Abstract

Background  Official guidance on out-of-area placements creates incentives that could lead to people being placed against their own best interests, with negative consequences for them and for the ‘receiving’ authorities.

Method  Information was collected for 30 people through interviews with them, their families, home managers and care managers. Interviews concerned resident needs, reasons for placement, the homes, care management arrangements, resident quality of life and social inclusion. Information on care standards was abstracted from official records.

Results  The main reasons for out-of-area placement were insufficient local services of acceptable quality, financial incentives and loss of family contact through prior institutionalization. The effects varied, with the most disabled people experiencing worst outcomes. Some aspects were worse than comparison studies (choice, community involvement, number of homes meeting all the national minimum standards), some were the same (participation, family visiting and other contact), and one was better (visits to families). Variation was also evident in the involvement of social services staff from the placing authority and in ease of access to local healthcare resources.

Conclusions  Social services and health authorities should develop services locally that can support people with the full range of individual needs. Perverse incentives should be removed, perhaps by increasing the application of direct payments and personalized budgets.

Keywords  learning disabilities, market, out-of-area placement, residential care

Introduction

A companion paper (Mansell et al. 2006) identified the growing shortage of residential care for people with learning disabilities leading to placement funded by one authority in another authority’s area. Such out-of-area placements are governed by guidance from different government departments in respect of different funding streams. The guidance is inconsistent and incomplete. It creates a framework of incentives for health and social services authorities, which could lead to people being placed out-of-area against their own best interests, with negative consequences for them and for the ‘receiving’ authorities.

There are no official data on the number of people placed out-of-area in England. A survey of one large English county (Beadle-Brown et al. 2005) estimated that, at a minimum, between 1000 and 1400 people with learning disabilities were placed in the county, although the number may have been as high as 2000
people. The number placed by the local authority was itself only approximately 1500 people. There is no information about the effects of out-of-area placement. The possible advantages and disadvantages outlined by Mansell et al. (2006) remain hypothetical in the absence of research to explore the lives of people placed out-of-area. This study reports the reasons for and effects of out-of-area placement in a sample of people from the survey by Beadle-Brown et al.

**Method**

Thirty service users were randomly selected from the people discovered in the survey by Beadle-Brown et al. This number was chosen to allow a reasonable spread of different ages, levels of disability and other relevant characteristics (e.g. presence of challenging behaviour). Individuals in the database were given a random number and the database sorted by that number. The managers of the homes in which the first 30 people on the list lived were contacted and screened for the following criteria:

- whether the service user still lived in that service;
- age;
- gender;
- ethnicity;
- level of disability;
- presence of additional/complex needs such as challenging behaviour, physical disabilities, sensory disabilities, epilepsy and communication problems;
- whether there was contact with the family;
- who would give consent;
- how long they had been at the placement; and
- funding authority.

Where individuals did not meet these criteria (for example, they had moved back to their funding authority), where other individuals from that service had already been included or where consent was refused, the next person on the list was contacted. Where criteria were fulfilled, the manager was asked to pass on an information letter and consent forms to whoever should give consent. Where possible, consent was obtained from the individuals with intellectual disabilities themselves, but where this was not possible, agreement was gained from the next of kin or another appropriate person.

In total, 48 service managers and service users were contacted, with 18 refusing to participate. For four of them, it was the service user themselves who refused. For two participants unable to give consent themselves, the parents withheld agreement. In one case, the service user was about to leave the service, and in two cases, the manager felt it was not in the best interests of the person to be included at that time due to very difficult situations (the short timescale of the project meant that it was not possible to wait until the situation was more stable). In the remaining nine cases, the person who normally gave agreement in these situations could not be contacted.

Each home was visited and the manager was interviewed using several schedules:

- background information on the service and on the service user (e.g. placement history, current placement, cost, family contact);
- service users’ needs and characteristics [adaptive behaviour (Hatton et al. 2001), social impairment (Wing & Gould 1978) and challenging behaviour (Aman et al. 1985)]; and
- service quality [participation in daily living (Raynes et al. 1994), choice making (Conroy & Feinstein 1986) and community involvement (Raynes et al. 1989)].

In addition, a semi-structured interview explored home managers’ views about liaison and coordination with the placing authority, and the effect of the placement on the service user.

Semi-structured interviews were also carried out with the service user where this was possible and where consent was received from the individuals themselves, with a family member where contact existed between the participants and their family (by visit), and with the care manager (by telephone). These interviews explored the reasons for out-of-area placement and the benefits and disadvantages perceived by the respondent.

A descriptive analysis was carried out, including comparison of results with those of other relevant studies, in order to illustrate the extent to which people in this sample differed in their characteristics or outcomes from others. Non-parametric inferential statistics were used to explore possible relationships and differences. Comparisons between two groups were conducted using Mann–Whitney U-test and chi-square test, as the majority of these data were at ordinal or categorical level. Association between categorical variables was analysed using chi-square test, and relationships for ordinal-level data were analysed.
using Spearman’s rank order correlation coefficient. In some cases, relationships were examined using a partial correlation coefficient in which age and ability were held constant.

Results

Residents

The residents were a diverse group, with different levels of learning disability and different backgrounds. The average age of participants was 39 years and 9 months (range 18–69 years). Sixteen of the 30 people (53%) were men, and 23 (77%) were of white British ethnic origin. Four people (13%) came from black Caribbean background, and the other three people were black African, Indian and other Asian. Ten people (33%) were rated by the home manager as having mild to moderate levels of disability, 22 (73%) as showing at least occasional challenging behaviour or mental health problems, 21 (70%) had impairments in communication skills, 6 (20%) had physical disabilities, 7 (23%) sensory disabilities and 7 (23%) epilepsy.

In terms of social impairment, 14 (47%) of the sample were rated as having a social impairment. Two people had a diagnosis of Down’s syndrome, three of autism, four of cerebral palsy and one of Down’s syndrome and autism. One person was diagnosed with Fragile X syndrome and two with Asperger’s syndrome. The remaining people had diagnoses of learning disability in association with other complex needs (e.g. challenging behaviour, epilepsy, etc.).

Of the 22 people reported as having challenging behaviour, eight were described as showing only one main type of challenging behaviour; the others all presented multiple challenges. Fourteen of the 22 showed aggression to other people or damage to property (usually both). There were no differences between those with and without challenging behaviour in terms of age, ability, social impairment, type of previous placement or number of previous placements.

Table 1 compares selected characteristics of this group with the results of two other surveys: a national survey of the homes provided by one charity (Mansell et al. 2002) and an unpublished study of 40 homes provided by another national charity (Mansell & Beadle-Brown 2004). These studies included people from both within- and out-of-area placements. Participants in this study fall generally between the other two in terms of the proportion of people with these characteristics. However, they have on average higher language ability and less social impairment, and include more people from black and ethnic minority groups.

Table 2 compares the participants of this study with those of the study by Mansell & Beadle-Brown (2004), with two samples in institutions reported by Aman & Singh (1986) and with people living in different settings studied by Emerson et al. (1999). In

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<tbody>
<tr>
<td>Mean age</td>
<td>40 (73)</td>
<td>46 (76)</td>
</tr>
<tr>
<td>Per cent &lt; 40 years</td>
<td>50 (83)</td>
<td>35 (86)</td>
</tr>
<tr>
<td>Per cent male</td>
<td>53 (88)</td>
<td>50 (88)</td>
</tr>
<tr>
<td>Per cent white British</td>
<td>77 (127)</td>
<td>97 (130)</td>
</tr>
<tr>
<td>Per cent SABS score</td>
<td>55 (92)</td>
<td>57 (92)</td>
</tr>
<tr>
<td>Per cent socially impaired</td>
<td>47 (78)</td>
<td>67 (71)</td>
</tr>
<tr>
<td>Per cent unable to walk alone</td>
<td>17 (29)</td>
<td>10 (21)</td>
</tr>
<tr>
<td>Understanding only simple phrases or less</td>
<td>17 (29)</td>
<td>24 (37)</td>
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SABS, Short Adaptive Behavior Scale.

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Table 2. Comparison of challenging behaviour

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<tbody>
<tr>
<td>Irritability</td>
<td>10.77</td>
<td>6.26</td>
<td>7.38</td>
<td>7.88</td>
<td>10.00</td>
<td>6.3</td>
</tr>
<tr>
<td>Lethargy</td>
<td>7.53</td>
<td>6.24</td>
<td>10.38</td>
<td>8.83</td>
<td>7.00</td>
<td>4.6</td>
</tr>
<tr>
<td>Stereotypy</td>
<td>3.17</td>
<td>2.12</td>
<td>4.88</td>
<td>3.80</td>
<td>3.40</td>
<td>1.8</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>12.30</td>
<td>6.65</td>
<td>10.56</td>
<td>8.48</td>
<td>9.60</td>
<td>5.6</td>
</tr>
<tr>
<td>Inappropriate speech</td>
<td>1.90</td>
<td>2.03</td>
<td>1.84</td>
<td>1.92</td>
<td>1.90</td>
<td>1.5</td>
</tr>
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</table>

ABC, Aberrant Behavior Checklist.

Table 2, data are the mean scores on each domain of the Aberrant Behavior Checklist (ABC). The comparisons show that the group taking part in this study were more challenging on four of the five domains than those in the study of Mansell & Beadle-Brown (2004), especially in terms of hyperactivity and irritability. On these two domains they were also more challenging than either men or women living in American institutions in the early 1980s. They presented similar levels of challenge to residents in National Health Service (NHS) campuses studied by Emerson et al. (1999).

Resident circumstances before placement

Is there something about the background of the people that explains why they have been placed out-of-area? Twenty-two people (73%) were placed by authorities in London. Seventeen people (57%) lived in long-stay hospitals at some time in their past. The largest number (13 people, 45%) had lived in their current home for 3–5 years. Seven (24%) had been in their current placement for 6–10 years, and six (21%) had been there for more than 10 years. Only three people had moved in the last 2 years, and in one case the home manager did not know when the person had moved to the home.

On average, people had had two placements before this one (range 0–4). The majority of people had had one previous placement, with just over a quarter having had three or four previous placements. Four people had three or more previous placements that were out-of-area.

Home managers were able to give the main reason for the present placement in 25 out of 30 cases. In practice, there was usually more than one reason involved in the move, but these answers give some indication of the main reasons for placement. In six cases, people had moved out of long-stay hospitals or (one person) a previous home that was closing.

At the time they were trying to emptying a large long stay hospital and basically anyone that stated they had a placement they interviewed and you just went up there and chose who you wanted and [this person] was one of our choices. (Home manager)

For seven people, the move had been planned, for example, to be nearer the person’s family (two people) or to meet family wishes about the kind of service provided.

Have you seen the others? [We were] 6 years looking. I just don’t know what to say except they were just awful, miserable, dire, no stimulation, sitting round the walls with people of all ages including elderly . . . There didn’t seem to be anywhere with just his age group around here where he would have proper stimulation, be taken out, have work to do. [This] is the only place I’ve seen where he is part of a family, a nice clean home with staff who are chatty and an upbeat atmosphere. (Family member)

For five people, the move was made in an emergency, either because of concerns about the previous placement (e.g. adult protection) or because of challenging behaviour.
Finally, for seven people, the move was made in order to secure access to specialist input of some kind, often because of the resident’s challenging behaviour.

I think it was the only option, I don’t think there was anything in London that was specialised in that area. The first choice is always to try to place someone in their area but then because of specific needs, certainly with people with dual diagnosis or very challenging behaviour, services within the borough are very limited and sometimes you need specialist services that are only available out of borough. (Care manager)

Thus, broadly speaking, two themes come through strongly as explaining why people have been placed away from their home area. First, many people suggest that there are insufficient services locally – either because they are not of acceptable quality, or because they are unable to support people with higher needs for support (for example, because of challenging behaviour). This was an important factor in respect of three-quarters of the participants. In the second case, people have been placed out-of-area possibly because locality is not thought to be important, for example, for those people who were in long-stay institutions. In this group, the people who had been in long-stay hospitals were no longer in touch with their families.

The homes in which people are placed

The average distance from the home to the placing authority was 59 miles (range 10–213). Twenty-three (77%) were provided by private care organizations and three by charities. Twenty-six (87%) of the homes were part of a larger organization.

The average size of home was 3 people (range 1–6). However, five homes were part of larger campuses, and for these the average number of service users on site was 17 (range 9–21). The average cost of placement was £47,411 (range £12,019–102,313). This is similar to the cost reported by Mansell et al. (2002), where the mean cost (updated by the Retail Prices Index) was £49,362 (range £8822–103,694). There was no significant difference in cost of care package by level of disability [Short Adaptive Behavior Scale (SABS) total score divided into quartiles] or by whether the person had been in long-stay hospitals, and there was no relationship between SABS score, age or any of the challenging behaviour measures and cost.

The distribution of cost did appear different from that reported by Mansell et al. (2002) (Fig. 1). The numbers in this sample are too small for these data to be anything other than suggestive, but it may be that there are two groups of out-of-area placements – one much less expensive and the other much more than the average.

Two-thirds of the homes specialized in the needs of residents they served. Eleven of the 30 specialized in challenging behaviour or mental health, sometimes in addition to autism. Four specialized in serving people with physical disabilities as well as learning disability, three specialized in serving people with autism and learning disability, and one was for elderly people with learning disabilities. Specialized homes cost higher than the others, although this
difference was not statistically significant \((z = 1.858, P = 0.066)\). They did have a higher proportion of residents from out-of-area placements \((z = 2.189, P < 0.05)\).

Home managers were asked how many other residents were placed by other authorities, and this information was provided for 27 out of 30 homes. Sixteen (59\%) had more than half their residents placed out-of-area. In six of them (22\%), every resident was placed out-of-area.

Managers were asked why they received referrals from out-of-area. Half said that these were the only referrals they got. Some managers identified specialist skill or family contacts as a reason people came to them from other areas.

"We’re usually approached, we don’t actually approach anybody. They approach us in the first place. Sometimes it’s because of the sort of home we’ve got that they’re looking for, sometimes they’ve got a link with the town, like . . . they’ve still got some family or friends here. Sometimes it’s just because of lack of homes in their own town." (Home manager)

Echoing the finding in the survey that placing authorities typically use the same homes, one manager said:

"It just seems that they all come from London boroughs – I don’t know why, it just seems that social workers have set down the details . . . It’s not done on purpose, it’s just those are the referrals [that] have come through the system.

A more common explanation was fee level.

"Everyone always assumes that [this authority] struggles with budgets and can’t always give the care they would like to give with what they can afford . . . [we] are quite expensive in level of staffing and training and so were not considered in the past . . . we [now] have quite a few from [this authority] in other services." (Home manager)

Money basically. It’s the cost. Not only that but obviously in London the prices are higher and they look for cheaper alternatives which would be down this way. (Home manager)

It was pointed out during the study that it had at one time been common practice for contract managers in this area to tell local residential care providers that there was a cap on fees, irrespective of the needs of particular individual residents, and that they would have to look elsewhere for business if they wanted higher fees.

Care management

Only 19 of the 30 residents were said to have a care manager or reviewing officer, although home managers reported that care managers were in touch at least every 6 months for seven residents, between 6 and 12 monthly for two residents, and less frequently or ‘when required’ for 13 residents. This discrepancy is due to the provision of duty care managers or reviewing officers in some cases.

Of 17 care managers interviewed (four of whom were reviewing officers), only four had actually arranged the placement of the person in their current home. Sixteen had met the resident, but for nine of them it was only in the context of the annual review. Two care managers felt they knew the person really well, nine fairly well and six said they did not know the person very well at all. Home managers reported that they knew the date of the last review for 28 of the 30 residents; 14 had had a review within the last 6 months, eight between 6 and 12 months ago, and six over 12 months ago.

Resident quality of life

Fifteen of the 30 residents were able to take part in an interview, at least to some extent. Twelve of the 15 said they had wanted to move to the home. When asked what was good about the home, residents mentioned they liked the staff and/or other residents, the opportunity to become more independent, and most frequently (eight people) the activities in which they could participate.

"Because of the activities. I like the staff more here because they take me out; they didn’t in the other place. I just played in the back garden. I just watched telly. I’d say here is better. I like all the service users, especially T." (Resident)

When asked what was bad about the home, six people identified problems – mainly relationships with other residents or staff.
If I’m naughty I don’t go out. I stay here, they punish me. If I’m naughty, or loud or walking around in circles, I don’t go out. (Resident)

Interviewers also assessed quality of resident experience using two measures adopted in other studies – the Index of Participation in Daily Life and the Choice Making Scale (see Table 3).

As would be expected, given the wide range of levels of adaptive behaviour of residents, there was wide variation in the extent to which people participated in activities of daily living (e.g. shopping, cooking, cleaning, laundry and gardening) and making their own choices. There was a statistically significant relationship between adaptive behaviour (as measured by the total score on the SABS) and participation in daily living (Spearman’s rho = 0.502, P < 0.01), and between adaptive behaviour and choice making (Spearman’s rho = 0.527, P < 0.01). The residents with lower support needs exercised more choice and participated to a greater extent.

A series of partial correlations controlled for age and level of adaptive behaviour showed statistically significant positive correlations between participation in daily living activities and shorter length of stay (r = −0.538, P < 0.01), smaller size of home (r = −0.486, P < 0.05) and higher proportion of residents from out-of-area placements (r = 0.498, P < 0.05). More choice was correlated with longer time since the last review meeting (r = 0.441, P < 0.05). It is not clear why these latter two correlations should be significant, and this requires further study.

There was no statistically significant relationship between challenging behaviour and either participation or choice. There was no statistically significant relationship between whether the home was specialized or how much it cost and either participation or choice.

The overall level of participation was similar to that reported by Raynes et al. (1994) in a study of community-based residential services for 2031 people with learning disabilities in 1988–1989. They found that on average, residents scored 38.8% on this measure. A more recent study by Mansell & Beadle-Brown (2004) of 398 people in small group homes, who were of similar level of adaptive behaviour though slightly older than this group, found a higher average score (47.3%), although this is not statistically significant (z = 1.866, P = 0.062). It does suggest, however, that these homes might not be achieving the same outcomes as other contemporary services.

Similarly, Raynes et al. (1994) found that on average, residents scored 64.2% on the Choice Making Scale. Mansell & Beadle-Brown (2004) found a significantly higher average score of 80.5% (z = 4.722 P < 0.001).

Social inclusion of residents

In general, service users reported themselves as going out at least sometimes – seven out of 13 people who answered the question said they went out a lot, and the remaining six said they went out a little. Of those able to be interviewed, three people had a job. Home managers identified that five people had a job. All of them were in special projects rather than open employment. One person worked full-time and the remainder part-time.

Managers reported that 17 residents out of 30 went to a day service, seven of whom were on the same site as the home. Two people went to local authority day services and eight went to private or voluntary day services off site. Home managers reported that 14 people went to college, for classes ranging from 1 to 35 h per week.

Twelve residents said that they went shopping and of these, eight did shopping for food and snacks, three for clothes and four said they went shopping for whatever was their own personal interest. When asked what they did for fun, 12 people said they went to the cinema, eight went swimming, six went to the town, 14 went to the pub, six went to a club, one went to church, seven went to a sports centre, two went to a café, three went bowling, four went walking, two went to parties and one went to the hairdresser.

Table 3 Resident participation and choice

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<th>Mean %</th>
<th>Standard deviation</th>
<th>Minimum–maximum %</th>
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<tbody>
<tr>
<td>Index of Participation in Daily Life</td>
<td>38.3</td>
<td>25.5</td>
<td>0–88.5</td>
</tr>
<tr>
<td>Choice Making Scale</td>
<td>70.2</td>
<td>21.1</td>
<td>1.4–97.2</td>
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</table>
Interviewers also assessed the extent to which residents used community facilities, using the Index of Community Involvement (Raynes et al. 1994). The mean percentage score for these homes was 46% (range 20–73%). This compares with 44% reported from a study of Scottish homes by Ager et al. (2001). It is lower than another recent study in England (Emerson et al. 1999), which found a mean percentage score of 63%. Overall, therefore, it appears that this group may be experiencing less community involvement than people living in other similar residential homes in England. In fact, the level of community involvement seen in this group was closer to that of residents studied is small, and other studies of larger groups have found that family contact declines with distance (Dalgleish 1985; Walsh et al. 2001).

As with daily living activity and choice, there was a statistically significant relationship between adaptive behaviour and community involvement (Spearman’s rho = 0.413, P < 0.05), so that the more independent residents were involved in more community activities. There was no relationship with challenging behaviour. Partial correlations controlled for age and adaptive behaviour were statistically significant for community involvement and shorter length of stay (r = −0.580, P < 0.01), and for less family contact other than visits to or from the family (r = −0.533, P < 0.05).

There was no statistically significant relationship between whether the home was specialized or how much it cost and community involvement.

According to the home managers, 23 (77%) of the 30 residents had some family contact. The frequency of contact as reported by the home managers is illustrated in Table 4.

This pattern is rather different from that found by Raynes et al. (1994). They found double the percentage of people having weekly visits to or from the family, a lower proportion (21%) never being visited. It is plausible that people placed out-of-area receive less contact than the much larger sample studied by Raynes et al. (1994), which included many people placed in their home areas. However, Raynes et al. (1994) also found a much higher proportion (42%) of residents never visiting their family. This may reflect the substitution of visiting modes – when it is easy to visit the residential home, people are less likely to have the resident visit the family home; or it may represent a change in the proportion of people who have lost contact with their family with the passage of time.

There was no statistically significant relationship between distance from home area and pattern of family visiting for this group. However, the number of residents studied is small, and other studies of larger groups have found that family contact declines with distance (Dalgleish 1985; Walsh et al. 2001).

When age and level of adaptive behaviour were controlled by partial correlation, statistically significant correlations were found between less non-visiting contact (e.g. letters or telephone calls) and more community involvement (r = −0.533, P < 0.05), and more non-visiting contact and less challenging behaviour on three of the ABC sub-scales: irritability (r = 0.530, P < 0.05), lethargy (r = 0.482, P < 0.05) and hyperactivity (r = 0.489, P < 0.05).

Ten of the 11 residents interviewed who expressed a view said they would like more contact with their family.

Fourteen out of 15 residents interviewed said that they had friends. Ten people said they had met their friends at the home where they lived or a previous home, and four people identified staff as friends. Only four people said they had friends beyond the home where they lived. Nine out of 13 people who answered the question said they would like more friends. Home managers reported that 21 out of the

Table 4 Family contact

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<thead>
<tr>
<th></th>
<th>Weekly %</th>
<th>Monthly %</th>
<th>Less than monthly %</th>
<th>Never %</th>
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<tbody>
<tr>
<td>Visit from family to residential home</td>
<td>7</td>
<td>17</td>
<td>45</td>
<td>31</td>
</tr>
<tr>
<td>Visit from resident to family</td>
<td>7</td>
<td>25</td>
<td>39</td>
<td>21</td>
</tr>
<tr>
<td>Other forms of contact (e.g. letter, telephone call)</td>
<td>36</td>
<td>14</td>
<td>29</td>
<td>21</td>
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30 residents (70%) had friends, although only 4 (13%) had friends beyond the home site.

Care standards
All the homes were inspected at least twice a year by the National Care Standards Commission and are now inspected by the Commission for Social Care Inspection. Reports of inspections were available for 27 of the 30 homes. Inspections report whether national minimum standards are met in respect of 43 standards in eight areas (Department of Health 2002). Although these inspection reports are of unknown accuracy and reliability, they are intended to be used to ensure that minimum standards are being met, and they are the only measures of the quality of residential care routinely collected in England.

Overall, the mean number of standards met was 31 out of a possible 43 (range 11–43). Five services met 50% of standards or less. There was no statistically significant relationship between whether the home was specialized or how much it cost and the percentage of national minimum standards met. Comparison of the data from this study with those from the study by Mansell & Beadle-Brown (2004) found no statistically significant differences between the groups. The National Care Standards Commission (2004) published national data for all care homes for younger adults collected by September 2003. These data show that, in the year 2003–2004, the proportion of homes achieving every standard was 46%. In this group of 27 homes providing out-of-area placements, only two homes (7%) met every standard.

Inter-relationships between measures
Consideration of all the data concerning the effects on residents suggested that there might be, broadly speaking, two different groups. One group consists of those who live in homes not meeting at least 50% of national minimum standards and/or with a pattern of lower scores on measures of quality of life and quality of service (n = 10), and the other of those not meeting either of these criteria – where homes met at least 50% of national minimum standards and the pattern of scores across outcome measures, although variable was somewhat higher (n = 20). This differentiation was checked statistically, and these two groups were found to differ significantly on participation (z = 2.271, P < 0.05), choice (z = 2.995, P < 0.01), community involvement (z = 2.669, P < 0.01), non-visiting family contact (z = 2.308, P < 0.05) and percentage of national minimum standards met (z = 3.082, P < 0.01).

In terms of explaining the existence of these distinct groups, there were no significant differences between the two groups in terms of challenging behaviour, overall ability, cost of placement or number of previous placements. However, those who had been in the home for more than 5 years were more likely to be in the poorer outcome group; 80% of those in the poorer outcome group had been in the service for more than 5 years, compared with 25% of the better outcome group (χ² = 8.213, P < 0.01).

Whether or not the person was socially impaired also appeared to be important and approached statistical significance (χ² = 3.281, P = 0.07), with 70% of those in the group with poorer outcomes/quality of service being socially impaired compared with 35% of those in the better outcome group.

Given the small and uneven group sizes, these results should be interpreted with caution. However, it does suggest that there are two different groups within the sample of people placed out-of-area, one doing better than the other, and that length of stay and social impairment might be relevant explanatory factors.

Discussion
The small number of cases included in this study provided limited opportunity for statistical analysis. In the absence of comprehensive national data on the characteristics of people with ID in residential care and the quality of that care, the results were compared with those of other published studies to illustrate possible differences between this sample and larger studies of people in residential care. These comparisons are limited by the extent to which they are representative and also because in some cases the larger studies may have had different sociodemographic characteristics. Nevertheless, the results of the project do provide, for the first time, evidence of the reasons for and effects of out-of-area placement.

The residents placed out-of-area were, on average, less socially impaired, had higher language ability and
were more challenging than other populations in residential care. There were also more people from black and ethnic minority groups (although this may reflect the importance of London boroughs in making placements).

The lack of suitable local services was a reason for out-of-area placement either when local services were not judged to be of a high-enough quality (an issue raised particularly by family members) or when local services were unable to support people with higher or more complex needs (for example, because of challenging behaviour). Arguably, either of these is a reflection of the failure by authorities to develop a sufficiently wide range of levels and styles of support in local accommodation. If each local area had a fuller, more comprehensive range of help available, then families and authorities would not be forced to seek out-of-area placement. Of course, some people might still choose out-of-area placement either because of service characteristics or in order to be near their family.

For a quarter of the fieldwork sample, the main reason for out-of-area placement seemed to be that people had been in institutions, and were not in contact with their families, and possibly therefore the people arranging their placements did not think that locality was important.

Finally, it seemed that out-of-area placements were being made because in some cases, other authorities would pay higher fees. The average cost of the placements studied was not different from that found in a larger study of residential services (a national study, so it might still be true that these rates were on average higher than rates paid by this authority). The data did raise the possibility that the distribution was different, with a low-cost and a high-cost group rather than an approximately normal distribution, but the sample is too small to make this anything other than a subject for further study.

The effects of out-of-area placement varied across individuals. Generally, the most disabled people experienced the worst outcomes. Overall, some aspects were worse than comparison studies (choice, community involvement, number of homes meeting all the national minimum standards), some were the same (participation, family visiting and other contact), and one was better (visits to families). Variation was also evident in the involvement of social services staff from the placing authority and in ease of access to local healthcare resources.

Again, the data suggested that there might be two different groups within the sample of people placed out-of-area, one doing better than the other. These were not related to cost or most other resident or service characteristics, but longer length of stay and social impairment might be relevant explanatory factors.

Not all of the differences in outcome can be attributed to being placed out-of-area. For example, the fact that this group was more challenging than other samples in residential care may explain some of the variation in the outcome. This group appears to have only slightly better community involvement than those with similar levels of challenging behaviour still in hospital settings (Emerson et al. 1999).

Some of the homes in this study served people placed by the local authority, as well as those placed by other authorities. Given the small size of this exploratory study, it is not possible to say what are the risk factors for out-of-area placements or whether there is a significant difference in outcome for those people placed out-of-area compared with those placed within the local area, controlling for resident needs and characteristics. Such a study should be the focus of further research.

However, what is clear is that some individuals placed out-of-area experience very poor outcomes and some homes are achieving well below acceptable standards of care. If the third of placements in this category found in the interview study is representative of the whole population of people from out-of-area placements in this county, then 300–700 people might be in this situation.

The processes at work here seem fairly clear. Many families and local authorities faced with no suitable local services have to seek out-of-area placement. This is more likely if people have challenging behaviour or (possibly) are from an ethnic minority, or if their family is dissatisfied with the quality of local services. Financial incentives make out-of-area placement an attractive proposition for some authorities.

Coordination arrangements are typically poor, with the receiving authority not being notified in about half of all cases. Some placements, in some respects, turn out well, although this may be at the expense of more difficult contact with family and friends. Family members in these cases often fear
making any criticism lest their relative loses their home. Some placements face problems and provide poorer quality of care. Official guidance is too muddled to effectively regulate out-of-area placement in the face of the practical difficulties.

The most important implication for local social services and health authorities is that they should develop services locally that can support the full range of individual needs, so that people are not driven to seek out-of-area placements. This was a key recommendation of the Mansell Report (Department of Health 1993) in respect of challenging behaviour, and it has recently been reiterated by the Department of Health (2004). The development of local services to reduce reliance on out-of-area placements is a priority for the Learning Disability Development Fund (Department of Health 2001).

In the meantime, however, steps need to be taken to remove the perverse incentives that encourage out-of-area placement irrespective of individual need. The cost incentives to use less expensive services in rural or coastal areas would be difficult to deal with directly, so that appropriate counterbalances may need to be provided elsewhere. Examples of this might include creating a stronger entitlement for people using services to get the help they need locally, or requiring that the costs of visits to and from family and friends when people are placed out-of-area are met by the placing authority (instead of being met by the service user or their family).

The second group of perverse incentives concerns the opportunity to escape responsibility for properly managing the care package and even providing some or all of it by placing people out of area. Here only one arrangement makes sense from the service user’s perspective. If they move to live in a new area, they need to become part of that community and have a legitimate claim on local services. A key part of this would be arrangements for local authorities to provide care management and healthcare services to people living in their area. Local services would then need to be reimbursed for this extra work, and this could be done either by changing existing resource allocation mechanisms or by making greater use of an extension of direct payments or other personalized budgets.

This would be entirely consistent with the principles that funds should follow the individual in the service system and that the total cost implications of services should be considered to avoid perverse incentives (Great Britain Cabinet Office Prime Minister’s Strategy Unit 2005). These changes might best be made not by reviewing the piecemeal guidance that exists, but within the context of new policies of increased personalization of services (by establishing clearer entitlements to local services), and by using personalized budgets to adjust the funding of local and health authorities to reflect the demand for their services.

References


Out-of-area placements of people with learning disabilities

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