

A SURVEY OF THE USE OF AN ASSESSMENT AND TREATMENT UNIT FOR ADULTS WITH LEARNING DISABILITY IN LANARKSHIRE OVER A SIX YEAR PERIOD (2001-2006)

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Introduction

The issue of how specialist mental health services should meet the needs of people with a dual diagnosis of learning disability and mental health problems has been debated in the literature (Day, 1988; Day, 1994; Bouras *et al.*, 1995; Tajuddin *et al.*, 2004), with how to provide inpatient assessment and treatment posing particular challenges for services. Bailey and Cooper (1997) found that only 70% of Trusts who provided Learning Disability Services, offered specialist admission beds. This paper seeks to highlight the use of the Assessment and Treatment Unit within the National Health Service (NHS) Lanarkshire.

The Assessment and Treatment Unit within the Lanarkshire Learning

Disability Service is currently a 9-bedded unit, (which serves a population of 560,000). During the study period, bed numbers increased from 6 to 9 with a plan to further increase bed numbers to 12 with the building of a new unit. This is less than the bed numbers suggested by Day (1993) and Reid (1994) and less than the number of assessment and treatment beds suggested in "The same as you?" (Scottish Executive, 2000). This document suggested that 4 assessment and treatment beds per 100,000 of population are required. Even although the plan is to eventually increase the Assessment and Treatment Unit bed numbers to 12, this is still less than that expected for a population of this size. Decisions about bed numbers for the Assessment and Treatment Unit were taken after the "The

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same as you?" (Scottish Executive, 2000) recommendations were applied to local knowledge about the population and bed usage at that time as well as information about previous discharges of long stay residents.

In addition there was a change in ethos of the service in line with "The same as you?" to a more community based service. There has been an increase in the size of community teams which include dietetics, nursing, occupational therapy, physiotherapy, psychiatry and psychology, as well as the appointment of 5 specialist practitioners in the fields of transition, acute liaison, forensic, epilepsy and autistic spectrum disorder (ASD). Close working practices have also been developed with local authorities, provider organisations, carers and service users. Through close inter-agency working and collaboration the service is often able to offer assessment and treatment in the community without resorting to in patient admission. In addition, the philosophy of the Learning Disability Service in Lanarkshire and also of North and South Lanarkshire Councils has been that continuing NHS beds should not be required as services can be provided in the community (NHS Lanarkshire, 2000). As NHS Lanarkshire provides a service which utilises a low number of assessment and treatment beds it is particularly important that the assessment beds are used appropriately and are supported by community services.

Referrals for admission are most often made by the Community Learning Disability Team (CLDT) and acute psychiatry but occasionally referrals come from other sources such as general practitioners (GPs) or social workers. The admission criteria for the Assessment and Treatment Unit are that the individual has a learning disability, is over the age

of 16 and has a psychiatric condition or challenging behaviour which requires admission for assessment and treatment. The Assessment and Treatment Unit is an open ward and, at present, cannot provide a low, medium or high secure environment.

In 2003 issues such as the number of individuals being admitted to and delayed discharges from the Assessment and Treatment Unit were addressed by the introduction of a number of protocols designed to ensure that the Assessment and Treatment Unit was utilised appropriately and services were streamlined and improved.

The Protocols

A brief description is given below of each of the protocols and their purpose. A copy of the full protocols can be obtained from the authors.

Admissions Protocol

This is a protocol to ensure that individuals are appropriately admitted to the unit. Decisions about admission are made jointly by nursing staff on the unit and the Consultant Psychiatrist who jointly assess the need for admission. If an admission is not felt to be the most appropriate course of action then both disciplines have a role to play in ensuring assessment and treatment in a community setting.

Ideally, a pre-admission meeting is held where the outcomes of admission are defined, roles are clarified and progress towards discharge begins. Indeed, it is not unusual to set a discharge date to work towards at a pre-admission meeting. Admission to the unit facilitates immediate contact with the multidisciplinary team to

allow immediate access to assessment and therapeutic intervention.

Discharge Protocol

This is a protocol to ensure smooth discharge of the individual, making sure that the correct information is passed on to the correct parties.

Delayed Discharge Protocol

This is engaged when an individual is clinically fit for discharge but cannot move on from the unit for other reasons. It ensures that the entire multidisciplinary and inter-agency team identify the issues delaying the discharge and maximises efforts to resolve these. It also ensures that those with management responsibility attend the regular review meetings. This allows those who make decisions about funding and budgets direct contact with the wider team and facilitates discussions about what can be achieved with the funding available and how each agency can support the discharge.

Acute Psychiatry Protocol (Shared Care Protocol)

This protocol ensures continuity of care. It was implemented after it was realised that patients known to the Learning Disability Service were being admitted out of hours to general psychiatry wards and discharged without the Learning Disability Service being aware of their admission. This protocol ensures that the general psychiatry service contacts the Learning Disability Service. The Learning Disability Service can then review and assume responsibility for the individual, transferring if necessary to the Assessment and Treatment Unit.

Aims

The aims of this survey were to:

- Review the use of assessment and treatment beds within the Learning Disability Service in Lanarkshire.
- Assess the impact of the protocols on admissions to and discharges from the unit.
- Review reasons for delayed discharge.

Method

Cases were identified using the ward admission register and Patient Information Management System (PIMS) to ensure that all admissions to the unit were included. Data regarding the admission and discharge processes, length of stay, diagnosis (as recorded in case notes), as well as demographic data was collected from case notes.

Results

Number of Admissions

The number of admissions was found to be fairly consistent over the years included in the survey (FIGURE 1).

The numbers of males and females admitted are comparable and the difference between the two is not statistically significant (FIGURE 2).

For any Admission Unit, patients requiring multiple admissions, so called "revolving door patients" are a concern for a variety of reasons. In 2001, sixteen patients were responsible for twenty admissions; in 2002, seventeen patients were responsible for twenty admissions.

FIGURE 1
Number of admissions

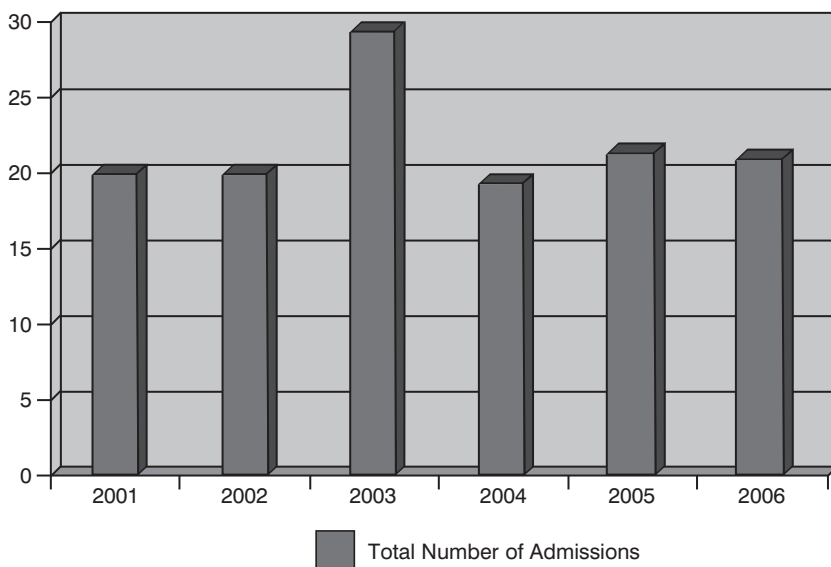


FIGURE 2
Gender of admissions

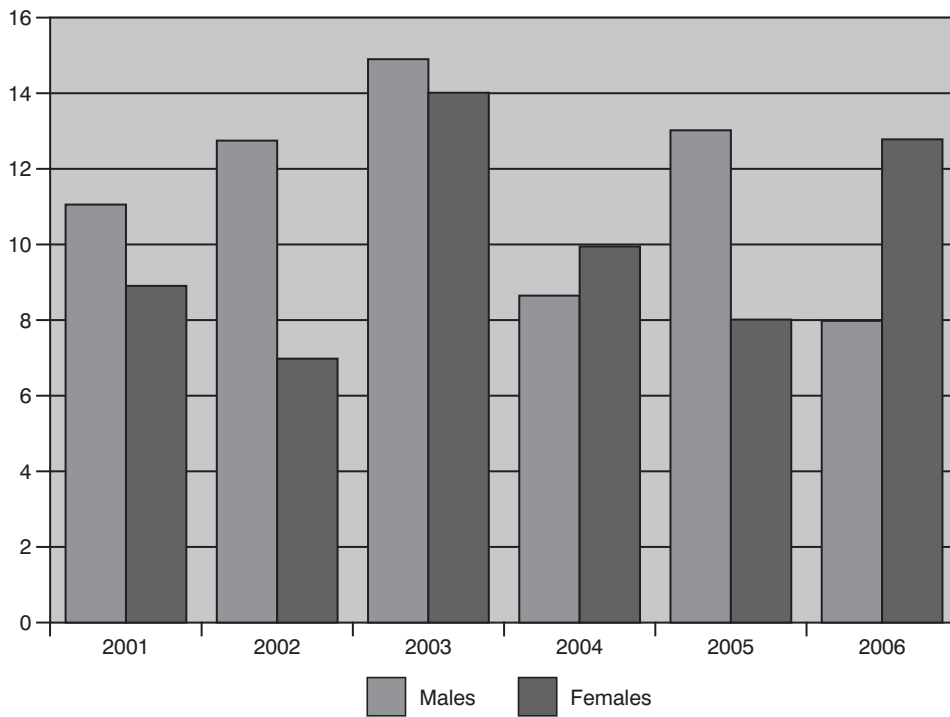
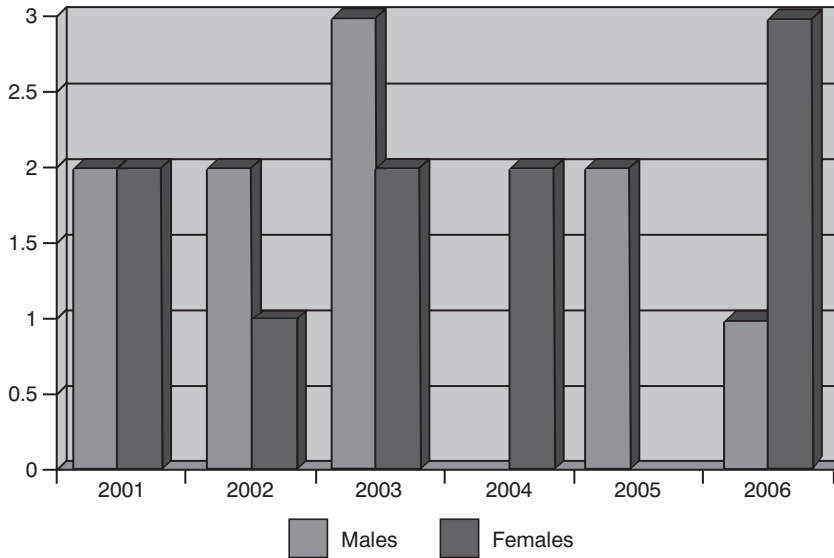


FIGURE 3
Number of patients requiring multiple admissions



In 2003, twenty-two patients were responsible for twenty-nine admissions; in 2004 seventeen patients were responsible for nineteen admissions; in 2005 seventeen patients were responsible for twenty-one admissions and in 2006 seventeen patients were responsible for twenty-one admissions.

Patients requiring multiple admissions were in the minority (FIGURE 3).

other sources e.g. GP or Social Work Department. The large number of admissions from acute psychiatry reflects the fact that the Assessment and Treatment Unit only receives admissions during office hours. Anyone requiring admission to the unit outside of these times would be admitted to the acute psychiatry ward, with a view to transfer to the Assessment and Treatment Unit as soon as possible thereafter (TABLE I).

Source of Admissions and Living Circumstances Prior To Admission

Prior to admission the majority of individuals lived either with family members or with paid carers, with relatively few individuals living in other circumstances (TABLE I).

The main source of referral for admission was the CLDT and acute psychiatry but was occasionally from

Type and Length of Admission

Admissions to the unit can either be on an emergency or planned basis. In 2001, 2002 and 2004, and 2006 the majority of the admissions were planned (80%, 60%, 63% and 81% respectively). In 2003 and 2005, the majority of the admissions were on an emergency basis (55% and 52% respectively) (TABLE II).

The majority of admissions to the Assessment and Treatment Unit (i.e. 74% of the total admissions) lasted for between 1 week and 3 months (TABLE II). The number of admissions lasting for more than 3 months accounted for only 20% of the total admissions. Patients whose admission lasted for more than one year were in the minority accounting for 5% of the total admissions. Nonetheless, this is a small, but important, population (TABLE II).

Some of the prolonged admissions were considered as delayed discharges; that is patients were clinically fit for discharge from a mental health point of view but continued to remain on the unit for other reasons (TABLE II). According to this definition, 11% of the total admissions were considered delayed discharges.

Where poor physical health prevented discharge, a delayed discharge would

be recorded as poor physical health and would not be a reason to remain on an acute psychiatric ward but would necessitate transfer to appropriate services (TABLE II).

The single biggest reason for delayed discharge was difficulty with an individual's placement in a community setting, either for reasons of funding or lack of available resources.

As the protocols mentioned above were put into place over the course of 2003, it seemed reasonable to examine the differences between the time period 2001 - 2003 and 2004 - 2006. It was felt that the measures which might best reflect the impact of the protocols were type of admission, length of admission and delayed discharges.

There is no statistical difference between the planned admissions for the two time periods; similarly neither

TABLE I
Living circumstances of admitted individuals and source of referral

	2001	2002	2003	2004	2005	2006	Total
Living Circumstances							
Alone	0	2	0	0	3	0	5
Family	10	7	14	5	11	10	57
Paid Carers	7	8	10	9	7	9	50
Hostel	1	2	0	0	0	1	4
Nursing Home	0	1	0	0	0	1	2
Homeless	0	0	0	0	0	0	0
Other	2	0	5	5	0	0	12
Source of Referral							
GP	2	0	0	1	0	0	3
CLDT	12	9	15	12	10	10	68
Acute Psychiatry	3	10	10	6	8	9	46
Social Worker	0	0	2	0	1	0	3
Other	3	1	2	0	2	2	10

GP - General Practitioner; CLDT - Community Learning Disability Team

TABLE II
Type of admission, duration of stay and number of individuals experiencing a delayed discharge and the reason

	2001	2002	2003	2004	2005	2006	Total
Admission Type							
Planned	16	12	13	12	10	17	80
Emergency	4	8	16	7	11	3	49
Not Recorded	0	0	0	0	0	1	1
Admission Duration							
< 1 week	1	0	2	0	3	2	8
1 week - 1 month	9	4	11	11	4	11	50
1 - 3 months	7	7	12	7	7	6	48
3 - 6 months	2	8	3	1	4	0	18
6 - 12 months	1	0	0	0	0	0	1
> 12 months	0	1	1	0	3	2	7
Reason Discharge Delayed							
Placement Difficulty	1	3	1	3	5	0	13
Physical Health	2	3	0	0	0	0	5

TABLE III
Comparison of results 2001-2003 and 2004-2006

	2001-2003 (%) N=69	2004-2006 (%) N=61	Chi squared (p value)
Admission Type			
Planned	41 (59.42)	39 (63.93)	
Emergency	28 (40.58)	21 (34.43)	0.279 (0.6)
Admission Duration			
0-3 months	53 (76.81)	51 (83.60)	
>3 months	16 (23.18)	10 (16.39)	0.934 (0.3 - 0.35)*
Delayed Discharges	10	8	0.052 (0.8-0.9)

* when comparing the difference between admissions under 3 months with admissions over

the length of admission nor the delayed discharges have altered significantly (TABLE III).

We looked at the diagnosis recorded for each admission and these are comparable between the two time periods (TABLE IV). Although a full range of psychiatric diagnoses are recorded, a diagnosis of challenging behaviour, psychosis, depression or ASD accounted for the majority of admissions. A minority of admissions had no psychiatric diagnosis. The lack of recording of a psychiatric diagnosis in the case notes in some instances was highlighted and this has been addressed. Co-morbid physical illness is common in this population and highlights the need for good medical

as well as psychiatric care (NHS Health Scotland, 2004).

Discussion

It is a challenge for Learning Disability Services to ensure that specialist beds for people with a learning disability are used appropriately (Lyll and Kelly, 2007). With the recommendation of 4 specialist beds per 100,000 of population (The Same As You? Scottish Executive, 2000), services need to be able to offer a broad range of interventions in community settings to ensure that assessment and treatment beds are utilised appropriately in order to

TABLE IV
Diagnosis at admission

	2001-2003	2004-2006
Challenging Behaviour	14	16
Depression	19	10
ASD +/- Challenging Behaviour	8	9
No Diagnosis	7	3
Alcohol Dependence	1	0
No evidence of psychological disorder	1	0
Bipolar Affective Disorder	1	5
Psychosis	6	11
Acute Confusional State	1	0
Somatoform Disorder	1	0
DSH/Suicidal ideation	1	0
Dystonic reaction	1	0
Anxiety Disorder	1	1
Eating Disorder	1	0
Personality Disorder	0	2
Situational Crisis	1	0
Level of LD only recorded	6	1

ASD - Autistic Spectrum Disorder; DSH - Deliberate Self Harm; LD - Learning Disability

meet the needs of this population group. This includes having robust community services and collaborative inter-agency working to ensure that a range of options are available, as well as ensuring that individuals can move on from specialist LD beds when they no longer require this level of care. Good working relationships with general psychiatrists to ensure care is not compromised when individuals are admitted to non-specialist units is essential (Chaplin and Flynn, 2000). When individuals remain in Assessment and Treatment Units for longer than necessary there is inevitably an impact on the individual and the Learning Disability Service as well as general psychiatric beds (Lewis and Glasby, 2006). The use of beds within Learning Disability Services in the wider setting of service provision is currently a matter of interest for the Scottish Executive.

Use of the Assessment and Treatment Unit within Learning Disability Services in Lanarkshire

The number of admissions remained fairly constant over the survey period despite the implementation of protocols and the development of community services. This would tend to suggest that there will always be a small, but important, number of people with learning disabilities whose mental health needs will require to be met within an acute admission ward setting, in keeping with the findings of Lyall and Kelly (2007).

A full range of psychiatric diagnoses are seen but the majority of the admissions are for challenging behaviour, psychosis, depression and ASD, reflecting the difficulties at times in managing these conditions in a community setting even

with the involvement of family carers, paid carers and the Community Learning Disability Team. It is likely that it is the degree of risk posed, to self and others, by individuals with these diagnoses at the time of admission which leads to that admission. However, further research would be required to clarify this.

The number of individuals who had multiple admissions is small but they comprises an important group who merit further study to discern whether the admissions are purely due to mental health needs or a need for increased or different community support. However, a limitation of this survey is that the numbers were too small to comment further on this aspect.

The large number of referrals for admission from the CLDT indicates that the teams are appropriately involved with people with a learning disability as well as severe and enduring mental illness and/or challenging behaviour who require specialist services.

Many factors impact on whether an admission is an emergency or a planned admission (diagnosis, level of risk, community services, etc). The admission protocols, however, aid the process by giving clear indications and expectations about what admission can achieve and what the roles of individual professionals are to be. This promotes good communication and enhances patient care.

Implementation of protocols

During the period of this survey service development has not been static. There have been additional developments in service provision for those with a learning disability within Lanarkshire

e.g. a continued discharge programme for long stay residents with a number of initiatives by local authorities and service providers, as well as an increase in the number of psychiatrists, development of the community learning disability teams and management restructuring, making it difficult to attribute any changes solely to the implementation of the protocols. However, the protocols would appear to have had an impact in a number of important areas.

Using admission type, length of admission and delayed discharges as indicators of the areas we would expect to have been influenced by the protocols we have found improvements in all areas: more people are admitted as a planned admission, admissions in the main are of a shorter duration and there are fewer delayed discharges. None of the results reach statistical significance and an ongoing study for a more prolonged period is necessary to fully explore the impact of the protocols. However, the protocols do provide a robust and standardised structure for the admission and discharge process and encourage multidisciplinary and inter-agency working.

Delayed Discharge

There has been much debate and discussion about how to tackle the issue of delayed discharges from acute Assessment and Treatment Units. This includes looking at reasons for delayed discharges and blocked beds with a view to finding a means of reducing them.

In 2000, the Scottish Executive issued the following definition of delayed discharge from NHS care: "Where a patient remains in hospital after his/her clinical readiness for discharge has been

determined by the Lead Clinician in consultation with all agencies involved in planning the patient's next stage of care. The date on which the patient is judged clinically ready for discharge is the ready for discharge date" (Information and Statistics Division, 2000).

However, establishing a clear definition is only the first step towards reaching an agreed and common measurement of the number of delayed discharges. Issuing a definition does not guarantee that it will be used; the National Audit Office of England and Wales found that only 27% of Trusts were following a national definition of what constitutes a delayed discharge from acute hospitals.

The length of the delay was found to be much longer for people with learning disabilities, who are a much smaller user group but who were sometimes felt to have complex needs that required much greater specialist (and often expensive) support in the community. The non-availability of such services in some areas, has been found to result in individual delays of up to a year (Lewis and Glasby, 2006). Reasons for delayed discharge in our study group were predominantly to do with placement difficulties, namely funding and lack of appropriate resources in the community. Lewis and Glasby (2006) highlighted that a wide range of factors could be contributing towards delayed discharge, including lack of funding as well as awaiting assessment, placement in care homes and further NHS care etc. Given that Assessment and Treatment beds are a limited resource, the impact of delayed discharge and ways of avoiding it needs to be tackled. The solution is not in the hands of one agency since both health services and social care services need to work in partnership in order to address the issue.

Conclusion

This study is a small descriptive survey of the use of assessment and treatment beds in NHS Lanarkshire's Learning Disability Service and the impact of protocols which were introduced in response to issues around the use of these beds. It also highlights the importance of further investigating delayed discharges.

There is continual emphasis on care in the community across all psychiatric disciplines in order to provide appropriate services and reduce associated stigma. However both this and other studies (Tajuddin *et al.*, 2004; Lyall and Kelly, 2007) indicate that there will always be a need for a small number of specialist assessment and treatment beds for those with a learning disability. It is up to services (health care, social care, justice and carer organisations) to co-ordinate their expertise to ensure that individuals' needs are appropriately met and that they do not remain in patients after their need for this level of care has diminished.

We would suggest that the use of joint protocols, robust risk assessments and inter-agency working gives the best opportunity for this.

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