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Commentary on "Why am I still in hospital? Evaluation of delayed discharges from two learning disability assessment and treatment units in England"

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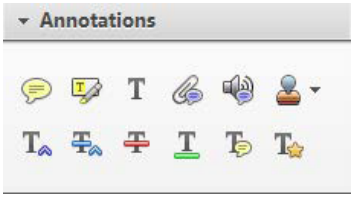

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Commentary on "Why am I still in hospital? Evaluation of delayed discharges from two learning disability assessment and treatment units in England"

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Abstract

Purpose – *This commentary explores the challenges and themes enumerated by the associated article "Why am I still in hospital? Evaluation of delayed discharges from two learning disability assessment and treatment units in England". This commentary broadens and outlines the research's background, premise and potential impact.*

Design/methodology/approach – *This commentary considers the attitudes to inpatient care for people with learning disabilities in the past decade and outlines a possible compact for the future.*

Findings – *Contrary to popular and emotive beliefs that using specialist inpatient psychiatric settings for people with learning disabilities is universally a poor practice, there are defined occasions when such settings are needed and imperative in the clinical pathway. If people with learning disabilities can access inpatient settings at the right time for the right reason, psychiatric outcomes could be improved. Timely discharge is imperative and currently lacking due to a lack of suitable engagement mechanisms between inpatient settings and the community. Thus, evidence-based outcome tools are essential to facilitate appropriate discharge.*

Originality/value – *There is an ongoing debate on the value and utility of specialist inpatient psychiatric units for people with learning disabilities. This commentary provides a balanced, evidence-based insight into this discussion.*

Keywords *Learning disabilities, Community living, Deinstitutionalisation, Challenging behaviour, Abuse, Intellectual disability*

Paper type *Viewpoint*

Introduction

Gibson *et al.* (2023; this issue) analysed the reasons for delayed discharges for 44 admissions in two regional assessment and treatment units for adults with learning disabilities between 2019 and 2022. This has been a topical and emotive subject in the past decade following the Winterbourne abuse scandal. The scandal, which horrified the nation, led to an in-depth inquiry into the hospital concerned and the larger commissioning and service delivery of mental health services for people with learning disabilities (Department of Health, 2012). Post Winterbourne, there were approximately 2,600 people with learning disabilities in specialist inpatient psychiatric beds. It was suggested that 24,000 adults were exhibiting severe behaviours that challenge, making them a high-risk group for inpatient admissions (Lowe *et al.*, 2007). The Bubb *et al.* (2014) report recognised that some people required specialist assessment and treatment. However, it highlighted the lack of suitable community provisions to prevent admissions or return people with learning disabilities back to their communities swiftly post treatment (Transforming Care and Commissioning Steering Group, 2014). To break the

gridlock, £100m was allocated to develop suitable community resources to reduce inpatient beds by 50% by 2023/2024 (NHS England *et al.*, 2016). This was an extension of the ambition of the English National Health System (NHS) to discharge 50% of the population of 2,600 inpatients to more appropriate care settings by 2015. However, as of 2022, over 2,000 people with learning disabilities remained in inpatient psychiatric settings. Of further interest was that the average length of stay as of 2022 for those in inpatient settings was over five years (Department of Health and Social Care, 2022). The resistance to change regarding the reduction of inpatient psychiatric beds in England can be attributed to various complex and multifactorial reasons.

Inpatient considerations

Mental illness and behaviours that challenge

Mental health conditions are more prevalent among people with learning disabilities than the general population (The Royal College of Psychiatrists, 2020). Recent epidemiological research suggests that the prevalence within the adult learning disabilities population is between 20.1% and 23.4%, excluding behaviours that challenge and autism, compared to 16% of the general adult population (Hughes-McCormack *et al.*, 2017; Sheehan *et al.*, 2015). The complexity of multi-morbidity, communication needs, assessment and diagnosis can lead to failure to recognise mental health conditions, and this is compounded by diagnostic overshadowing (Reiss *et al.*, 1982).

Around 25% of people with learning disabilities exhibit behaviours that challenge (Bowring *et al.*, 2019). In certain cases, behaviours can be extreme, making it challenging to evaluate and determine the underlying reasons, including psychiatric needs. Consequently, it is reasonable to anticipate that individuals with learning disabilities may require inpatient assessment and support to address their psychiatric needs. While justifiable for psychiatric concerns and risk mitigation, there is limited evidence to support a prolonged inpatient stay solely for that reason.

Specialist settings vs generic psychiatric settings

Work has been underway since the 2000s and updated at different points, using the Greenlight toolkit to enable people with learning disabilities to access mainstream psychiatric services (National Development Team for Inclusion, 2022). However, more research is needed on the challenges and strengths local generic psychiatric units can offer (or not!) in post-Winterbourne recommendations (Department of Health, 2012). Recent evidence suggests that admission to inpatient services is associated with improvements in mental health for this population with some evidence indicating better outcomes for those admitted to specialist inpatient units (Melvin *et al.*, 2022).

Equally, there are significant limitations on what general psychiatric services can offer (Walton *et al.*, 2022). Significant perception gaps exist between expectation and reality by decision-makers about workforce competency, resource availability and individual patient complexity, which tend to be lacking in these services (Jones *et al.*, 2021). The following two issues illustrate this. Firstly, in England, since 1987/1988, psychiatric beds have fallen by 73% from around 67,100 to 18,400, and mental health bed occupancy currently exceeds 90%. Secondly, while the average length of stay in psychiatric inpatient units has varied, it has not fallen. The average stay in a psychiatric bed in 2016/2017 was seven weeks (The Royal College of Psychiatrists, 2019). The average time for assessing and treating a person with learning disabilities in a specialist assessment and treatment unit, irrespective of the cause of admission, was six months. Recognised challenges to finding suitable discharge lead to staying up to nine months (Abraham *et al.*, 2022).

Given these contextual issues and pressures on existing acute psychiatric units, supporting individuals with learning disabilities can be challenging to deliver in the current climate.

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What appears to be of benefit is bespoke models of specialist inpatient care developed and implemented locally as parallel and in addition to local general psychiatric inpatient services (Burrows *et al.*, 2022). A further need is to ensure evidence-based outcome measures are embedded into the inpatient system to inform better the debate on which setting is more appropriate (Abraham *et al.*, 2022).

The proposed mental health act reforms

Another influencer to this debate is the draft Mental Health Bill (Secretary of State for Health and Social Care and Lord Chancellor and Secretary of State for Justice, 2021). It proposes to remove detention in hospitals for people with learning disabilities in the absence of mental illness post 28 days (MHA Section 2). To a large part, this amendment is focused on reducing delayed discharges. However, there are concerns about significant unintended consequences, not in the least that the loss of MHA safeguards would increase the likelihood of more people with learning disabilities being incarcerated in prison, being prescribed more psychotropics off licence and being discriminated against (Tromans *et al.*, 2023).

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Community factors

Suitable housing standards, staff support/training and health-care access influence the success of sustainable repatriation or prevent admission (Lennard *et al.*, 2020). However, this has been problematic in practical delivery, mainly as it requires interagency working across private and public sectors. This has led to complex and high-risk individuals being placed permanently in out-of-their-home area placements despite UK national guidance advocating for the opposite (Shankar *et al.*, 2015). Service users who do not have close family members to advocate for them appear to be especially vulnerable to this practice (Shankar *et al.*, 2015). There is concern that the pressure to reduce delayed discharges and reduce specialist beds will further accentuate this problem. Evidence-based toolkits are proposed to enable safe, sustainable and timely discharge (Lennard *et al.*, 2020).

Other significant influencers

Private–public inpatient unit divide

As NHS beds have been reduced, the private sector has grown to fill the void (Brown *et al.*, 2019). There is no uniform focus on quality and outcomes across all providers, with much of the "bottom-up" research on these matters emerging from NHS sites. There should be a requirement for all inpatient providers to contribute to evidence of quality, standards and outcomes.

Psychotropic medication prescribing

Along with the concerns about delayed inpatient discharge, there was recognition that people with learning disabilities are significantly overprescribed psychotropic medication, specifically antipsychotics (Sheehan *et al.*, 2015). Over the past decade, due to initiatives against this practice (Branford *et al.*, 2019), there has been a focus on antipsychotic medication, leading to increased prescribing of antidepressants and antiseizure medications outside their licenced indications, to manage behaviours that challenge (Branford *et al.*, 2023). Reducing inpatient facilities increases the risk of people with learning disabilities increasingly being subject to irrational psychotropic prescribing to mitigate the risk of inpatient admission (Sheehan *et al.*, 2018). This possible unintended consequence can lead to iatrogenic harm over time.

Patients and their families

Patients and their families should be empowered to engage in informed decision-making. Unfortunately, their voices can be quite masked in the larger political–clinical discussion.

Although there are individual case studies, particularly when horrific abuses are perpetuated, little discussion is balanced with the evidence presented. There is also little debate on what works well, with the focus much on what has gone wrong in inpatient settings. On a positive aspect, some passionate charities are knowledgeable of these issues, hold services to account and are politically active.

Conclusion

In summary, efforts to address the issue of specialist inpatient beds have focused on reducing beds without improving community care. However, it is important to challenge the simplistic view that inpatient settings are inherently flawed and community settings are inherently good. This perspective is especially rigid when it comes to psychiatric beds, particularly in learning disabilities, unlike medical fields where the emphasis is on enhancing care. This raises questions about the appropriate number of specialist inpatient beds and whether removing beds reduces delayed discharges. AQ:

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