Outcome Study

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

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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

Scatter Chart - duration of rough sleeping

Duration of homelessness (Months)

Patient Number
Diagnosis

Schizophrenia; 71,9%
Schizoaffective; 6,3%
Delusional disorder; 6,3%
Schizotypal; 3,1%
Psychosis, unspecified; 9,4%
Alcoholic dementia; 3,1%

Concurrent Drug/alcohol misuse: 14/32 (44%)
Previous hospital admission(s)?

- Yes: 43.8%
- No: 56.3%
“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

Number of days

Patient Number
Outcomes
Outcomes at 1 year follow-up

Engagement with CMHT at 1 year follow-up

- In hospital: 6%
- Appropriately discharged: 6%
- Loss to follow-up: 6%
- In contact with CMHT: 81%

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

- Good engagement (no documented concerns): 53.3%
- Partial engagement: 40.0%
- No engagement: 6.7%

Medication Adherence

- Good; 23.3%
- Partial; 40.0%
- None; 20.0%
- Not prescribed any; 16.7%
Accommodation status

% of patients

Before/1 year after hospital admission

Before

Homeless; 100.0%

After

Homeless; 18.8%
<table>
<thead>
<tr>
<th>Accommodation Type</th>
<th>Number of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported accommodation</td>
<td>18</td>
</tr>
<tr>
<td>Shared accommodation with no support</td>
<td>1</td>
</tr>
<tr>
<td>Residential care home</td>
<td>1</td>
</tr>
<tr>
<td>Flat</td>
<td>6 (2 flats funded by NRPF Panel)</td>
</tr>
<tr>
<td>Homeless</td>
<td>6</td>
</tr>
</tbody>
</table>
Engagement in

Social activities?

- Yes: 50.0%
- No: 50.0%

Voluntary work/employment?

- Yes: 13.3%
- No: 86.7%

*2 patients in hospital not included
% patients who were registered with a GP

Before hospital admission:
- Before: 37.5%
- After: 62.5%

1 year follow-up:
- Before: 78.1%
- After: 21.9%
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?

- yes; 34.4%
- no; 65.6%
## Repeat Admissions

<table>
<thead>
<tr>
<th></th>
<th>Repeat hospital admission</th>
<th>No repeat hospital admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td>11/32 (34.4%)</td>
<td>21/32 (65.6%)</td>
</tr>
<tr>
<td>Number of patients discharged</td>
<td>5/11 (45.5%)</td>
<td>2/21 (9.5%)</td>
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<tr>
<td>to streets after first</td>
<td></td>
<td></td>
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<tr>
<td>admission</td>
<td></td>
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<tr>
<td>Reasons for discharge to</td>
<td>-No mental illness (4)</td>
<td>-Refused help (2)</td>
</tr>
<tr>
<td>streets</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Plan to find accommodation afterwards (1)</td>
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</tr>
<tr>
<td>Reasons for no medication</td>
<td>Repeat hospital admission</td>
<td>No repeat hospital admission</td>
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<tr>
<td>---------------------------</td>
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</tr>
<tr>
<td></td>
<td>7/11 (63.6%)</td>
<td>4/21 (19.0%)</td>
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<tr>
<td>Not discharged on medication following first admission</td>
<td></td>
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<tr>
<td></td>
<td>-In patient team felt no mental illness (4)</td>
<td>-Meds felt not to be appropriate (2)</td>
</tr>
<tr>
<td></td>
<td>-Patient refused medication (2)</td>
<td>-Patients refused medication (2)</td>
</tr>
<tr>
<td></td>
<td>-Meds stopped as felt not to be appropriate (1)</td>
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<tr>
<td></td>
<td>-Went AWOL (1)</td>
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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 (e.g. 2 years)
- Use of statistics