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## Specialist psychiatric beds for people with learning disability

### AIMS AND METHOD

To examine the use of specialist psychiatric beds for people with learning disability, created following the closure of a long-stay institution. Admission and discharge data were examined, including history of previous institutional admission, diagnosis at discharge and number of subsequent readmissions.

### RESULTS

Out of 348 admission episodes, 59 were accounted for by 40 patients who were previously resident in the

long-stay institution. Most admissions were for new patients from the community. Over time, admissions to the specialist unit decreased when occupancy reached and persisted at 100%, coinciding with a significant rise in admissions of adults with learning disability to general adult psychiatric wards.

### CLINICAL IMPLICATIONS

Resettlement after closure of long-stay learning disability institutions has not been accompanied by a high

readmission rate for former residents, but neither has there been a decreasing need for psychiatric beds for those with learning disability and severe psychiatric disturbance. Most of these admissions are for people with learning disability who are relatively new to the service. There has been a persistent problem with full occupancy of these beds, which reflects delayed discharges indicating a lack of community resources and an increasing demand for admission.

The closure of long-stay institutions for people with learning disability has been a political and social imperative in much of Western Europe for the past 20 years. In Scotland, the Executive's review of services for people with a learning disability (Scottish Executive, 2000) endorsed the continued programme of hospital closure but also recognised a need for specialist health services. Although the figures for assessment and treatment beds quoted in that report are used as a benchmark, there is increasing concern among professionals that they underestimate the need.

This view is supported by recent reports in newspapers ('Minister in Court. No secure place could be found for Nicol (mental age 6) after he tried to kill himself 6 times in prison', *Sun* 15 September 2005; 'Killed by Special Brew. Woman with known autism died after drinking 5 cans of Carlsberg', *Metro*, 12 May 2006). These items, which report incidents involving people with learning disability who have appeared to require a specialist service, have inevitably been couched in emotive terms. Nevertheless, reports saying that a mother has killed her son who had severe learning disability and Down syndrome because she could not get help with his increasing violence (*Daily Mail* 5 November 2005), and others where the failure to provide a specialist in-patient service has resulted in inappropriate placement in prison or even death are bound to raise levels of anxiety.

In 1994, agreement was reached between Lothian Health Board and the local authorities to close the locality long-stay institutions for people with learning disability and provide staffed residential places in the community. Although there had been a continuous reduction in people living in hospital for many years, the final phase of the process required an increase in funding. Transfer of resources from health to social work was included in the agreement to fund community developments.

Like many areas Lothian had substantial in-patient facilities for people with learning disability, which peaked in the 1960s and 1970s. In 1970 there were 1111 beds occupied (Scottish Home and Health Department & Scottish Hospital Services Committee, 1970) and a substantial reduction in size occurred over the next two decades. The final closure of Gogarburn Hospital and two smaller institutions took place between 1994 and 1999. As part of the re-provision, a specialist psychiatric assessment and treatment unit was created in the grounds of, and is administratively part of the locality general psychiatric hospital (Royal Edinburgh Hospital). The facility provides specialist beds for people with learning disability and additional mental illness, severe challenging behaviour or forensic problems. There are 24 acute beds in the service: 12 beds that are designed to cater for those with severe challenging behaviour in one building and a second unit with 12 beds that were designed to be used for assessment and treatment of mental illness in those with learning disability deemed unsuitable for treatment in a general adult psychiatric ward. Both units are locked and fit the description of low security. In practice the beds for those with challenging behaviour have been used as planned; it was surmised when they opened that the patients would often have severe learning disability and their behaviour problems would require long-term in-patient treatment. The beds in the acute assessment and treatment unit, however, rapidly became filled and it proved very difficult to return some patients to an appropriate community setting. One six-bed ward in the acute unit has become a more secure unit for those who have severe behaviour problems that involve risk of violence. Many have a diagnosis of autistic-spectrum disorder.

This study describes the use of the specialist beds as a component of psychiatric services for people with a learning disability in Lothian. In Lothian beds for general



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adult in-patients are in open wards which do not have any designated beds which can be used and adapted to those with learning disability. Patients with learning disability, who might require extra help with activities of daily living or a locked door to keep them safe, can only be catered for in the intensive psychiatric care unit which is usually used for very disturbed and violent general adult patients.

## Method

Data were obtained on all admissions to the specialist unit from 1 January 1995 to 31 December 2003. Patients were divided into resettled (former in-patients from institutional care) and those who were referred directly from the community. Clinical diagnosis was established from the Patient Information Management System (PIMS) and, where necessary, by examination of the case notes to gather information needed to make diagnoses according to ICD-10 criteria (World Health Organization, 1992); 8 patients were not included as they met criteria for continuing long-term healthcare needs and were direct transfers to the new hospital unit without discharge.

Data relating to admission of patients with learning disability to general adult psychiatric beds were also obtained from PIMS. All patients with a clinical diagnosis of learning disability were identified, and those known to the learning disability service or subsequently admitted to the specialist service were included in the calculations. Those with no active connection to the learning disability service were excluded. This procedure is conservative and restricts the analysis to those where the learning disability could be clearly validated by specialist psychiatrists in learning disability

## Results

### Admission episodes

In the study period, there were 348 admission episodes of which 59 (16.9%) were for individuals formerly resident in a local long-stay hospital (resettled group). The 348 admission episodes were accounted for by 213 individuals, of whom 40 (18.7%) were resettled; 41 individuals had two or more admissions.

### Discharge diagnoses

The degree of learning disability was recorded for 167 of the 213 people admitted; 63% were recorded as having mild, 30% moderate and 7% severe learning disabilities. In addition to learning disability, 244 additional diagnoses were made in these 213 individuals (Table 1); some patients had multiple additional diagnoses.

**Table 1. Additional diagnoses in patients with learning disability admitted to specialist beds (1995–2003)**

Diagnosis (ICD-10)	<i>n</i>	%
Organic mental disorder (F0–9)	3	1
Substance abuse (F10–19)	3	1
Psychosis (F20–29)	51	20
Affective disorder (F30–39)	72	29
Anxiety disorder (F40–48)	10	4
Personality disorder (F60–69)	7	3
Conduct disorder (F90–98)	23	9
Autistic-spectrum disorder (F84)	34	14
Epilepsy (G40)	21	8
Physical <sup>1</sup>	17	7
Identified genetic disorder	8	3

1. Physical refers to any non-psychiatric diagnosis excluding epilepsy and genetic disorders.

## Admissions to general psychiatric beds

Table 2 shows the number of admissions to specialist learning disability beds, the number to general psychiatric beds and the totals for each year since opening.

There is a highly significant upward trend in admissions of people with learning disability to general psychiatric beds (Pearson's  $r=0.812$ ,  $P=0.008$ ). Comparison of the last 4 years with the first 5 shows a highly significant increase of admissions to these beds (independent samples  $t$ -test:  $t=11.11$ ,  $P<0.001$ ) with an associated decrease in admissions to learning disability specialist beds. The reduction in overall admissions is non-significant ( $P=0.105$ )

## Discussion

Until the late 1970s, health services for people with learning disability were based in long-stay specialist hospitals. These provided assessment and treatment as well as long-term social care. At their height such institutions accounted for the care of a quarter of people with a learning disability in Scotland. Since then, the emphasis on a social model of care has integrated more people with learning disability into mainstream society.

People with learning disability make up 2–3% of the UK population. (O'Hara, 2000). Both as children and adults, these individuals are at increased risk of developing severe mental illness and emotional disorder. Up to half will have significant mental health problems at some time in their life (Bregman, 1991; Hassiotis *et al*, 2000).

Adults with learning disability often have highly complex additional needs that cannot be met by current mainstream mental health services. (Bouras, 1999) The Government White Paper *Valuing People* (Department of Health, 2001) states that all people with learning disability should have access to community-based multidisciplinary healthcare, and it has also been suggested that appropriate in-patient treatment should be available when required (Scottish Home and Health Department &

**Table 2. Admission of patients with learning disability to hospital beds (1995–2003)**

	Year of admission									
	1995	1996	1997	1998	1999	2000	2001	2002	2003	
Admissions to learning disability beds, <i>n</i>	55	34	57	31	47	32	30	14	19	
Admissions to general psychiatric beds, <i>n</i>	7	5	7	8	7	21	20	20	16	
Total, <i>n</i>	62	39	64	39	54	53	50	34	35	

Scottish Hospital Services Committee, 1992; Holt & Joyce, 1999).

In the UK, specialist mental health services that can respond effectively to the needs of people with learning disability have now been developed (Lindsey, 2000). Such separate services should, however, not debar people with learning disability from access to mainstream mental health services if they would benefit from them. Indeed, part of the role of specialist learning disability services is to facilitate access to all mainstream healthcare, including mental health services (Hassiotis *et al*, 2000; Lindsey, 2002).

The Scottish Executive's strategic review of services (Scottish Home and Health Department & Scottish Hospital Services Committee, 2000) estimated that, as long-stay hospitals are closed, 4 specialist assessment and treatment beds will be required for every 100 000 head of population. These beds should form part of a comprehensive learning disability service with appropriate community-based staff and resources to help minimise admission. Although the review recognises the need for specialist care, and acknowledges the likely increase in need for assessment and treatment beds, it suggested that much of it can be provided within non-healthcare settings and that access to mainstream services is an important part of the range of services available.

The present study looked at the period before and after the first closure of a long-stay learning disability institution in Scotland. Closure was complete in 1999 just prior to the publication of the strategic review. The population of Lothian is and was around 800 000 for which the review would predict a need for 32 specialist assessment and treatment beds rather than the 24 that exist. This might, in part, be a reason for the increasing numbers admitted to the general psychiatric hospital, but delayed discharges and increased pressure for admission of 'new-to-service' patients must also play major roles.

Although there is no conclusive evidence that specialist learning disability beds are better than general psychiatric beds for those with mild or moderate learning disability (Chaplin, 2004), a recent survey (Cooper *et al*, personal communication) carried out in response to the implementation of the strategic review revealed that 93% of learning disability services in Scotland believed that a dedicated learning disability assessment and treatment facility was the best option. The predominant opinion was that only those who had a mild learning disability and good communication skills and were not considered vulnerable would receive a better service in an adult general psychiatric ward. The proportion of patients with learning disability reported as having been admitted to an 'inappropriate' general psychiatry bed ranged from 4 to

57%. Some of these patients have to be transferred to a general psychiatry intensive psychiatric care unit because of their behaviour, which may be a reflection of their fear and inability to communicate verbally. As clinicians we believe that although there are a few patients with mild learning disability who may require the facility for risk of harm to self or others, usually in response to a psychotic episode, for most patients with learning disability a general psychiatry intensive psychiatric care unit is very inappropriate and can be detrimental. A total reliance on general psychiatric in-patient provision, which may be overstretched anyway, might therefore result in people with learning disability being denied access to appropriate or effective assessment and treatment. A total reliance on social care is also perhaps likely to endanger some patients who require more security or more medical expertise to understand and treat their illness.

Our study had a number of limitations. It was a retrospective case note study and depended on the accuracy of the information in the case notes. It is well known that the accuracy of such data cannot be guaranteed. However, the temporal changes presented here are clear: a reduction in the rate of admissions to specialised beds with an associated rise in admissions to general psychiatric beds. This change coincided with an increasing delay in discharging people both from acute learning disability assessment beds and learning disability rehabilitation beds. In the learning disability beds, at the end of 2003, 11 patients (46%) were regarded as having delayed discharges.

Additional evidence that general psychiatric services have not been available to absorb or manage all those patients with learning disability who require admission is perhaps seen in the recent growth in Scotland of private hospital capacity, particularly in the area of forensic learning disability beds, presumably in response to a shortfall in National Health Service (NHS) and social care provision for this group of patients. Interestingly Preibe *et al* (2005) show growing evidence of reinstitutionalisation in mental healthcare across many European countries. They comment that this is often in the form of forensic beds and they also worryingly point out the increasing numbers of prison placements, which we know from our own clinical work include some individuals with learning disability.

## Conclusions

Deinstitutionalisation has resulted in a greatly improved quality of life for most people with learning disability. The individualised, social care model emphasises rights to



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services and a place in the community. Our study cannot answer the question of whether people with learning disability who are disturbed should be cared for in specialist learning disability units. However, it does indicate that extant and well-developed community services were not sufficient to prevent admission to psychiatric beds and that when NHS specialist beds are unavailable these admissions will tend to be to general adult wards. For some people, the preferred management strategy of admission could not be adopted owing to a lack of appropriate beds, resulting in an unsatisfactory and potentially clinically unstable situation. The response to the data presented here must be to seek ways of providing a better understanding of the in-patient needs of people with learning disability.

### Declaration of interest

None.

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AISLINN CHOKE, MANI V. PERUMAL AND MARY HOWLETT

## Lorazepam prescription and monitoring in acute adult psychiatric wards

### AIMS AND METHOD

This study examines prescription and monitoring of lorazepam on three acute adult psychiatric wards at a university teaching hospital. Retrospective data from 102 consecutive in-patients were analysed.

### RESULTS

There were 83 patients (81.4%) who were prescribed lorazepam, however

45 of these (46%) were never administered it. Indication for lorazepam prescription was documented by the doctor in 35 patients (42.2%).

Administration by nursing staff was documented in the medical notes on 86 occasions (60.0%) and on 32 of these (37.0%) the indication was unclear. On 21 occasions (14.7%) more than 2 mg was given; 13.7% of

prescriptions were not reviewed and 64% of those reviewed after more than 4 weeks.

### CLINICAL IMPLICATIONS

Lorazepam was overprescribed and inadequately monitored, which may increase the risk of dependence.

Benzodiazepines are widely prescribed in psychiatric practice but because of their strong propensity to cause dependence, several guidelines have been published regulating their use (Table 1). There is concern that despite

recommendations from national guidelines, benzodiazepines may be used for prolonged periods, thus risking dependence, and for inappropriate indications on acute psychiatric wards (Vandel et al, 1992; Noble et al, 1993).