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## Delay in the discharge of psychiatric in-patients with learning disabilities

### AIMS AND METHOD

The study aimed to identify factors delaying discharge of psychiatric in-patients from a learning disability service. A census was completed, categorising in-patients as unready for discharge ( $n=181$ ); discharge planned within 12 weeks ( $n=22$ ); or ready for discharge but experiencing delay ( $n=44$ ), the latter were followed-up 16 months later.

### RESULTS

Delayed patients were more disabled or disturbed and often awaiting adequate community provision. They were older, had been in hospital longer and were 'informal' admissions. At follow-up 23 remained in hospital, 21 of whom had been delayed by lack of placement.

### CLINICAL IMPLICATIONS

De-institutionalisation has led to the expectation that more complex and challenging people be placed in the community. This study suggests the community to be, as yet, unready to cope with the needs of these service users.

Nearly everyone with a learning disability can have their health and social needs met in a community setting. This realisation has led to considerable changes in the provision of learning disability services, and a national policy that there should be adequate community provision for all, except those whose health needs can only be met by an in-patient service (Departmental Health and Social Security, 1989; Department of Health, 1990). It was recognised at the outset that this would depend on the availability of suitable accommodation, and that good quality community care would cost, on average, 17% more than the equivalent hospital care; a disparity which increases further for those with more severe disability or disturbance.

Government initiatives and financing arrangements halved the number of in-patients between 1981 and 1991 (Glover *et al*, 1993) but the process has not been straightforward. Those who remained in hospital were often those with the most severe disabilities and disturbance (Kelly, 1996), requiring specialist community accommodation which was often unavailable (Lelliott & Wing, 1994; Tyrer & Creed, 1995). The result was that in-patient beds 'silted up' with a combination of existing long-stay patients and new acute admissions; the latter also being unable to return to their communities due to inadequate accommodation (Knapp *et al*, 1997) and changes in their circumstances.

Northgate and Prudhoe NHS Trust is a specialist learning disability trust, based on two hospital sites and providing social care in approximately 45 community homes throughout the north-east of England. From a peak of over 2500 beds the Trust now has about 250 treatment beds on its hospital sites providing a range of national, regional and local services. Concerns about the effective use of these beds led to a study to identify the factors that delay patient discharge from the service.

### The study

We carried out a census of the psychiatric in-patient population of Northgate and Prudhoe in July 1996.

Medical and nursing staff recorded the details of 247 in-patients, allocating them to one of three categories: those for whom discharge was planned within the next 12 weeks; those who were ready for discharge and able to cope in the community with appropriate support, but could not be discharged; and those who were not ready for discharge due to ongoing treatment, assessment, or long-term in-patient care needs.

Sixteen months later we followed up those whose discharge was delayed and identified two further groups, those who had achieved discharge, and those who still remained in the hospital.

## Findings

### The population

The patients were aged from 6–71 years (mean=34), with learning disabilities ranging from borderline to profound. They had been admitted between 1951 and 1996, for reasons which included both short-term treatment and long-term psychiatric care. Most were from nine health districts in the north-eastern region, only 29 (12%) coming from outside this immediate catchment area. Just under half of the group were detained under the Mental Health Act. In addition to their learning disability the patients had a wide variety of concurrent mental health, developmental and behavioural problems, including autism, schizophrenia, a variety of personality disorders, acquired head injuries, offending behaviour and behavioural disturbance.

### Delaying factors

Three-quarters of the population ( $n=181$ ) were found not to be ready for discharge, the remaining 66 cases were, however, ready for discharge to appropriate placements. Twenty-two (9%) of those ready for discharge had a discharge planned, but 44 (18%) were experiencing delay and a 'lack of resources' was common to all of this group.



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More specifically, delay was ascribed to a combination of factors, including lack of suitable accommodation ( $n=34$ ), insufficient funding ( $n=10$ ), carers who were deemed unable to cope ( $n=17$ ), insufficient clinical support ( $n=11$ ), and a lack of a suitable educational placement ( $n=13$ ).

At follow-up 16 months later, all of those delayed by the last two factors, as well as 70% of those with insufficient funding, had been discharged. However, only 39% ( $n=13$ ) of those who had been delayed by a lack of accommodation had achieved discharge, suggesting that this was less easily resolved.

At follow-up all of the patients who had discharge planned, and 23 (13%) of the patients with long-term care needs had been discharged. Of the 44 patients whose discharge had been delayed 23 (52%) were still in the hospital. Only 20 had been discharged and, of these, 10 had been in the previous three months, and one had died.

Three of the patients whose discharge was delayed had been discharged but had had to be readmitted: one had discharged herself to an unsuitable environment, and with hindsight, the placements of the other two were inadequate.

Further informal inquiry found that five of the 23 patients whose discharge was delayed who remained in hospital were now considered not ready for discharge: (three had deteriorated and two had had failed discharges as mentioned above). The others were ready for discharge, of whom five had a discharge planned, and 13 were still subject to delay. All required medication and the lack of appropriate accommodation remained a significant problem.

Additional information was available on 20 of the 23 delayed discharge group who were still in hospital, showing them to require a high level of care, despite being clinically ready for discharge. This highlighted a combination of care needs, for example 95% required 24-hour care, 55% needed waking night staff, 95% needed experienced staff and 75% required a high level of staffing support.

### Between group comparison

The expected discharge and delayed discharge groups were compared because both consisted of patients, who at the time of the census were considered ready for discharge. However, whereas discharge proceeded smoothly for the former group, there were obstacles to the progress of the latter. The comparison revealed consistent differences between the two groups which might have caused or promoted the delay. We also

compared those who subsequently achieved a discharge and those who did not.

The groups were split into mild (borderline and mild) and severe (moderate and profound) categories of disability as well as by legal status into informal, civil (Mental Health Act Sections 2 and 3), and criminal (Mental Health Act Sections 37 and 37/41). Only three patients were on a restriction order (Mental Health Act Section 41) and three were subject to Section 2; the small numbers did not allow us to treat these categories. There were no statistically significant differences between the patients not ready for discharge and those ready for discharge.

A delay in discharge was significantly associated with older age, a longer period in hospital (see Table 1), a more severe learning disability, and informal status under the Mental Health Act 1983 (see Table 2).

### Discussion

This study had two main aims. First, to determine which of the psychiatric in-patients within the specialist learning disability trust were ready for discharge. Second, to identify any factors that might hinder this. Our findings are limited by the small numbers in each category and the large range of potential variables. Nevertheless, they are in accordance with the studies of resettlement by Kelly (1996) and Shepherd *et al* (1996) which found those who remained in hospital longer were the least able, and most challenging, patients. We also found that those whose discharge was delayed were likely to be older, have been in the hospital longer, and were less likely to be subject to legal constraints. In addition, once discharge becomes delayed, age and length of stay, but not disability, can effect the speed with which patients are eventually discharged. However, in addition to the above relationships, there was, within the general in-patient population ( $n=247$ ), a significant association between age and length of stay ( $r=0.36$ ,  $P<0.0001$ ), and between legal status and the level of ability ( $\chi^2=43$ ,  $P<0.001$ ) so that these interactions will limit the conclusions drawn.

Increased age, disability and institutionalisation are associated with greater and more costly care requirements. It is the lack of such appropriate community provision and support which is the strongest reason for delay. This assertion is supported by earlier studies of resettlement (Lelliot & Wing, 1994; Tyrer & Creed, 1995). Here this lesson is reinforced by the three patients whose discharge was delayed were later discharged into services

**Table 1. Age and length of stay**

Discharge group	Age (years)			Length of stay (years)		
	Mean	Range	Mann–Whitney	Mean	Range	Mann–Whitney
Discharge planned ( $n=22$ )	24.8	7–48	$U=229$	2.7	< 1–10	$U=341$
Discharge delayed ( $n=44$ )	35.8	6–58	$P=0.0005$	8.3	< 1–45	$P=0.05$
Discharge delayed but released ( $n=20$ )	29.4	6–45	$U=96$	3.8	< 1–23	$U=130$
Discharge delayed, still in hospital ( $n=23$ )	41.5	22–58	$P=0.001$	12.4	< 1–45	$P=0.014$

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Table 2. Level of disability and discharge status

Discharge group	Level of disability (re-coded variables)			Legal status (re-coded variables)			
	$\chi^2$	Percentage of group		$\chi^2$	Percentage of group		
		Border- line—mild	Moderate— profound		Informal	Criminal (Section 37 or 37/41)	Civil (Section 2 or 3)
Discharge planned (n=22)	$\chi^2=13.8$	90.9	9.1	$\chi^2=8.02$	45.5	31.8	22.7
Discharge delayed (n=44)	$P=0.0002$	43.2	56.8	$P=0.02$	79.5	13.6	6.8
Discharge delayed (n=20)	$\chi^2=1.77$	55	45	$\chi^2=0.24$	80	15	0
Discharge delayed, still in hospital (n=23)	$P=0.2$	34.8	65.2	$P=0.9$	78.3	13	8.7

which proved wanting in some constituent of the package, deteriorated and required readmission.

Poor inter-disciplinary communication can lead to unnecessary hospital care, delays in the provision of patient needs, and delays in locating appropriate community placements (Patterson *et al*, 1995). As a result we have moved on to review the quality of our communication with external agencies during discharge planning. In the meantime, the Trust is monitoring the progress of patients towards discharge more closely.

That legal constraints affect discharge status implies the framework of the Mental Health Act may assist smooth discharge. A similar framework is included in the Care Programme Approach and, it is hoped that a joint commitment to this procedure will reduce the proportion of patients delayed.

After 16 months, 43 of the 66 patients who were ready to be discharged (including those planned and those delayed) had been discharged, and in only five cases was it necessary to alter the clinical judgement that they were ready for discharge. This reflects the stability and predictability of this group of patients, and that most people with a learning disability are discharged readily. However, the changing pattern of care has led to the expectation that people with far more complex needs who previously would have remained in hospital, will live

in the community. This study suggests that the community is not yet equipped to cope with the complex, and consequently expensive needs of this service user group.

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## Provision of psychotherapy services for older people

### AIMS AND METHODS

A postal questionnaire was sent to 100 departments of psychotherapy within the UK in an attempt to gauge the use of psychotherapy services by patients in the third and fourth age.

### RESULTS

Eighty-seven per cent of respondents felt that the needs of this group for

psychotherapy were not met as well as those of younger people in their catchment areas. This is most marked in people over 65 years of age who are infrequently referred to psychotherapy departments. Suggestions are made for improving services.

### CLINICAL IMPLICATIONS

The psychotherapy needs of this

group need to be considered in service planning. All professionals need educating about the availability and applicability of the psychotherapies for the older patient. Without additional resources it seems unlikely that the needs of this patient group will be met.

Throughout our lives internal and external events demand that we change and adapt. The developmental specific

struggles and necessary alterations in internal object relations associated with childhood and early adulthood