Inpatient Services for People with Intellectual Disabilities and/or Autism

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Aims

• To briefly review the available literature about outcomes from inpatient services for people with intellectual disabilities and/or autism.

• To consider publicly available data about the use of inpatient services, including secure units.

• To examine variables that may be related to an increasing or decreasing use of inpatient beds for people with intellectual disabilities and/or autism.
Background

- The launch of a new national service model for people with intellectual disabilities and/or autism shifted focus towards increasing community-based provision for people, while reducing the need for inpatient admission (Local Government Association, Association of Directors of Adult Social Services in England, & NHS England, 2015a, 2015b).

- By 2019, each Sustainability and Transformation Plan (STP) region should have planned for approximately 10 to 15 beds Clinical Commissioning Group (CCG) commissioned beds, and no more that 20 to 25 beds for NHS England commissioned beds (NHS England, 2016), while in other documents these figures have been 10 per 1 million persons (Local Government Association et al., 2015a)
Background

- These numbers suggest that approximately 45 to 65% of CCG commissioned beds, and 25 to 40% of NHS England commissioned beds should close, and across services, this means that nationally approximately 35 to 50% of beds should close, meaning the number of beds should be between 1300 to 1700 (Local Government Association et al., 2015a).

- There are two broad approaches to providing inpatient care to people with intellectual disabilities and/or autism:
  - general psychiatric or mental health wards, units of hospitals.
  - specialist units, which includes forensic units, intended only for people with intellectual disabilities and/or autism.
Background

• The Royal College of Psychiatrists (2013) previously developed a classification system of inpatient services which is used by NHS England to categorise services as part of the way in which national data are collected:
  • Category 1: high, medium and low secure forensic beds
  • Category 2: acute admission beds within specialised learning disability units
  • Category 3: acute admission beds within generic mental health settings
  • Category 4: forensic rehabilitation beds
  • Category 5: complex continuing care and rehabilitation beds
  • Category 6: other beds including those for specialist neuropsychiatric conditions.
What do we know about outcomes from services?

- We completed a systematic search of the literature in order to (a) update the previous review (Royal College of Psychiatrists, 2013) by undertaking a further systematic search of the literature available regarding effectiveness of Tier 4 inpatient treatment for individuals intellectual disabilities and/or autism who have additional mental health needs and/or challenging behaviour, and (b) to complete a narrative synthesis of the literature in order to:

  (i) consider and describe the different models of service provision, and

  (ii) evaluate the evidence for their effectiveness.
What do we know about outcomes from services?

- This is funded by Health Education England and the Royal College of Psychiatrists.
- A comprehensive search was undertaken, covering the various terms for intellectual disabilities and/or autism, the different inpatient units available, and treatment outcomes/interventions.
- No data limiters were applied to the search and studies involving adult or child services were included.
- After duplicates were removed 2,465 hits remained, and 2,210 items were excluded during the title and abstract phase (including a further 83 duplicates), leaving 239 articles for full text review. Of these articles, 196 were excluded, resulting in 51 studies.
Figure 1: Flow diagram detailing the search results.

Records identified through database searching (n = 3,475)

Additional records identified through other sources (n = 15)

Records after duplicates removed (n = 2,465)

Records unavailable (n = 16)

Records screened (n = 2,449)

Records excluded (n = 2,210)

Full-text articles assessed for eligibility (n = 239)

Full-text articles excluded (n = 196)

Studies included in synthesis (n = 43)

Admission/discharge papers (n = 8)

Total studies included in review (n = 51)
Results

- The studies identified were structured according to the type of inpatient treatment for individuals with intellectual disabilities and/or autism as follows:
  - Studies involving general mental health inpatient units (n=8)
  - Studies involving specialist inpatient units (n=20)
  - Studies involving specialist secure or forensic inpatient units (n=7)
  - Studies involving children and young people within inpatient services (=3)
  - Studies inpatient services for those with ASD (n=5)
  - Studies concerning admission and/or discharge inpatient figures for individuals (8)
Results

- The studies reflected a variety of inpatient service types, but many lacked appropriate comparison samples or experimental designs allowing for conclusions about causality regarding the relationship between admission and outcome.

- The retrospective studies, audits and case files relied on the completion of case notes and information regarding the process for collecting/collating this information varied.

- Some case file reviews had been completed across different time periods and under different social agendas or political policies, and therefore it may be possible that the reporting of this may have varied in focus and priority, potentially introducing some bias.
Results

- Where data were available, collectively, the age of adults who were admitted ranged from 16 to greater than 65 years, with their average age being, $M = 34.24$ years.

- Where gender information was available, only two studies reported less than 50% of their sample were men (Lunsky et al., 2010; Singh, Khalid, & Dickinson, 1994), while the range for the remainder was between 50% and 78.1% for non-forensic services.

- The percentage of men within forensic services was considerably higher, ranging between 65% and 100%.

- The percentage of men within studies involving people with autistic spectrum disorders, the range was also high, relative to other studies, being 74% to 86%.
Results

• For the handful of studies about children and young people, the age ranged between 3-19 years, and the average age was, $M = 13.87$ years, with again, a higher percentage of males, ranging from 63% to 79.4% male.

Effectiveness

• Seven of the eight papers that compared length of stay for inpatients with and without intellectual disabilities and/or autism. Those with intellectual disabilities and/or autism tended to stay longer than those without disabilities within general mental health services.

• Across all studies, the average length of stay for people with intellectual disabilities within general mental health services was, $M = 524.70$ days, $SD = 954.07$, Minimum = 8, Maximum = 2409.
Results

• **Effectiveness**
  - A number of studies have explored length of stay following admission to specialist units or general mental health services, and they have reported longer stays on specialist wards.
  - The average length of stay across studies for those admitted to specialist units was, $M = 1467.21$ days, $SD = 2943.09$, Minimum $= 46.60$, Maximum $= 14052.50$, and within studies where comparison data was reported for GMH wards, the length of stay was on average shorter, $M = 55.3$ days, $SD = 27.12$, Minimum $= 79.00$, Maximum $= 26.00$.
  - Variables related to length of stay? Depression both shorter and longer in two separate studies; schizophrenia longer length of stay; personality disorder in forensic services longer length of stay; mild IDs and being a man associated with longer length of stay.
Results

• Effectiveness
  • For children and young people, similar findings as with the literature involving adults.
  • Children and young people with intellectual disabilities stay longer than those without intellectual disabilities.
  • Chaplin et al. (2015) found that children and young people with intellectual disabilities had a significantly longer length of stay, M = 109.9 days, than other children and young people, M = 78.2 days; there were no differences between length of stay for children and young people with intellectual disabilities when comparisons were made between specialist or general mental health services.
  • Gabriels et al., 2012 reported shorter admission periods for children and young people with intellectual disabilities admitted to specialist units, M = 21.6 days, compared to a general mental health services, where the average length of stay was, M = 45 days.
Results

- **Effectiveness**
  - Two studies reported that inpatients with autism have a significantly longer length of stay (Kokoski & Lunsky, 2009; Lokhandwala, Khanna, & West-Strum, 2012).
  
  - Three further studies found no difference between those with and without a diagnosis of an autism spectrum disorder (Esan, Chester, Gunaratna, Hoare, & Alexander, 2015; Kokoski & Lunsky, 2009; Siegel et al., 2014).
  
  - Tajuddin et al., 2004 reported that a diagnosis of an autism spectrum disorder was associated with a longer length of stay for inpatients who also had intellectual disabilities.
Results

- **Effectiveness: Treatment Models**
  - One controlled trial compared inpatient admission with a community services for adults with intellectual disabilities.
  - van Minnen *et al.*, 1997 randomised people with intellectual disabilities to an outreach community treatment team who worked with people in the community by visiting them at home, within sheltered accommodation, or other types of residential services.
  - The team consisted of a psychiatrist, “educationalist”, social worker and three psychiatric nurses. Time was spent with each person observing them in their home and work environment and a tailored treatment plan was developed and implemented.
  - While not explicit within the paper, it is suggestive that individual clinical formulations were developed for each person.
Results

- **Effectiveness: Treatment Models**
  - Interventions offered were medication, behavioural therapy and social skills training, and the team worked with carers and other people, encouraging others to support the implementation of interventions, intervening at both a social and environmental level.
  - The team also modelled good care for the carers, and this was all offered as an alternative to admission to hospital.
  - The degree of improvements within the community were similar to that achieved by those in hospital.
  - However, four in the community arm had to be subsequently admitted to hospital.
  - They concluded that up to 84% of hospital admissions may be prevented.
  - The average length of stay for those who were admitted to hospital was, $M = 103$ days.
Results

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Results

- **Effectiveness: Treatment Models**
  - Hall et al (2006) outlined the development of a specialist community service for people with intellectual disabilities which was described as a “virtual team”.
  - Team members included care managers and support workers, as well as health care staff. The team met weekly and responded to crises while focusing on mental health, and continuing to work with patients during any admission, working across health and social care as needed.
  - It was noted that those receiving either treatment in hospital or the community improved, bearing in mind those admitted had a higher level of need.
  - The inpatient group continued to improve on most measures following discharge, whereas the community group showed a slight deterioration at 9 weeks, and at 6 months follow up.
Results

- **Effectiveness: Treatment Models**
  - Richings et al., 2011 described the development of a specialist treatment service for people with intellectual disabilities that comprised: (a) assertive outreach, (b) day assessment, and (c) admission to one of six beds.
  - The new service worked collaboratively with existing community teams when needed, and service users could access any combination of the three components.
  - The team worked collaboratively with a supported living outreach team and a community forensic team.
  - Individuals who were assessed as needing intervention from the new team were assigned to received assertive outreach, day assessment or admission on the basis of need.
  - Over two-years, 102 patients were assessed, and 35% were not accepted, having received advice or signposting to other teams.
Results

- **Effectiveness: Treatment Models**
  - Thirty-seven per cent of those referrals that were accepted received outreach, 28% received outreach and admission, 18% became inpatients, and 11.5% received day assessment, or this combined with outreach, while 3% received all three.
  - Seventy-three percent of patients remained or returned to their previous placement, while this was only 51% for those who ended up being admitted.

- Alongside these, there are studies demonstrating that those receiving intensive community-based interventions may both benefit and have a shorter length of stay should they be admitted (Coelho, Kelley, & Deatsman-Kelly, 1993; Tyrer, Hassiotis, Ukoumunne, & Piachaud, 1999)
Results

- **Effectiveness: Treatment Models**
  - Comparing admission to general mental health care to specialist units using the existing literature is somewhat problematic, but inpatients do stay much longer within specialist services. Some of the issues are:
    - there are more data available from research studies about the length of stay of people within specialist units, and fewer data available for patients admitted to general mental health wards
    - across studies, groups were not matched on various factors that may impact length of stay, and as a consequence, those with more severe problems may have been admitted to specialist units, and therefore a longer length of stay is appropriate; it may be the case that the most complex cases are referred for admission to these services
    - many of the studies have taken place over time, and it may be the case that earlier studies had a longer length of stay because longer stay beds within hospital settings were more common.
Results

- **Effectiveness: Treatment Models**
  - It remains uncertain whether a longer length of stay within specialist units is associated with better or improved outcomes over and above a shorter length of stay on general wards.
  - There is a lack of clarity about the reasons for the longer length of stay within specialist units. At times, it may be the case that those within specialist units stay for longer because of difficulties finding an appropriate discharge setting, or difficulties with arranging community-based care, bearing in mind that one study comparing both specialist units and general mental health wards found no differences in the discharge pathway for patients, while those within specialist units were actually less likely to be discharged out of area (Xenitidis et al., 2004). Note a study from Canada noted that those within specialist units tended to have slightly higher levels of recommended care than those who were within GMH units, bearing in mind that this difference was not statistically significant (Lunsky et al., 2008).
Results

• **Effectiveness: Discharge**
  • The evidence suggests that many individuals with intellectual disabilities and/or autism return to community settings following admission, with more recent studies suggesting an increase in discharges to residential services or supported living than to the family home.
  • In some of the studies, factors identified as being associated with non-community discharge included having a history of criminal offending (Reed et al., 2004), and in one study, specifically, fire setting (Xenitidis et al., 2004).  
  • Lohrer et al., 2002 reported no greater difficulty in discharge planning for those with intellectual disabilities and found that they were significantly less likely to require a different discharge placement following admission than those without intellectual disabilities (9.1% compared to 26.7%).
Results

• **Effectiveness: Discharge**
  • In looking at differences in the discharge pathway of specialist units and general mental health services, Xenditis et al. (2004) reported no significant differences between the two. However, notably, those in specialist units were less likely to be discharged to an out of area placement.
  • There may have been some changes to discharge accommodation over time. Oxley et al. (2013) found that a higher number admissions during 2009 to 2011 were associated with a change of residence, and discharge to an alternative residential placement or supported living, while an earlier cohort from 1999 to 2001 were discharged to the family home or the original place of residence.
  • For children and young people, Smith and Berney (2006) reported that 82% of those within secure services were discharged to specialist units away from home, which sometimes included highly staffed forensic units intended for adults.
Results

- **Effectiveness: Discharge**
  - Considering inpatients within secure services, they were reported as more likely to be discharged to a less restrictive setting than their admission, suggesting progress within a care pathway from levels of higher security (Reed et al., 2004).
  - Alexander et al. (2006) found a higher number of discharges (70%) from a medium secure unit in 1987 to 1993 were to their own home, while only 48% of those admitted from 1994 to 2000 were discharged to their own home. Across both time periods, 59% underwent a change of residence, and of those that did, they were four times more likely to be re-admitted. Fifty-three percent remained under the Mental Health Act, with 28% detained in hospital, a special hospital or a nursing home.
Results

- **Effectiveness: Outcomes**
  - The vast majority of studies showed improvements of some kind between admission and discharge, and were found across specific and global measures of outcome.
  - Comparing change over time between specialist units and general mental health care services, White *et al.*, 2010 reported significant improvements following admissions to either type of unit, but the degree of improvement was more marked for those who had been admitted to specialist units.
  - Chaplin *et al.* (2015) demonstrated that HoNOSCA improved for children and young people with intellectual disabilities following admission. Kids with mild IDs tended to be admitted to general mental health care services, while kids with more severe IDs went to specialist units.
• **Effectiveness: Forensic Services**
  
  Reed *et al.*, 2004 reported that inpatients who did not have a history of receiving a custodial sentence or detention under Part III of the Mental Health Act had assaulted staff and required restraint more frequently, while those with a history of having received a custodial sentence, or detention under Part III of the Mental Health Act had higher rates of self-harm. However, it was further noted that those with a history of conviction were more likely to have been admitted to the service from other hospitals, specialist hospitals or prison settings, while those without conviction tended to come from community settings.

  • Across all studies reviewed involving forensic services, the readmission rate was 25 to 44%.
## Results

### Table 8: Final framework of outcome domains and sub-domains

<table>
<thead>
<tr>
<th>Effectiveness</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge outcome/direction of care pathway</td>
<td>1</td>
</tr>
<tr>
<td>Delayed discharge/current placement appropriateness</td>
<td>1</td>
</tr>
<tr>
<td>Readmission (i.e. readmitted to hospital or prison)</td>
<td>1</td>
</tr>
<tr>
<td>Length of hospital stay</td>
<td>1</td>
</tr>
<tr>
<td>Adaptive functioning</td>
<td>1</td>
</tr>
<tr>
<td>Clinical symptom severity/treatment needs: patient rated</td>
<td>1</td>
</tr>
<tr>
<td>Clinical symptom severity/treatment needs: clinician rated</td>
<td>1</td>
</tr>
<tr>
<td>Recovery/engagement/progress on treatment goals: clinician rated</td>
<td>1</td>
</tr>
<tr>
<td>Recovery/engagement/progress on treatment goals: patient/carer rated</td>
<td>2</td>
</tr>
<tr>
<td>Reoffending (i.e. charges/convictions) on discharge</td>
<td>1</td>
</tr>
<tr>
<td>Offending-like behaviour (no CJS involvement) on discharge</td>
<td>1</td>
</tr>
<tr>
<td>Incidents (violence/self-harm) (in care setting)</td>
<td>1</td>
</tr>
<tr>
<td>Risk assessment measures</td>
<td>1</td>
</tr>
<tr>
<td>Security need (i.e. physical/procedural/escort/leave)</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient safety</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premature death/suicide</td>
<td>1</td>
</tr>
<tr>
<td>Physical health</td>
<td>1</td>
</tr>
<tr>
<td>Medication (i.e. PRN usage/exceeding BNF limits/side-effects patient rating)</td>
<td>1/2</td>
</tr>
<tr>
<td>Restrictive practices (restraint)</td>
<td>1</td>
</tr>
<tr>
<td>Restrictive practices (seclusion/segregation)</td>
<td>1</td>
</tr>
<tr>
<td>Victimisation/safeguarding</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient and carer experience</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient experience: involvement in care</td>
<td>2</td>
</tr>
<tr>
<td>Patient experience: satisfaction/complaints</td>
<td>1</td>
</tr>
<tr>
<td>Quality of life: patient rated</td>
<td>1</td>
</tr>
<tr>
<td>Therapeutic climate</td>
<td>1</td>
</tr>
<tr>
<td>Access to work/meaningful activity (where appropriate)</td>
<td>2</td>
</tr>
<tr>
<td>Level of support/involvement in community (post discharge)</td>
<td>2</td>
</tr>
<tr>
<td>Carer experience: communication with services/involvement in care</td>
<td>2</td>
</tr>
</tbody>
</table>

Source of domain: Stage 1, systematic review; Stage 2, patient/carer involvement groups; Stage 3 = Delphi; CJS, criminal justice system; PRN, pro re nata; BNF, British National Formulary.
Conclusions

• The quality of the evidence regarding inpatient provision and subsequent alternative models is questionable. There are few well designed experimental studies.

• There is some evidence that well developed community services can lead to clinical improvements similar to that achieved by inpatient services, but some service users may need admission.

• General mental health units have a shorter length of stay. It is unclear whether this is beneficial or associated with more frequent readmission. Specialist units have a longer length of stay.

• Creative and innovative teams which are formulation-driven may be exceptionally helpful.
So where are we?

- Are people with intellectual disabilities and/or autism leaving hospital?

- There are three sources of data:
  - The discontinued annual census of the provision of inpatient services in 2013, 2014, and 2015.
  - The current monthly data returned as part of the Assuring Transformation Collection. This data is returned by commissioners.
  - The Mental Health and Learning Disabilities Minimum dataset. This is provider returned data. Any provider of mental health services paid for by the NHS should report the number of people with intellectual disabilities and/or autism within services.
Figure 1: Total number of inpatients in England taken from the Assuring Transformation collection (monthly commissioner returns) or annual LD census for years 2013, 2014 and 2015.
Difference between datasets?

- Considering the eligibility criteria for being counted as an inpatient during the LD Census, it is possible that a greater number of patients who did not have intellectual disabilities and/or autism were returned because they were using a bed on a ward intended for people with intellectual disabilities and/or autism, or

- Data collected as part of both the Assuring Transformation collection and the LD Census are not entirely accurate.

- It is perhaps likely that both reasons have impacted upon the validity of the data to a degree, and may account for some of the differences between the two datasets.

- Many of the data points within the Assuring Transformation collection were divisible by 5, and while not absolutely certain, it suggested that rounding may have had occurred.
Figure 28: Number of inpatients recorded as part of the LD Census, within the Assuring Transformation Collection, and the Mental Health and Learning Disabilities National Dataset (MHLDDS)
Figure 2: Number of inpatients within differing age bands
Figure 3: Frequency of inpatients who are female or male per month

- **Female**
- **Male**
Figure 5: Number of inpatients with either intellectual disabilities, autism, both, or neither.
Figure 6: Frequency of differing diagnostic categories upon admission
Figure 7: Frequency of different sources for admissions each month

- Usual Residence
- Secure Forensic Services
- Other Hospital
- Prison
- Linear Trend (Usual Residence)
- Linear Trend (Temporary Residence)
- Linear Trend (Prison)
- Linear Trend (Secure Forensic Services)
- Linear Trend (NHS Acute Bed)
- Linear Trend (Residential Care)
- Linear Trend (Other Hospital)
Figure 8: Frequency of different periods of Length of Stay
Figure 9: The number of admissions, discharges and transfers per month

- Number of patients admitted
- Readmission (Readmission but was discharged for more than 30 days)
- Readmission (Discharge and admission on the same day = Transfer)
- Readmission (Episode of care in the previous year)
- Linear Trend (Number of patients discharged or with a discharge/transfer date within the month)
- Number of patients discharged or with a discharge/transfer date within the month
- Readmission (Discharged less than 30 days long before readmission)
- Readmission (No episodes of care in previous year)
- Linear Trend (Number of patients admitted)
Figure 10: Monthly Frequency as to whether a Planned Transfer Date had been Agreed, Not Agreed, or is Overdue

- **Planned transfer date agreed**
- **Planned transfer date not agreed**
- **Planned transfer date overdue**

Linear Trend (Planned transfer date not agreed)
Linear Trend (Planned transfer date agreed)
Linear Trend (Planned transfer date overdue)
Figure 11: Monthly Frequency of Time to Planned Discharge

- 0 to 3 months
- 3 to 6 months
- 6 to 12 months
- 1 to 2 years
- 2 to 5 years
- > 5 years
- Linear Trend (0 to 3 months)
- Linear Trend (3 to 6 months)
- Linear Trend (6 to 12 months)
- Linear Trend (1 to 2 years)
- Linear Trend (2 to 5 years)
Figure 12: Frequency count of reasons why discharge has not occurred
Figure 13: Reasons for delayed discharge

- Awaiting healthcare funding
- Awaiting residential placement
- Awaiting community-based equipment
- Lack of social care
- Linear Trend (Awaiting nonacute NHS bed)
- Linear Trend (Awaiting social care funding)
- Awaiting nursing home bed
- Family choice
- Lack of housing
- Linear Trend (Awaiting Residential Placement)
- Linear Trend (Awaiting care package)
- Lack of local health services
- Linear Trend (Awaiting social care funding)
- Linear Trend (Lack of Social Care)
Figure 14: Frequency of actual discharge settings

- Discharged: Total - Community Settings
- Discharged: independent living
- Discharged: family home
- Discharged: residential care
- Discharged: low secure
- Discharged: medium secure
- Discharged: mental health ward
- Discharged: complex care
- Discharged: No transfer
- Discharged: other
- Discharged: supported housing
- Discharged: Total - Hospital Settings
- Discharged: Total - Other Settings
- Discharged: acute LD ward
Care and Treatment Reviews

- As part of the Transforming Care agenda, Care and Treatment Reviews (CTRs) were developed and implemented in order to try to determine whether patients were receiving the right care. They are intended to: (a) ensure that patients and family members are included within care pathways, (b) reduce admissions to hospital, (c) ensure that there is a clear treatment plan with associated outcomes, (d) stakeholders work together with patients and families to help expedite discharge, (e) treatment plans are challenged when needed, and finally, (f) to highlight the barriers to discharge and make recommendations about these should be overcome (NHS England, 2015).

- CTRs had the target of supporting the discharge of one half of all patients with intellectual disabilities by the end of March 2015. CTRs completed in 2014 and 2015 were said to have revealed that: (a) people with intellectual disabilities come into hospital unnecessarily and stay for longer than needed, (b) being in hospital unnecessarily causes harm, (c) some patients have no treatment and discharge plans, (d) people in hospital are more likely to receive medication and physical interventions, and (e) improved community services, together with better commissioning, is the most appropriate why of meeting the needs of people with intellectual disabilities (NHS England, 2015).
Figure 23: Frequency count of monthly pre-admission CTR
Figure 24: Frequency count of monthly post-admission CTR

Number of Patients

Month

Postadmission CTR: Yes
Postadmission CTR: No
CTR: 0 to 7 days after admission
CTR: 8 to 14 days after admission
CTR: over 14 days after admission
Linear Trend (Postadmission CTR: Yes)
Linear Trend (Postadmission CTR: No)
Figure 25: Monthly frequency count of the time elapsed since the last post-admission CTR.
Figure 26: Monthly frequency count of the outcome from Care and Treatment Reviews
Other issues?

- Demands on services?
- How many service users are using the NHS?
- Staffing?
Figure 29: Number of people in contact with learning disabilities services as recorded within the Mental Health and Learning Disabilities National Dataset (MHLDDS)
Figure 30: Number of open referrals for people with intellectual disabilities and/or autism as recorded within the Mental Health and Learning Disabilities National Dataset (MHLDDS)
Figure 31: Monthly frequency count of medical staff employed to work with people with intellectual disabilities in the NHS
Figure 32: Monthly frequency count of community nursing staff employed to work with people with intellectual disabilities in the NHS
Figure 33: Monthly frequency count of non-community nursing staff employed to work with people with intellectual disabilities in the NHS
Figure 34: Monthly frequency count of all nursing support staff employed to work with people with intellectual disabilities in the NHS
Figure 35: Monthly frequency count of community nursing support staff employed to work with people with intellectual disabilities in the NHS.
Figure 36: Monthly frequency count of non-community nursing support staff employed to work with people with intellectual disabilities in the NHS
Conclusions

- The number of inpatients with intellectual disabilities and/or autism has not decreased substantially from 2013.
- A substantial portion of admissions originated from other hospitals, suggesting churn within the system.
- Relatively fewer patients are staying for long periods of time, and this is decreasing.
- The number without a planned transfer date is increasing.
- Time taken to discharge appears to be falling.
- The number who cannot be discharged because of risk is increasing.
- Considering those discharged, most go to the community, but the number planned to be discharged to the community is falling.
- The number with a planned discharge to secure and forensic rehabilitation beds has remained relatively stable, noting that no discharges to forensic rehab took place in 2016.
Conclusions

- The number without a planned discharge accommodation has been increasing.
- The vast majority in hospital are in secure care. Closing these beds has implications for criminal justice and the Prison Service.
- The number of NHS nursing and nursing support staff working in the NHS within both community and inpatient services has dropped substantially. Patient numbers have not dropped.
- Where have they all gone?
- We do not have data on clinical scientists (i.e. clinical psychologists) working in intellectual disabilities. There has been some national benchmarking (0.89 fte per 10 LD beds, or 0.23 per 10 acute MH beds)
- We do not have data on allied health professions or social workers working with intellectual disabilities, but again there has been some national benchmarking. (OTs: 0.81 fte per 10 LD beds or 0.75 per 10 acute MH beds; SLT: 0.26 fte per 10 LD beds)
Relationships within the data?

- Using modelling we investigated the relationships between variables. This is not causal.

- Total number of inpatients
  - Use of IMCAs (-8.18, p < .0001)
  - Use of IMHAs (-4.75, p = .0003)
  - Care plan involves family (2.68, p = .018)
  - Post admission CTR (-4.00, p = .028)
  - Number said to be not dischargeable (2.84, p = .014)
  - Number with a transfer plan (3.05, p = .009)

- Ratio of secure:acute beds
  - Nursing support staff (3.92, p = .001)
  - Pre admission CTR (-4.42, p = .007)
  - Number said to be not dischargeable (-2.69, p = .019)

- Total number of Admissions
  - Number of people with IDs in contact with services (2.88, p = .013)
  - Community nursing staff (2.96, p = .008)
  - Nursing support staff (-5.19, p < .0001)
  - Use of advocacy of any type (-3.63, p = .002)
  - Use of IMCAs (2.62, p = .02)
  - Use of IMHAs (2.86, p = .013)
  - Care plan involves family (-5.50, p < .0001)
  - Number said to be not dischargeable (3.33, p = .006)
  - Number with a transfer plan (-3.32, p = .005)
Relationships within the data?

- **Total Number of Discharges**
  - Number of people with IDs in contact with services (2.75, \( p = .016 \))
  - Community nursing staff (3.06, \( p = .007 \))
  - Use of advocacy of any type (-3.30, \( p = .005 \))
  - Use of IMCAs (7.75, \( p < .0001 \))
  - Use of IMHAs (12.43, \( p < .0001 \))
  - Care plan involves family (-5.91, \( p < .0001 \))
  - Post admission CTR (5.30, \( p = .003 \))
  - Number with a transfer plan (-5.54, \( p < .0001 \))
  - Local authority aware (-2.97, \( p = .025 \))

- **Readmission > 30 days post discharge**
  - Number of people with IDs in contact with services (48.02, \( p = .0004 \))
  - Community nursing staff (-4.08, \( p = .007 \))
  - Nursing support staff (-3.87, \( p = .008 \))
  - Use of advocacy of any type (-3.52, \( p = .013 \))
  - Use of IMCAs (2.92, \( p = .043 \))
  - Use of IMHAs (2.81, \( p = .048 \))
  - Care plan involves family (-2.58, \( p = .042 \))
Relationships within the data?

- Readmission within 30 days post discharge
  - Number of Consultant Psychiatrists (-2.79, p = .032)
  - Community nursing staff (-2.95, p = .026)
  - Nursing support staff (-2.57, p = .042)
  - Use of advocacy of any type (-7.37, p = .0003)
  - Use of IMHAs (4.11, p = .001)
  - Care plan involves family (-5.74, p = .001)
  - Post admission CTR (3.80, p = .013)
  - Local authority aware (-3.72, p = .010)