Audit of Admissions to the Weston Unit and Adult Mental Health Wards

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CONTENTS

• Executive Summary 3

• Introduction 6

• Aims 7

• Method
  o Procedure 7
  o Analysis 7

• Results
  o Admissions 8
  o Length of stay 9
  o Gender 10
  o Ethnicity 10
  o Age 10
  o Level of LD 10
  o Diagnosis
    • On admission 11
    • On discharge 11
  o Pervasive developmental disorder 12
  o Mental Health Status 12
  o Type of Residence on Admission 12
  o Borough and type of Residence on Discharge 13

• Discussion 13

• Conclusions and recommendations 16

• References 18
Executive Summary

Introduction

Whether generic mental health services or specialist services provide the best service for individuals with learning disabilities (LD) and mental health problems remains a subject of debate among professionals. Currently there remains a lack of evidence regarding the effectiveness of both types of service. The 6 bed Weston Unit provides a mixed secondary and tertiary service for individuals with LD and mental health problems, and is a care option for MHiLD service users requiring inpatient treatment alongside generic wards. This audit aims to describe admission trends for people with LD to a specialist unit (the Weston Unit) and generic AMH (adult mental health) wards.

Method

- Socio-demographic and clinical data were collected on MHiLD service users admitted to both the Weston Unit and generic adult mental health wards between the dates of June 1999 to December 2004.

- Data collected through use of structured questionnaires by clinicians and research workers.

- Data categorised into three groups (those admitted exclusively to the Weston Unit, those admitted exclusively to AMH wards, and those admitted to both).

- Two exclusive admission groups were compared for statistical differences using Pearson chi-square testing, Mann-Whitney or independent t-tests. Length of stay was also used as a grouping variable for statistical analysis.

Results

- 154 admissions were made to mental health wards, 22.7% (n=35) to the Weston Unit exclusively, 40.3% (n=62) to AMH wards exclusively, and 37% (n=57) to both types of unit.

- The majority of admissions to both the Weston Unit and generic AMH wards were male, white, and aged mid/late 30s with a mild level of LD. Individuals were more likely to have diagnoses of schizophrenic spectrum disorders than other psychiatric diagnoses, to be admitted on an informal basis and to be discharged to supported accommodation. No significant differences were found between the Weston Unit group and the generic AMH ward group for gender, ethnicity, age on admission, level of LD, mental health status on admission, presence of autism and borough on admission and discharge.

- Individuals admitted to the Weston Unit stayed significantly longer than those admitted to AMH wards: 19.3 weeks (range 2-159.3 weeks) compared to 5.5 weeks (range 0.1-71 weeks).

- Admissions to both types of ward who stayed longer than
the median length of stay were more likely to have moderate LD, and those staying shorter than the median were more likely to have mild LD. Admissions to the Weston Unit who stayed longer than the median length of stay were less likely to be discharged to Lewisham and more likely to be discharged to Southwark. Those admitted to AMH wards were less likely to be discharged to independent accommodation if they stayed longer than the median.

- Admissions to AMH wards were significantly more likely to receive a diagnosis of affective disorder compared to admissions to the Weston Unit (29% or n=18 compared to 8.6% or n=3).

- Diagnoses of Weston Unit admissions were shown to change over the course of the admission.

- The majority of individuals admitted to the Weston Unit resided with their family prior to admission, whilst most individuals admitted to AMH wards were admitted from supported accommodation.

- Individuals admitted to AMH wards were more likely to come from “other” accommodation (i.e. un-staffed hostels, prison and homelessness).

- A total of 14 individuals were transferred from AMH wards to the Weston Unit.

- 45.2% (n=14) of Weston Unit admissions were discharged to supported housing, making this the largest group (in contrast to residence prior to admission).

Discussion points

- Admissions to the Weston Unit and AMH wards shared numerous similarities, but some difference in clinical need was also evident.

- The longer length of stay of Weston Unit admissions reflects the operational criteria and the need for a lengthier multi-disciplinary intense process of specialist assessment and treatment.

- More admissions to AMH wards had a diagnosis of affective disorder than individuals admitted to the Weston Unit, possibly because of emergency admissions due to suicidal ideation. Diagnostic changes were made suggesting that the Weston Unit’s assessment process may lead to the reformulation of diagnosis.

- Individuals admitted to the Weston Unit were more likely to reside with their family prior to admission. This may reflect higher levels of need and differences in care pathways. Fewer Weston Unit admissions return to live with their family, which is indicative of the unit’s role in formulating appropriate discharge placements and care packages when breakdown in original placements occur.
• 14 individuals were transferred from AMH wards to the Weston Unit. This suggests that individuals with complex needs requiring longer, more intense specialist periods of care that can be offered on AMH wards are transferred to the Weston Unit, and that the Weston Unit may have an important role in supplementing treatment provided by generic services.

• There were several limitations of the study. The small sample size may have prevented some admission trends from reaching the level of significance.

• Crucially, the audit does not include outcome data, which is necessary to evaluate how effective services are. Further outcome studies are essential in ensuring that services are meeting service targets.

Conclusions

There is evidence to suggest that individuals admitted to the Weston Unit have differing needs to their counterparts admitted to AMH wards. As these services are designed to complement each other rather than compete, this may suggest that specialist services are useful in achieving objectives which AMH may find problematic due to lack of specialist resources. However, this audit does not examine treatment outcomes, and future studies examining this are recommended.
Audit Report

Introduction

Following the closure of large, specialist hospitals for individuals with learning disabilities (LD), there has been debate in mental health regarding the use of generic or specialist services. Government policy states that individuals with LD and mental health problems should receive care provided by generic services to promote inclusion and prevent discrimination (DOH, 2001a). Policy also recognises that in some instances, specialist services provide an important service in the treatment of individuals with LD and mental health problems. In regards to service outcomes, there is limited evidence for the effectiveness of both types of unit for this client group, both nationally, and locally within South London and Maudsley (SLAM) NHS trust.

Supporters of mainstream provision suggest that specialist services can lead to stigmatisation, labelling and negative professional attitudes. In addition, longer, more staff-intensive admissions may lead to a more expensive service. However, mainstream services have been shown to be insufficient for some individuals, leading to expensive, specialist out of area placements (O’Brien, 1990). Out of area placements have created major problems for LD services, with several thousand service users with LD and mental health difficulties being placed in areas removed from their original community (DoH, 2001b).

Atypical presentation, difficulties in communication and a lack of self-report may lead to difficulties in the assessment and treatment of mental health problems in this population (Day, 1994). Professionals working in specialist services receive training specific to individuals with mental health problems and LD. These skills are practiced and refined daily, whilst the relatively small proportion of LD service users on generic units make it more difficult for staff to refine skills and learn from experience (Bouras and Holt, 2004).

Individuals with LD and mental health problems may experience difficulties mixing with their non-LD peers on generic ward environments (Spiller et al, 2004). They may feel less supported by staff, perceive staff as uncaring and find the ward environment stressful (Scior and Longo, 2005). It has also been suggested that whilst individuals with mild LD and mental health difficulties benefit from admissions to generic mental health wards, specialist units can have greater capacity to treat individuals with greater developmental challenges, in addition to offering planned admissions which may help to prevent severe relapse (Charlot and Beasley, 2005).

Mental Health in Learning Disabilities (MHiLD) is a specialist service. It offers a specialised, multi-disciplinary service to adults with LD and mental health problems via a community team and a small inpatient unit (the Weston Unit), and is integrated with generic mental health services within SLAM. The 6–bed Weston Unit was opened in 1999 to complement the community specialist service and existing mainstream inpatient provision. Admissions are almost always planned. Individuals admitted to the Weston Unit improve on a variety of outcome measures (Xenitidis et al, 2004) but there is no equivalent data available for individuals admitted to generic services. The study by Xenitidis et al also found that individuals admitted to the specialist unit had a longer length
of stay and were less likely to be discharged out of area compared to individuals with LD admitted to generic wards.

LD admissions to generic wards have been found to have longer admissions than their non LD peers and are more likely to be male, young, informal patients, have schizophrenic spectrum and admitted to chronic rather than acute wards (Saeed et al 2003). Saeed et al concluded that policies and services designed for service users without LD will not necessarily be adequate for the unique mental health needs of people with LD. This audit is designed to examine admission trends as part of the ongoing evaluation of the Weston Unit.

Aims of audit

- To describe admission trends for people with LD to the Weston Unit and generic AMH wards.
- To compare the characteristics of individuals admitted to the Weston Unit and generic AMH wards in order to highlight differences in need between both groups of service users.

Method

Procedure

Data were collected between June 1999 and December 2004. A questionnaire focusing on demographic and clinical details was designed to obtain information. In the case of the Weston Unit, this was already in use as part of admission protocol.

Socio-demographic information included: borough of admission and discharge, gender, ethnic origin, age, and type of residence at admission and discharge. Clinical factors included length of stay, level of LD, psychiatric diagnosis on admission (as made by a psychiatrist using the ICD-10), the presence of pervasive developmental disorder and status on admission under the Mental Health Act of 1983. Diagnosis on discharge was also collected for individuals admitted exclusively to the Weston Unit.

Analysis

Data were entered onto SPSS and divided into 6 groups reflecting the year of admission. As the Weston Unit opened half way through 1999, data for the first group were collected over a 6 month period. Admission trends revealed three major groups: those admitted exclusively to the Weston Unit (n=35), those admitted exclusively to AMH wards (n=62) and those experiencing at least one admission to both types of unit (n=57). Data from all three groups are presented descriptively. The socio-demographic and clinical characteristics of the exclusive groups were compared using Pearson Chi-Square, Mann-Whitney or independent t-tests (depending on the nature and distribution of the data) to identify any differences in the character of individuals using alternative forms of service provision. The median length of stay was used to divide the sample into two further groups, long stay (those over the median) and short stay (under the median). The characteristics of short and long stay users were compared for each type of ward using chi-square.
Results

Admissions

154 individuals were admitted to the Weston Unit and generic AMH wards. Table 1 shows the number, year and borough of admission of individuals using the Weston Unit exclusively, AMH wards exclusively, or a mixture of ward types.

Table 1: Total number of admissions by year, type of ward & borough (1999-2004)

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>Total</th>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lewisham</td>
<td>0</td>
<td>1 (1%)</td>
<td>2 (28.6%)</td>
<td>1 (16.7%)</td>
<td>1 (33.3%)</td>
<td>2 (33.3%)</td>
<td>7 (20%)</td>
</tr>
<tr>
<td>Southwark</td>
<td>5 (83.3%)</td>
<td>5 (71.4%)</td>
<td>3 (42.9%)</td>
<td>3 (50%)</td>
<td>0</td>
<td>3 (50%)</td>
<td>19 (54.3%)</td>
</tr>
<tr>
<td>Lambeth</td>
<td>1 (16.7%)</td>
<td>1 (14.3%)</td>
<td>2 (28.6%)</td>
<td>2 (33.3%)</td>
<td>2 (66.7%)</td>
<td>1 (16.7%)</td>
<td>9 (25.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>6 (100%)</td>
<td>7 (100%)</td>
<td>7 (100%)</td>
<td>6 (100%)</td>
<td>3 (100%)</td>
<td>6 (100%)</td>
<td>35 (100%)</td>
</tr>
<tr>
<td>AMH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lewisham</td>
<td>2 (33.3%)</td>
<td>1 (12.5%)</td>
<td>3 (42.9%)</td>
<td>5 (62.5%)</td>
<td>4 (26.7%)</td>
<td>6 (33.3%)</td>
<td>21 (33.9%)</td>
</tr>
<tr>
<td>Southwark</td>
<td>2 (33.3%)</td>
<td>5 (62.5%)</td>
<td>3 (42.9%)</td>
<td>2 (25%)</td>
<td>5 (33.3%)</td>
<td>6 (33.3%)</td>
<td>23 (37.1%)</td>
</tr>
<tr>
<td>Lambeth</td>
<td>2 (33.3%)</td>
<td>2 (25%)</td>
<td>2 (14.3%)</td>
<td>1 (12.5%)</td>
<td>6 (40%)</td>
<td>6 (33.3%)</td>
<td>18 (29%)</td>
</tr>
<tr>
<td>Total</td>
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<td>8 (100%)</td>
<td>7 (100%)</td>
<td>8 (100%)</td>
<td>15 (100%)</td>
<td>18 (100%)</td>
<td>62 (100%)</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lewisham</td>
<td>3 (42.9%)</td>
<td>7 (70%)</td>
<td>3 (23.1%)</td>
<td>4 (36.4%)</td>
<td>4 (50%)</td>
<td>2 (25%)</td>
<td>25 (40.4%)</td>
</tr>
<tr>
<td>Southwark</td>
<td>3 (42.9%)</td>
<td>2 (20%)</td>
<td>5 (38.5%)</td>
<td>4 (36.4%)</td>
<td>3 (37.5%)</td>
<td>4 (50%)</td>
<td>21 (36.8%)</td>
</tr>
<tr>
<td>Lambeth</td>
<td>1 (14.3%)</td>
<td>1 (10%)</td>
<td>5 (38.5%)</td>
<td>3 (27.3%)</td>
<td>1 (12.5%)</td>
<td>2 (25%)</td>
<td>13 (22.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>7 (100%)</td>
<td>10 (100%)</td>
<td>13 (100%)</td>
<td>11 (100%)</td>
<td>8 (100%)</td>
<td>8 (100%)</td>
<td>57 (100%)</td>
</tr>
</tbody>
</table>

Taking into account that the category “1999” only contains admission data for 6 months rather than a 12 month period, total admissions to the Weston Unit have remained stable, despite a decrease in numbers in 2003. Conversely, admissions to AMH wards appear to be increasing. Individuals admitted to both types of ward steadily increase until 2001, and then numbers start to decrease again.

Figure 1.1 shows the total number of individuals admitted to the Weston Unit, AMH wards or both according to the borough they were referred from.

Figure 1.1 - Total number of Admissions by borough (1999 – 2004)

Overall, the largest group of individuals admitted exclusively to the Weston Unit originated from the borough of Southwark (54.3% or n=19), with 25.7% (n=9) from the borough of Lambeth and 20% (n=7) from Lewisham. Likewise, the largest
group of admissions to AMH wards exclusively originated from Southwark, accounting for 37.1% (n=23). A further 33.9% (n=21) were from Lewisham and 29% (n=18) from Lambeth. Of those individuals using a both types of ward, 40.4% (n=23) were from Lewisham, 36.8% (n=21) from Southwark and 22.8% (n=13) from Lambeth. No association was found between type of ward admitted to and borough prior to admission.

**Length of stay**

*Figure 2.1 – Median length of stay by borough (1999-2004)*

Figure 2.1 presents the median length of stay for each type of ward according to borough. The median length of stay was significantly longer for individuals admitted to the Weston Unit compared to those admitted to AMH wards; 19.3 weeks (range 2-159.3) for the Weston Unit and 5.5 weeks (0.1-71) for AMH wards(U= 425.5, p = <0.001). The overall range of the length of stay is much larger for the Weston Unit and specifically longer for the borough of Southwark. This is due to one individual’s admission lasting for a total of 159.3 weeks. No associations were found between length of stay and borough prior to admission, gender, ethnic origin, psychiatric diagnosis, pervasive developmental disorder, mental health status and residence prior to admission for either ward.

However, for both the Weston Unit and AMH groups, individuals with mild LD were significantly more likely to have short stays and individuals with moderate LD were significantly more likely to have long stays ($\chi^2 = 4.833$, df = 1, $p = 0.028$, and $\chi^2 = 4.292$, df = 1, $p = 0.038$ respectively). While no significant overall association was found between length of stay and residence discharged to for the Weston Unit, post hoc testing in the AMH group indicated that long stay individuals were less likely to be discharged to independent accommodation ($\chi^2 = 4.440$, df = 1, $p = 0.036$). A higher proportion of this group were also discharged to supported accommodation, but this difference just failed to reach significance ($\chi^2 = 3.696$, df = 1, $p = 0.055$). Similarly, there was no association found between length of stay and borough of discharge for AMH wards, whilst in regards to the Weston Unit, length of stay and district discharged to just failed to reach significance. ($\chi^2 = 7.814$, df = 3, $p = 0.050$). Post hoc testing indicated that individuals who stay longer than the median length of stay were less likely to be discharged to Lewisham ($\chi^2 = 5.044$, df = 1, $p = 0.025$) and more likely to be discharged to Southwark ($\chi^2 = 5.042$, df = 1, $p = 0.025$).
Gender

*Figure 3.1 – Percentage of total admissions by gender (1999-2004)*

Figure 3.1 shows the total percentages of gender for each ward for the entirety of the audit period. 60% (n=21) of those individuals admitted exclusively to the Weston Unit and 61.3% (n=38) of admissions to the AMH wards were male. The majority of the third group were also male (54.4% or n=31). There was no association between gender and the type of unit to which individuals were admitted.

Ethnicity

*Figure 4.1 – Percentage of total admissions by ethnicity (1999-2004)*

Figure 4.1 shows the total percentages of ethnic origin according to type of ward overall. The majority of admissions to the Weston unit (54.3% or n=19) were white. 50% (n=31) of individuals admitted to AMH wards and 56.1% (n=32) of admissions in the third group were white. There was no association between ethnicity and the type of unit into which individuals were admitted.

Age

Overall, the mean age was 37.7 years, ranging from 17 years to 66, for those individuals admitted to the Weston Unit, and 39 years ranging from 18 to 77, for those admitted to AMH wards. Individuals in the third group had a mean age of 35 years, range 17-61 years. There was no significant difference in the age of service users admitted to the Weston Unit and AMH wards.

Level of LD

*Figure 6.1 – Percentage of total admissions by level of LD (1999-2004)*

Figure 6.1 shows that the majority of admissions to both the Weston Unit and AMH wards were for individuals in the mild LD range, making up over 3 quarters of admissions (80% or n=28 and 83.7% or n=52 respectively). A total of 20% (n=7) of individuals admitted to the Weston Unit and 16.1% (n=10) admitted to the AMH wards had moderate LD. No
admissions to either the Weston Unit or AMH wards exclusively were diagnosed as severely LD. Similarly, the majority of 73.7% (n=42) of individuals using both generic and specialist services had a diagnosis of mild LD. A total of 21.1% (n=12) were classified as having a moderate LD, and a small minority of admissions were categorised as having severe LD (5.3% or n=3). There was no association between the level of LD and the type of unit to which individuals were admitted.

### Diagnosis on admission

Figure 7.1 – Percentage of total admissions by diagnosis on admission (1999-2004)

Figure 7.1 shows Axis III diagnosis on admission for each group overall. Of those admitted to the Weston Unit, a total of 51.4% (n=18) had a diagnosis of schizophrenic spectrum disorder, 8.6% (n=3) had affective disorders, 14.3% (n=5) had another diagnosis and 25.7% (n=9) had no diagnosable disorder. This compares to 35.5% (n=22), 29% (n=18), 22.6% (n=14) and 12.9% (n=8) for admissions to AMH wards respectively. A total of 43.9% (n=25) of individuals in the third group had a diagnosis of schizophrenic spectrum disorder, while 26.3% (n=15) had a diagnosis of affective disorder, 14% (n=8) had a diagnosis of an “other” psychiatric disorder, and 15.8% (n=9) did not have a psychiatric diagnosis.

Analysis indicated an association between the type of admission and the presence of an affective disorder ($\chi^2 = 5.521, df = 1, p = 0.019$), with a significantly greater proportion of individuals admitted to the AMH wards having this diagnosis compared to the Weston Unit. There was no association between the type of admission and a diagnosis of schizophrenic spectrum disorder, other diagnoses, or no diagnosis.

### Weston Unit – Diagnosis on Discharge

Diagnosis on discharge was recorded for the Weston Unit group only, to assess whether an inpatient stay on the Weston Unit had an effect on formal diagnosis.

Table 7.2 – Diagnosis on Admission and Discharge for individuals admitted to the Weston Unit (1999-2004)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Admission</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenic spectrum disorder</td>
<td>18 (51.4%)</td>
<td>10 (33.3%)</td>
</tr>
<tr>
<td>Affective disorder</td>
<td>3 (8.6%)</td>
<td>4 (12.9%)</td>
</tr>
<tr>
<td>Other</td>
<td>5 (14.3%)</td>
<td>4 (12.9%)</td>
</tr>
<tr>
<td>No axis III diagnosis</td>
<td>9 (25.7%)</td>
<td>12 (40%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35 (100%)</strong></td>
<td><strong>31 (100%)</strong></td>
</tr>
</tbody>
</table>

A total of 51.4% (n=18) of Weston Unit admissions had a diagnosis of schizophrenic spectrum disorder on admission, compared to 33.3% (n=10) on discharge. There were also small changes in other diagnostic categories.
Pervasive developmental disorder

Figure 8.1 - Percentage of total admissions with pervasive developmental disorder (1999-2004)

Figure 8.1 shows that 14.4% (n=5) of individuals admitted to the Weston Unit had a diagnosis of pervasive developmental disorder compared to 9.7% (n=6) admitted to AMH wards and 21.1% (n=12) of individuals admitted to both types of ward. There was no significant association between the type of admission and the presence of pervasive developmental disorder.

Mental Health Act Status

Figure 9.1 – Percentage of total admissions by Mental Health Act Status on admission (1999-2004)

Figure 9.1 shows that a total of 37.1% (n=23) of individuals admitted to AMH wards were admitted under a section of the Mental Health Act (MHA) of 1983. This compares to 25.7% (n=9) of those admitted to the Weston Unit. Although a smaller proportion of those admitted to the Weston Unit were detained under the MHA, there was no association between the type of admission and MHA status. In contrast, 52.6% (n=30) of individuals accessing both specialist and generic services were admitted formally under the MHA.

Type of Residence on Admission

Figure 10.1 – Percentage of total admissions by residence prior to admission (1999-2004)

Figure 10.1 shows residency prior to admission overall. The majority of individuals admitted to the Weston Unit lived with their families prior to admission (54.8% or n=19). In contrast, individuals living in supported accommodation formed the largest group of those admitted to AMH wards (38.7% or n=24). There was a significant association between type of ward admitted to and residence prior to admission. Specifically, individuals admitted to the Weston Unit were more likely to reside with family prior to admission (χ² = 12.553, df = 1, p = < 0.001) and individuals admitted to AMH wards were more likely to come from “other” forms of residence (χ² = 5.600, df = 1, p = 0.018).
In common with those admitted exclusively to AMH wards, individuals living in supported housing formed the largest group of those admitted to both types of ward (33.3% or n=19). Individuals transferred from psychiatric wards constituted 24.3% (n=14) of the combined group. All of these transfers were from AMH wards to the Weston Unit. No individuals were transferred from the Weston Unit to general AMH wards in SLAM.

**Borough and Type of Residence on Discharge**

*Figure 11.1 – Percentage of total admissions by residence discharged to (1999-2004)*

The type of residence discharged to for each admission subgroup is presented in Figure 11.1. Following inpatient care there was a decrease in the number of Weston Unit admissions discharged back to live with their families (35.5% or n=11 compared to 54.8% or n=19 on admission) One person was discharged to an out of area private hospital. One individual admitted to AMH wards was transferred to an out of area psychiatric ward. However, a significantly larger proportion of individuals accessing the Weston Unit were discharged to live with family members ($\chi^2 = 3.903$, df = 1, $p = 0.048$).

A total of 3.2% (n=1) of individuals admitted to the Weston Unit and 11.9% (n=7) of individuals admitted to AMH wards were discharged out of area. A total of 12.7% (n=7) of individuals admitted to both types of ward were discharged out of area. Since 1999, the overall number of out of area placements has decreased, for example, no AMH ward admissions were discharged to out of area placements in 2003 and 2004. The only out of area placement on the Weston Unit was in 1999. Of those individuals accessing both types of ward, there was only one out of area placement in 2004.

**Discussion**

As recommended in Valuing People most individuals with LD and mental health problems are admitted to generic AMH units but specialist services are also being utilised, either separately or in conjunction with generic services. Fewer admissions to the Weston Unit reflect the unit’s role as a specialist service, arising from planned admissions and fewer beds being available at any given time.

The majority of admissions to both types of ward were male, white, and aged mid or late 30s. Individuals were likely to have mild LD, a diagnosis of schizophrenia spectrum disorder and to be admitted on an informal basis. The majority were discharged to supported accommodation. Despite these similarities, analysis indicated a number of differences in the characteristics of individuals served within specialist and generic inpatient settings. Individuals admitted to the Weston Unit stayed significantly longer compared to those in AMH wards. The longer length of stay may
reflect the special needs of individuals with LD and additional mental health problems as discussed in the introduction and the specific role of a specialist unit in meeting those needs. The specialist unit was created for the use of service users experiencing difficulties requiring inpatient treatment which could not be resolved quickly, therefore the longer length of stay for individuals admitted to the specialist unit is to be expected. Xenitidis et al (2004) found the same trend. The longer length of stay on the Weston Unit may also reflect bed blockage and a lack of suitable places for discharge. It is also likely to reflect increased bed pressure on AMH wards compared to Weston Unit beds and an emphasis on a crisis management approach in the former. The Weston Unit, by being a specialist service, has more time to complete comprehensive assessment and treatment before discharge planning. Therefore differences in length of stay indicate the differences in function of the two types of service, which are designed to complement each other, not compete.

Differences were also observed in diagnostic trends. Although diagnoses of schizophrenic spectrum disorder made up the biggest group for both types of ward, individuals with affective disorders were significantly more likely to be admitted to generic AMH wards. Such diagnostic differences may indicate differences in the clinical needs of individuals accessing generic and specialist services. The higher proportion of individuals with affective disorders using generic services may reflect the need for emergency admissions if individuals are experiencing suicidal ideation. Suicidal ideation would be a clear reason for such an admission, and individuals experiencing suicidal ideation may be more likely to be diagnosed with affective disorders.

Whilst it failed to reach significance a greater proportion of admissions to the Weston Unit had no Axis III diagnosis (a total of 25.7% or n=9). This poses the further question, why did a quarter of admissions to the Weston Unit not have a psychiatric diagnosis on admission? One possible explanation is that those individuals using specialist inpatient services are more likely to present with complex, difficult to classify symptoms and behavioural problems that do not easily adhere to standard diagnostic categories. This may be compared to the finding of Hall et al (in press) of inpatient admissions having lower functioning and being at greater risk (in addition to more unmet needs) yet not significantly differing from service users in the community in regards to clinical factors.

When diagnosis on admission and discharge are compared in the Weston Unit group, there were changes. This suggests that the specialist and comprehensive mental health assessment offered by the Weston Unit may lead to the reformulation of diagnosis. Unfortunately there is no comparable data available for those individuals admitted to AMH wards.

The majority of individuals admitted to the Weston Unit resided with their families prior to admission. In contrast, individuals admitted to AMH wards were more likely to live in supported housing, and to live independently. This difference may again reflect the higher level of needs of individuals using specialist services and an inability to live independently, either needing the support of their family or staff in supported housing schemes. It is also probable that the higher proportion of admissions to AMH
wards from independent accommodation reflect differences in care pathways. Individuals living alone may find it more difficult to access everyday support and monitoring. Thus early warning signs might not be spotted so quickly potentially leading to crisis management. Individuals who reside with their family or in supported accommodation however have continual monitoring and thus services may be alerted more rapidly. A significantly larger number of individuals admitted to AMH wards were also admitted from “other” housing. “Other” included hostels, prison and one instance of homelessness. Like those residing in independent accommodation, it may be that early warning signs are harder to spot when service users live in such forms of accommodation. This may increase the likelihood of emergency (and formal) admission.

Whilst the number of individuals living with their family were the largest group admitted to the Weston Unit, the majority were discharged to supported housing. This may highlight the potential impact of mental health problems in the breakdown of family placements and the role of the Weston Unit in formulating appropriate discharge placements and care packages following return to the community. Due to the specialist nature of the Weston Unit there are resources to comprehensively plan discharge so that the individual is discharged to the most advantageous setting for their individual needs. While AMH wards will also try and discharge admissions to the most appropriate setting, increased bed pressure may decrease the time in which placements are searched for. This also may be a reason for the large number of transfers from AMH to the Weston Unit, as discussed further on.

For both types of ward, individuals with moderate levels of LD were more likely to have longer inpatient stays. This may reflect the more complex needs of individuals with a moderate LD and mental health problems. The discovery that individuals staying for shorter periods of time on AMH wards were more likely to be discharged to independent accommodation may reflect the relative ease of discharge for independent forms of accommodation and the difficulties of discharge to supported housing. Alternatively, these individuals who require supported housing may require more support as an inpatient due to more complex needs, which may extend their stay.

A substantial number of individuals with LD were using both specialist and generic services. Overall, the third group shared many similarities with the two exclusive ward groups. The majority were male, white, with mild LD and without the presence of pervasive developmental disorder. The largest diagnostic group was schizophrenic spectrum disorder and supported housing was the most frequent residence type on admission and discharge. However, there were some notable differences. For example, the majority of individuals were admitted with formal status under the MHA. This is likely to be due to the complex needs of those individuals who require multiple admissions. Interestingly, all admissions included in this audit with a diagnosis of severe LD were found in this group. Some service users admitted to both types of service used these services consecutively (transferred from AMH wards to the Weston Unit) and some used the two different services at different time periods. That some service users have been admitted to
both types of ward at different time periods would indicate that other factors other than clinical profile, such as care pathways and bed availability, at least partly determine what ward individual MHiLD service users are admitted to.

Of a total of 17 transfers, 82% (14 individuals) were transferred from generic wards to the specialist unit. The other transfers were to a psychiatric intensive care unit and two out of area placements. No Weston Unit admissions were transferred to generic AMH wards. This may indicate that individuals with complex needs are transferred to the Weston Unit if a longer period of care in a specialist service is required. This may suggest that AMH wards often utilize the Weston Unit as a treatment option when they feel they do not have sufficient resources for the treatment of these individuals, and that when there are spare beds in the Weston Unit they are used by the service. These resources may include time/bed space as well as specialist staff knowledge in working with individuals with co-morbid LD and mental health problems. An alternative explanation is that service users on the Weston Unit’s waiting list may deteriorate, reaching a level of functioning where emergency admission is necessary before there is an available bed. AMH wards may admit these individuals, transferring them to the Weston Unit when a bed is available. This highlights the interactive nature of generic and specialist services. While the Weston Unit may offer lengthier and more comprehensive assessment and treatment, AMH wards play a vital role in stabilising individuals in crisis situations and ensuring that they receive prompt emergency treatment.

By identifying the service users characteristics associated with the uptake of generic and specialist mental health services by individuals with LD, this audit casts light on the respective roles of each type of service. Several limitations are evident in the methodology employed in this audit. The sample size was small. Some characteristics may have shown significant differences if the sample size had been larger. For example, although a relatively higher proportion of individuals admitted to the Weston Unit had pervasive developmental disorder and were admitted on an informal basis compared to AMH wards, these differences failed to reach the level of significance. It also should be noted that while this audit has described admission trends to both types of unit, it was not designed to compare the quality or type of care received on generic and specialist types of ward, therefore this does not help indicate which service is more effective. Further studies are required to identify the outcomes of each service type and to identify the circumstances, and type of individual, for whom specialist care is necessary and most effective.

Conclusions and recommendations

There are many similarities in the characteristics of individuals admitted to AMH wards and the Weston Unit, but also important differences. Compared to AMH wards, individuals with LD using the specialist service have a significantly longer length of stay.

Those with affective disorders were more likely to be admitted to AMH wards. Those admitted to AMH wards were more likely to be living in supported housing, whereas those
admitted to the specialist unit were more likely to be living with family members prior to admission. These results suggest differences in the characteristics and care pathways of individuals accessing specialist and generic services.

14 individuals were transferred from the AMH group to the Weston Unit group. This may suggest that AMH wards use the Weston Unit as a tertiary treatment option, or that AMH wards initially admit service users requiring admission who are on the Weston Unit’s waiting list if a bed is not available. This demonstrates how the Weston Unit and AMH wards can be used to complement each other.

A combination of generic and specialist inpatient units for individuals with LD and mental health problems may be a suitable way of offering services to a wider number of individuals from this group, while remaining in accordance with the recommendations in the government white paper, Valuing People (DoH, 2001a). However, before further assertions can be made data looking at the overall effectiveness and outcomes of both types of services needs to be examined.

It has been noted in this audit that research directly comparing specialist services with generic AMH services is limited at present. The information presented in this audit is designed to act as an initial comparison between the two types of unit. The following are possible suggestions for future research.

- Outcome data to be collected on admission (baseline), discharge and follow up on both admissions to specialist units and respective generic AMH wards in the location, to be compared. This may take the form of:
  - A research project which co-ordinates the collection of data
  - An audit of routine outcome measures due to be collected as part of The Patient’s Journey
  - A qualitative focus on a selection of admissions to both types of ward to explore their experiences on the ward and in the community following their discharge. Not only will this explore the effects and types of treatment service users experience on both types of ward but may explain why some readmissions happen. For example, from this audit one readmission to the Weston Unit was due to relapse following a bout of pneumonia when the individual was unable to continue psychiatric medication.
  - More detailed recording of psychiatric diagnosis, e.g. a distinction between bipolar and unipolar depression rather than both being recorded as “affective disorder”, a separate category for personality disorder etc.
  - A focus on physical health care. The Weston Unit often explores physical health problems in order to eliminate the chance of psychiatric disturbance being caused by physical health needs, and to offer a holistic care program. A comparison with AMH inpatient services may provide useful data.
References


