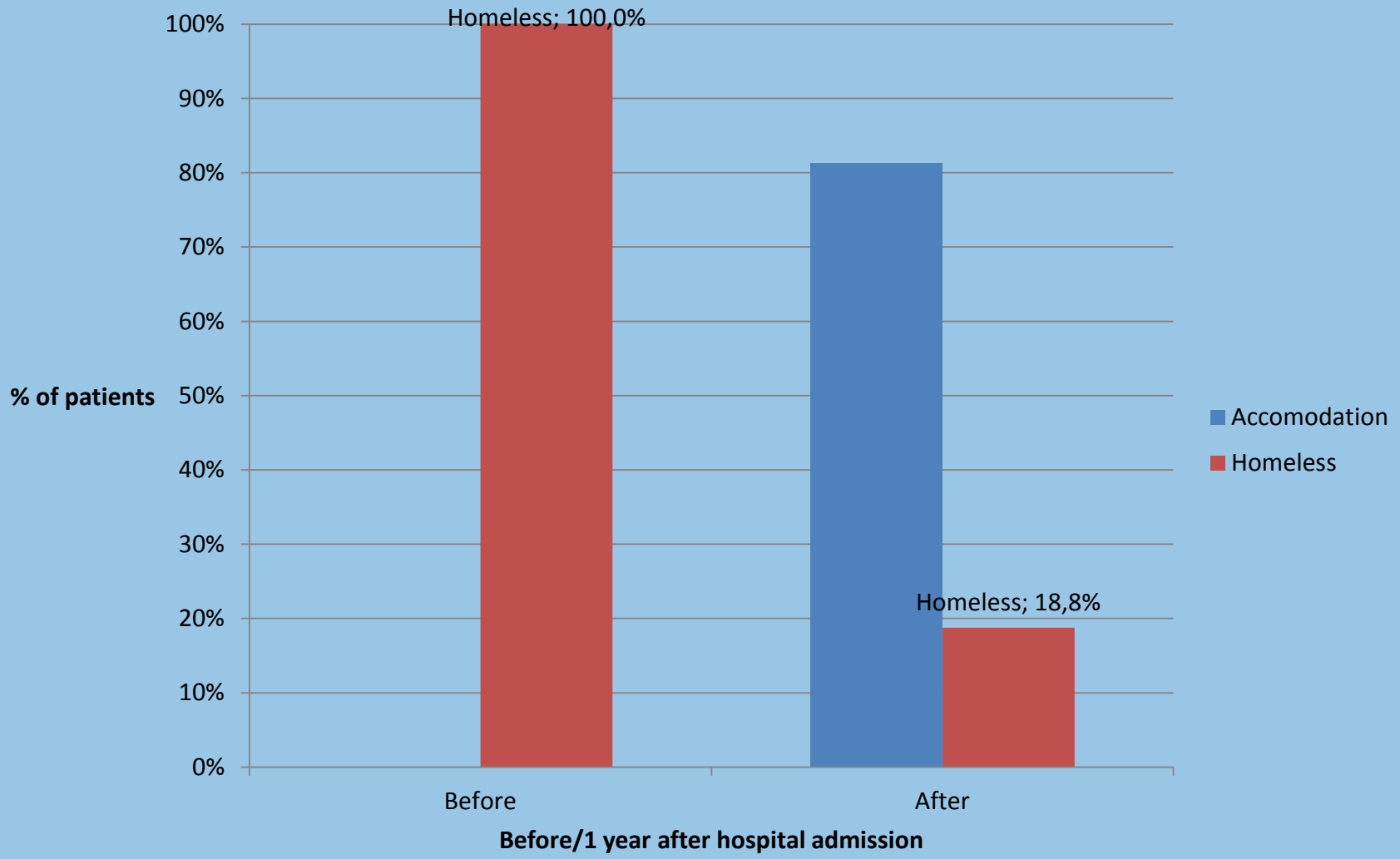
Engagement with CMHT



Medication Adherence



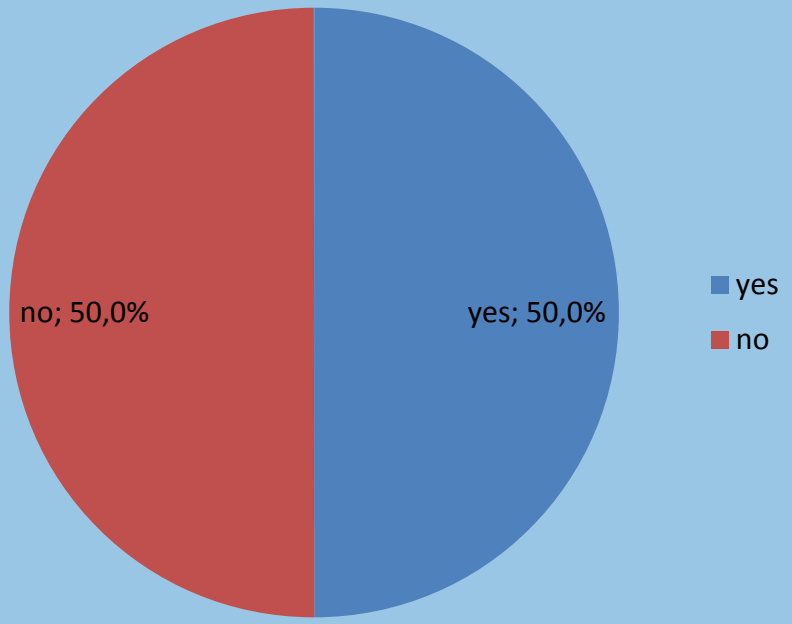
Accommodation status



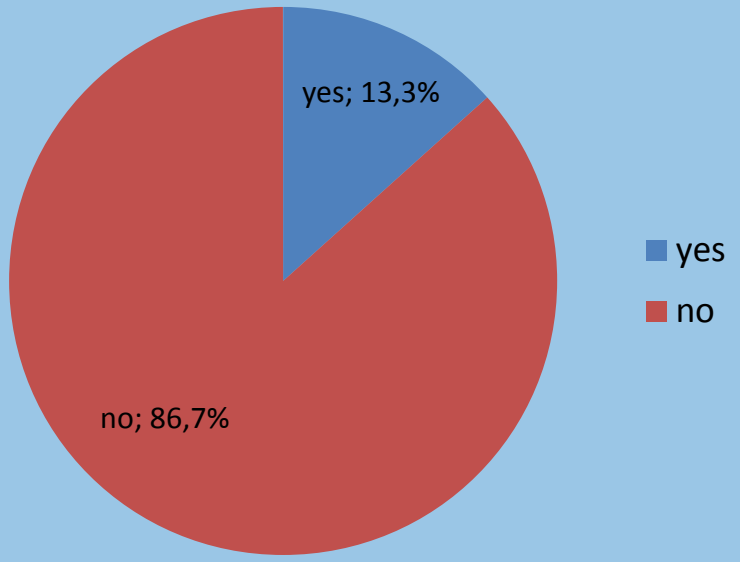
Accommodation Type	Number of clients
Supported accommodation	18
Shared accommodation with no support	1
Residential care home	1
Flat	6 (2 flats funded by NRPF Panel)
Homeless	6

Engagement in

Social activities?

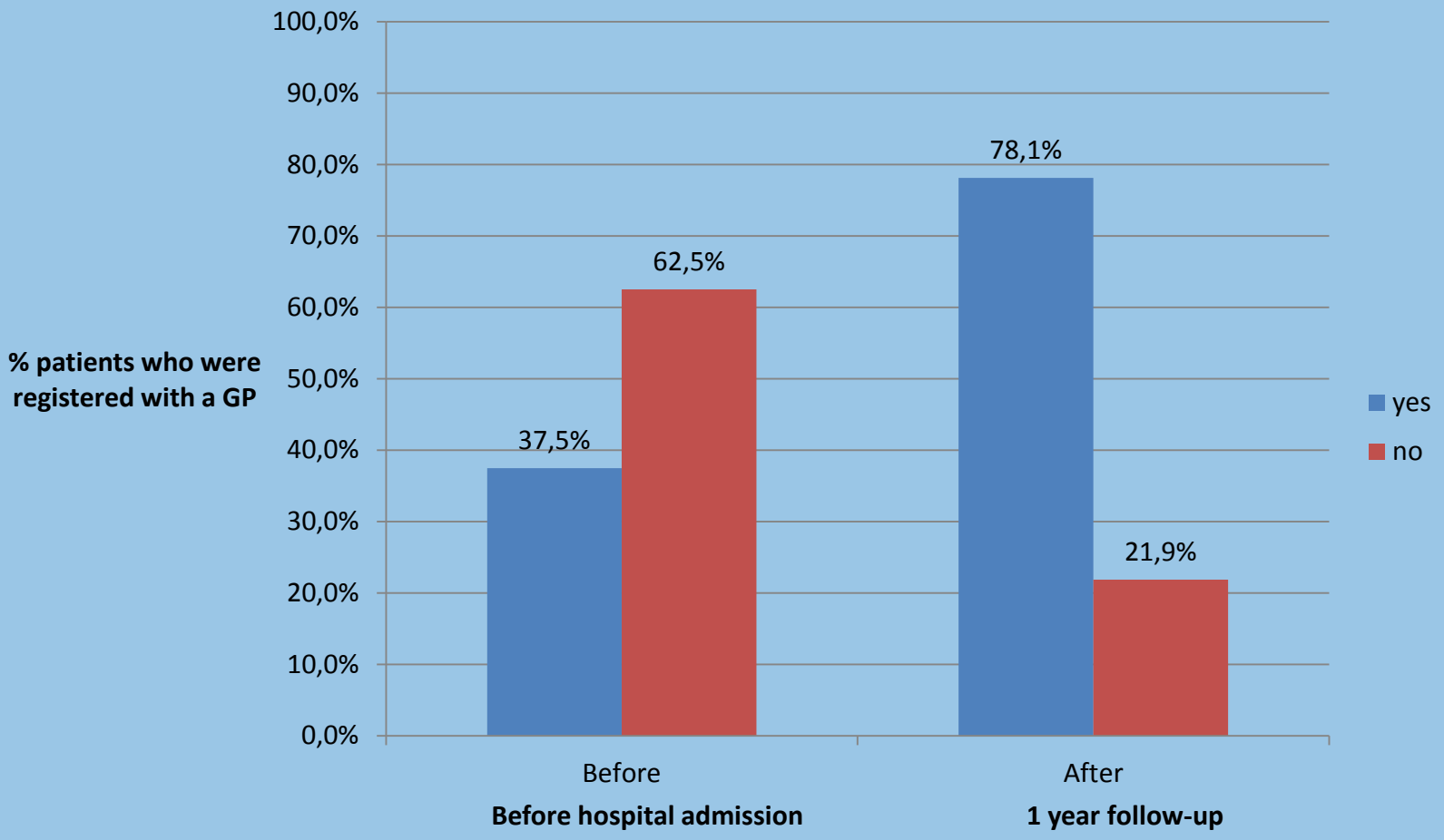


Voluntary work/employment?



*2 patients in hospital not included

GP Registration?



Discussion

- Positive Outcomes:

-Accommodation Status

-GP Registration

-Engagement with team

-Medication compliance

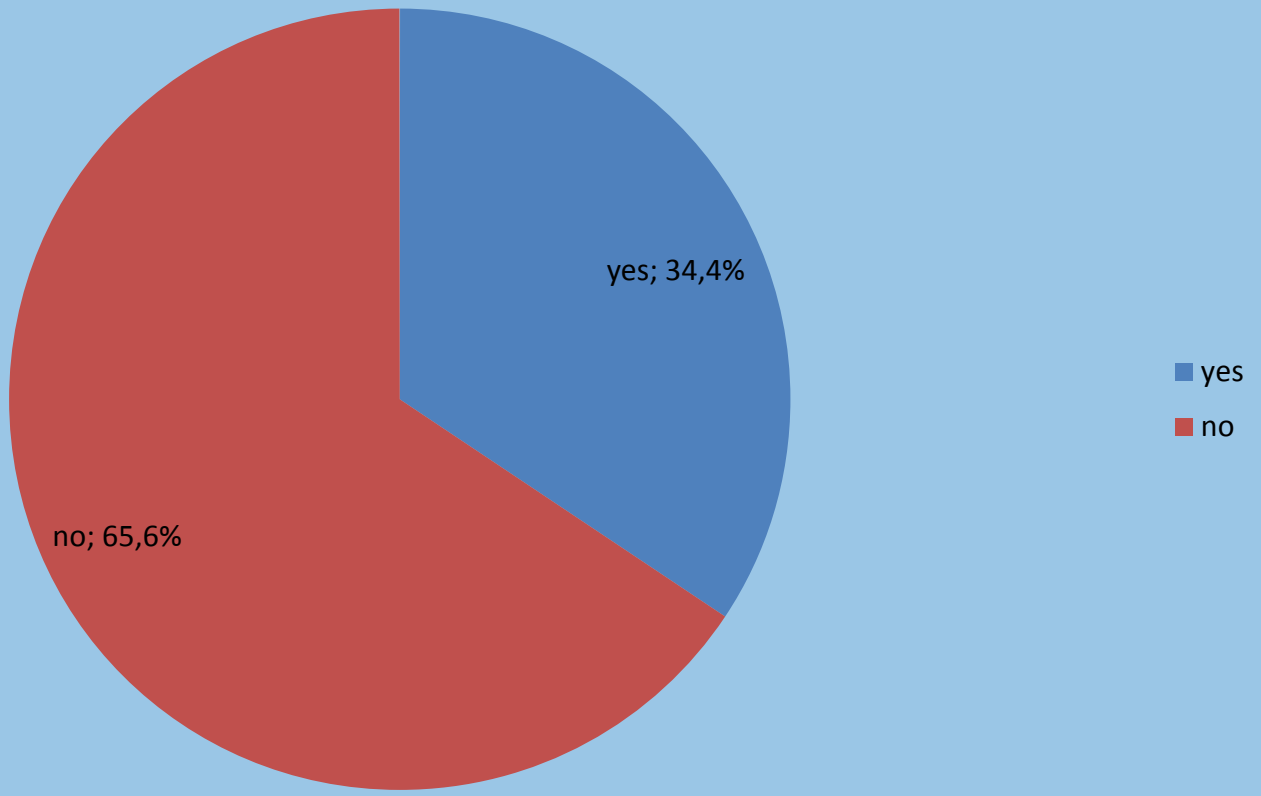
-Engagement in social activities

- Poor outcomes:

-Repeat hospital admission

-Employment

What happened with those re-admitted within 1 year?



Repeat Admissions

	Repeat hospital admission	No repeat hospital admission
Number of patients	11/32 (34.4%)	21/32 (65.6%)
Number of patients discharged to streets after first admission	**5/11 (45.5%)**	2/21 (9.5%)
Reasons for discharge to streets	**-No mental illness (4)** **-Plan to find accommodation afterwards (1)**	-Refused help (2)

	Repeat hospital admission	No repeat hospital admission
Not discharged on medication following first admission	7/11 (63.6%)	4/21 (19.0%)
Reasons for no medication	**-In patient team felt no mental illness (4)** **-Patient refused medication (2)** **-Meds stopped as felt not to be appropriate (1)** **-Went AWOL (1)**	-Meds felt not to be appropriate (2) -Patients refused medication (2)

Questions to pursue .....

- Being discharged to the streets without medication, ?associated with readmission
- Differences in opinion between CMHT and hospital ward re diagnosis
- ?Argument for homeless teams having their own hospital beds

Limitations

- Retrospective
- Small sample size
- Data collected from e-notes- reliability
- 1 year follow-up- ?not long enough
- No control group – but this would probably be unethical

Further Work on this project

- Increase sample size- application made to use CRIS to get a larger sample size
- Look at longer follow-up (eg 2 years)
- Use of statistics