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Development and Implementation of a Discharge Pathway Protocol for
Detained Offenders with Intellectual Disabilities

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Abstract

Background. *Building the Right Support*, a national plan for people with intellectual disabilities in England aims to avoid lengthy stays in hospital for such people. Discharge planning is understood to be helpful in facilitating successful transition from hospital to community services, however there is little guidance available to help those working with detained patients with intellectual disabilities and offending histories to consider how to effect safe and effective discharges.

Method. In this paper the development and implementation of a multi-faceted and systemic approach to discharge preparation and planning is described. The impact of this intervention on a range of outcomes was assessed and the views of stakeholders on the process were sought.

Results. Initial outcome data provides support for the effectiveness of this intervention in terms of increased rates of discharge, reduced lengths of stay and low readmission rates. Stakeholders viewed the intervention as positive and beneficial in achieving timely discharge and effective post-discharge support.

Conclusions. People with intellectual disabilities are more likely to be detained in hospital and spend more time in hospital following admission. A planned, coordinated and well managed approach to discharge planning can be helpful in facilitating timely and successful discharges with low risks of readmission.

Keywords: detained offenders, delayed hospital discharge, discharge preparation, discharge planning, Transforming Care

Introduction

Official UK government census data show that a disproportionate number of people with intellectual disabilities (ID), that is 7.7% or one in 13 overall, are detained under Mental Health Act (MHA) 1983 in England (Health and Social Care Information Centre, 2014). In NHS hospitals the number is more than double what would be expected in the general population (5.6% or 1 in 18); this rises to more than five times the expected number in independent hospitals (13.1% or 1 in 8). The median length of stay for male inpatients with ID in NHS hospitals in England and Wales was five times greater (at 31 months) than that (5.8 months) for non-ID male mental health inpatients (Care Quality Commission, 2011). The situation was even worse for female inpatients with ID. Their median length of stay was 11 times longer than for non-ID women mental health inpatients (31 months and 2.5 months respectively).

Delayed discharges of inpatients who are clinically fit to leave hospital are costly for patients and for services supporting them. They can negatively affect therapeutic alliances, disrupt discharge pathways and create dependency in vulnerable groups, including people with ID. The Department of Health (DoH) has acknowledged that delayed discharges can lead to an increased risk of patients experiencing serious incidents on hospital wards (Care Services Improvement Partnership, 2007). This was confirmed in the results of the 2010 *Count Me In* census when it was found that over a three-month period 28% of hospital inpatients with ID had been the victim of one or more physical assaults compared with 11% of non-ID mental health inpatients (Care Quality Commission, 2011). During the same period 30% of inpatients with ID had been physically restrained and 22% had self-harmed. The comparison figures for non-ID mental health inpatients were 12% and 8% respectively.

In summary, people with ID are more likely to be detained in hospital, spend more time in hospital following admission, and experience more adversity within hospital settings

than other client groups. *Building the Right Support*, a national plan to develop community services and close hospital beds for people with ID and autism in England who display challenging behaviour was published in October 2015 by NHS England and its local authority partners (NHS England, 2015). The genesis of this plan was the *Winterbourne View* scandal in 2011 which involved the systematic abuse of people with ID in an independent sector hospital unit run by Castlebeck Care Ltd. in Bristol, England (Department of Health, 2012a). This led to a concordat 'plan of action' that committed the DoH to prevent unnecessary admissions and avoid lengthy stays in hospital for people with ID and autism (Department of Health, 2012b).

In general healthcare settings, discharge planning has been shown to be essential for facilitating effective transition from hospital to the community (Holland, Kanpfl & Bowles, 2013). In these settings, Rorden and Taft (1990) have described discharge planning as involving a process that is made up of a number of phases; the immediate goal of which is to anticipate changes in patient care needs and the long-term goal of which is to ensure continuity of health care. Without good discharge planning, people leaving general hospital settings have difficulties with getting the help they need from a range of agencies at this critical transition point (Bowles, Naylor & Foust, 2002; Tyson & Turner, 2000; Yost, 1995). Mistiaen, Francke and Poot (2007) outlined the core components of general healthcare discharge planning and discerned between *discharge preparation* (interventions during inpatient stays aimed at organising care and preparing patients and community care providers for a smooth transition) and *discharge support/aftercare* (interventions that focus on prevention and problem-solving post-discharge).

It has been suggested by the DoH that delayed discharges from mental health services occur as a result of a number of factors including a lack of partnership working and clear protocols regarding discharge. In its good practice guidance (Care Services Improvement

Partnership, 2007) the DoH indicates that timely and effective discharge is facilitated by: (i) effective clinical leadership; (ii) a clear risk management model; (iii) a defined discharge protocol; (iv) rapid follow-up arrangements; and (v) partnership working across agencies.

Petch, Cook and Miller (2013) interviewed service users concerning the features of health and social care partnership working that led to better outcomes. Co-location of services and multidisciplinary team working were found to be associated with improved outcomes for patients. Also important were specialist partnerships that could support the needs of specific user groups. Partnerships that extended into other sectors such as housing, benefits and the third sector were found to improve outcomes for service users.

Steffen, Kösters, Becker and Puschner (2009) completed a systematic review and meta-analysis of 11 studies involving discharge planning interventions in mental health care with patients with a wide range of mental disorders ($N = 5,456$). These authors suggested that in mental health care the primary objective of discharge planning is ‘to smoothen the transition from in-patient to out-patient care by coordinating fragmented services, and thus to improve patient outcome and medication adherence, to prevent rehospitalisation and save costs.’ Six of the studies included in this review were randomised controlled trials, three were non-randomised controlled trials and two were cohort studies. Discharge planning interventions resulted in significantly lower readmission rates, higher adherence to treatment following discharge, and better mental health outcomes compared with control conditions.

Effective planning can prevent delays in the discharge of clinically fit patients from hospital and can improve clinical outcomes following discharge. However, within secure settings there are no specific guidelines concerning effective discharge planning. With this in mind we set out to develop a discharge pathway protocol for detained patients in secure services that was based on the available evidence and reflected the particular needs of patients with ID and significant forensic histories who have ongoing clinical and risk

management needs at the point of transition from hospital to community services. This service development project and preliminary outcomes are described and discussed in this paper.

Method

Setting and Participants

This project took place in an 18-bedded locked rehabilitation unit (Alnwick Unit) for men that was located within the forensic service of a National Health Service (NHS) Foundation Trust hospital (Northgate) in northeast England which provides specialist secure services to people with ID referred by statutory health and local authorities, the courts, and prison and probation services. The forensic service has several units providing medium secure, low secure, and locked rehabilitation facilities.

The population served by this service is relatively high functioning intellectually – that is, mild/borderline in learning disability terms (Hogue et al., 2006), shows high levels of psychiatric comorbidity (Alexander et al., 2011), personality disorder characteristics (Taylor & Novaco, 2013), and outwardly-directed high impact offending behaviour that has resulted in criminal convictions and/or detention under the Mental Health Act (MHA) 1983 on the basis of ‘abnormally aggressive’ and/or ‘seriously irresponsible’ behaviour. Chief amongst the behaviours that bring these patients into these services are serious violence and aggression, sex offences, damage to property and firesetting (O’Brien et al., 2010).

Generally patients are admitted to either medium and low secure units within the service where following careful clinical assessment and formulation patients receive offence focussed interventions including anger, sex offender and firesetter treatment. Having completed these interventions patients usually move to rehabilitation units where the emphasis is on preparing for a successful re-entry to the wider community.

The clinical team on Alnwick Unit is multidisciplinary with representation from a range of disciplines (nursing, psychiatry, psychology, occupational therapy, speech and language therapy and day services staff). Following the introduction of extended statutory professional roles in the amending MHA 2007, from September 2010 onwards clinical leadership of Alnwick Unit was shared between psychology and psychiatry responsible clinicians (RC). Patients were allocated to a particular RC depending on their primary clinical needs.

Discharge Planning Intervention

A discharge pathway protocol was developed by the unit's clinical team in collaboration with patients and other stakeholders including colleagues from community health and social care services. The protocol takes into account DoH guidance and the limited evidence available in the literature. It comprises a number of core components that are delivered both pre- and post-discharge stages of the pathway. The components of the protocol are implemented in a manner that reflects the needs of individual patients and can be applied flexibly in terms of order and pace.

Pre-Discharge Phase

(i) *Pre-discharge planning meetings (PDPM)*. These meetings take place between the scheduled care programme approach (CPA) meetings to ensure progress is maintained with developing plans for the patient's discharge. These meetings are led by the RC and are attended by the unit clinical team and community colleagues involved in the planning process. Initially this will include the social worker/care manager and community care coordinator (community nurse). In the later stages the identified community service provider will attend these meetings. The patient does not routinely attend but his solicitor, independent mental health advocate (IMHA) and family members can attend and are able to reflect the views and preferences of the patient.

(ii) Identifying a community service. During initial PDPM meetings, the clinical team and other stakeholders work to identify an appropriate service to meet the patient's clinical needs and manage their forensic risks. This process involves a number of discrete stages:

- A service specification is drafted using a specially designed template which outlines the patients' clinical needs and extant risks on discharge.
- The care manager then uses the service specification to ascertain if there are any services which could meet the required needs of the patient.
- Once a service or services have been identified members of the clinical team and the care manager will visit these potential services to ensure that risks can be managed safely and quality of life needs are addressed.
- The views of the clinical team and other stakeholders are then canvassed within a PDPM meeting and a preferred service is then agreed.

(iii) Identifying a programme of occupation. In parallel with the identification of a community service, a schedule of occupation and leisure activities is developed. This varies from patient to patient based on their needs and interests and informed by occupational therapy assessments. The development of a post-discharge structured timetable of meaningful occupation and activity is an essential component of the discharge planning process.

(iv) Securing funding. At this stage the care manager will approach the responsible local authority and clinical commissioning group (CCG) seek funding approval for the package of care (accommodation, service provider support, occupation) which has been identified for the patient through the planning process.

(v) Transition plan. Once funding has been approved by the responsible authorities a transition plan timetable is agreed at either a CPA or PDPM meeting. Transition plans usually involved the following sequential stages:

- Orientation visits to the hospital unit by members of the receiving community support team.
 - Orientation visits to the community service by the patient (supported by hospital staff).
 - Patient visits to the receiving community service in the care of the receiving staff support team.
 - Patient attends identified community-based occupation/education/leisure activities.
 - Overnight leave to the community service in the care of the receiving staff support team
- The patient's response to each stage of the plan determines the length of time for progression to wards eventual discharge.

(vi) *Risk management planning workshops (RMPW)*. The RMPWs are facilitated jointly by the clinical psychologist working with the patient and the named nurse. Frequently they are delivered in the identified community placement to the service provider support team, occupation services staff and other relevant professionals who will be involved within the patient's care within the community, for example community nurse, psychologist, social worker. The aim of the workshops are to facilitate a seamless transition from hospital to the identified community placement by:

- Sharing information about the patient's background, family, development, offending history, treatment, current care plans, strengths, needs, etc.
- Considering the patient's risks.
- Sharing ideas on how the patient's risks can most effectively be managed within the community setting.

The workshop focuses on discussion of the patient's forensic risk management needs.

Participants work together to identify and consider:

- Why the patient presents the risk they do?
- Who is affected by the identified risks?

- How is the patient's risk behaviour displayed?
- Where and when are high risk situations likely to occur in relation to this risk?
- What are the likely consequences of identified risks?
- What strategies can be put in place to reduce the likelihood of the risk occurring?

The workshop facilitators outline the risk management strategies that are in place within the hospital environment to provide a frame of reference to guide the development of strategies relevant to the patient's proposed community placement. Working in small groups the workshop participants look at adapting effective hospital care plans to be relevant to the proposed community placement setting.

A RMPW report detailing the discussion and provisional risk management plans from the workshop is written members of the clinical team and sent to all stakeholders within seven days of the workshop.

(vii) Care planning/risk management planning. Following dissemination of the RMPW report the clinical psychologist and named nurse meet separately with key staff from care and day service providers to discuss the draft care and risk management plans utilising the templates used within their own services. The social worker and community nurse are also invited to join this meeting. This is a collaborative meeting where suggestions and queries are addressed and any amendments made. A large part of this work involves cross-referencing care plans and risk management plans.

(vii) Discharge. Patients detained under civil and unrestricted criminal sections of the Mental Health Act (MHA) are discharged from hospital at the appropriate stage by the RC, usually onto a Community Treatment Order (CTO) so that they can continue to receive the care and treatment they require in the community. Patients subject to restricted criminal sections they are required to apply to the Secretary of State for Justice or a mental health tribunal for conditional discharge from hospital at an appropriate point.

Post-Discharge Phase

(i) RC transition period. For three-six months following discharge from hospital (either on a CTO or a Conditional Discharge), the inpatient RC remains the RC for the patient to ensure continuity of care during this transition period. This means that if during initial period significant problems occur then the inpatient RC can recall the patient to the unit from which he was discharged to try to deal with the issues quickly with a familiar staff team and environment. The patient receives regular RC reviews within their new placement during this transition period (usually one per month) to check on progress and monitor clinical and risk management needs. If there are no concerns following discharge then responsibility for patient's care and treatment is transferred to the community RC at a pre-arranged post-discharge CPA meeting.

(iii) Consultation with the hospital clinical team. In addition to continued RC involvement, the hospital clinical team (clinical psychologist and a member of the senior nursing staff) continue to offer consultation and support to the patient and direct support and advice to the service provider team and community learning disability team. This support takes the form of post-discharge consultation visits to the patient within their community placement. During these visits the focus is on current progress and reviewing care and risk management plans in light of the experiences which living in community provides for the patient and his support network.

Following this work the clinical psychologist writes a summary letter outlining the input provided and recommendations made which is sent to community service provider team, RC, care coordinator and care manager.

(iii) Forensic outreach clinics. An additional component of the post-discharge intervention available to patients discharged from hospital is attendance at monthly multidisciplinary outreach clinics provided by the hospital clinical team in local community

areas. Discharged patients and their families, carers and professional supporters are invited to discuss progress and any emerging issues with the clinic team that comprises a consultant psychologist, nurse consultant and consultant psychiatrist (one of whom is likely to be the patient's RC during this transition period). This aspect of the discharge pathway protocol allows for an authoritative oversight of the patients aftercare to ensure that agreed plans are being adhered to and resources are available to support the patient's successful transition from hospital to community living.

Discharge Pathway Protocol Outcomes

The primary aim of the discharge pathway protocol was to facilitate the safe and effective discharge of complex patients in a timely fashion by ensuring that their needs are met and risks managed successfully thus preventing readmission to hospital. Figure 1 shows that between October 2011 and September 2015 the Alnwick rehabilitation unit where this project took place worked with a total of 67 patients. Over this four year period a total of 48 of the 67 patients (72%) were discharged from the unit. Thirty-seven (55%) were discharged to community placements and 11 (16%) were transferred to other units/services (a mix of other secure units within Northgate hospital and services more local to the patient's origins), and a further five (7.5%) had active discharge plans for discharge to community settings at the end of September 2015 (and were subsequently successfully discharged). One patient died during this period. Just three (4.5%) of the 37 patients discharged to community settings were re-admitted to hospital during this period. These patients were subject to hospital recall and then revocation of their CTOs due to escalating risks of harm to themselves or others.

Discharge Rates

The rate of discharge from Alnwick Unit during the project period remained quite stable over the first three years (7, 6 and 8 discharges respectively) but jumped by 100% to 16 discharges during the year 2014/2015 (see Figure 2).

Length of Stay

The mean length of stay in hospital for the discharged group of 37 patients was 6 years 1 month - ranging from 2 months to 22 years 6 months. As can be seen in Figure 3, the mean length of stay on Alnwick Unit during the four year period of the discharge protocol project reduced by over 60% from 39 months (3 years 3 months) to 14 months (1 year 2 months).

Stakeholders Views

During the project period the views of a range of stakeholders were sought on the utility of the discharge pathway protocol via an e-mail survey. Stakeholders were asked to respond to following questions:

1. Have you found the discharge planning protocol used on Alnwick Unit useful/helpful?
2. If yes, then what aspects/components of the protocol have been useful/helpful?
3. Would you support/recommend the discharge planning protocol being extended to other Northgate hospital forensic units/wards?

Out of a total of 33 people who were approached, 13 (39%) stakeholders responded to this request. Respondents included community nurses, clinical psychologists, consultant psychiatrists, social workers, community service providers, a CCG commissioner and a solicitor working in the Sunderland, Newcastle, Durham, Cumbria, and Northumberland areas.

All respondents reported that they found the discharge pathway protocol to be useful and helpful and they all indicated that they would recommend that the protocol is used in other secure units within the hospital's forensic service. Survey respondents identified four key areas in which they found the protocol to be useful/helpful.

1. Clarity of the Process and Roles

Respondents reported that the discharge planning protocol provided clarity for everyone involved. It was viewed as “a useful framework as it gives clarity to the identification of what needs to be done, when and by whom” (community nurse). This clarity was achieved by “setting out the processes/steps that need to be completed for a person to be discharged” (social worker) and by defining “clear roles and responsibilities” (clinical psychologist) and “priority events and tasks” (social worker). Compared to what came before, the protocol was said to provide “definite improvements upon what could sometimes be a fragmented process” and ensured that “a plan can be developed which helps prevent ‘planning drift’” (social workers).

2. *Partnership Working*

Respondents commented that the protocol “has been particularly helpful...bringing together all relevant parties from within the hospital and meeting with the relevant parties involved in community supervision” (social worker), which has “removed the 'silo' effect of hospital” (social worker). The bringing together of stakeholders was viewed positively as it “enhances decision making and brings together professionals who should work towards common goals” (commissioner) and enables people to “work alongside” one another (service provider) towards a common goal.

3. *Risk Management Training*

The specialist training (in the form of risk management planning workshops) provided by the hospital clinical team was considered to be an “element which is most useful” (community nurse) and was identified as a core component within the discharge planning process. The workshops were identified as providing “supportive training which has been...extremely valuable” (service provider). They provided community colleagues with “the tools and information to assist...with a very smooth transition for individuals moving from a hospital to a community placement” (service provider) and “aids in the development

of knowledge and presenting issues of the patient” (community nurse). The collaborative ethos of the workshops was echoed in many of the responses with workshops being noted to “have given us, as a team, an opportunity to not only identify risks but to talk openly and find solutions and protective measures to put in place to minimise these risks” (service provider).

4. Post-Discharge Follow-Up

The follow-up support provided following a patient’s discharge was reported to be “positive” (community nurse) and “invaluable” (service provider). It provided the “chance to discuss any unforeseen risks associated with community living and to review the care plans accordingly” (service provider). This outreach support was viewed as essential in ensuring the success of the discharge as it provides “continuity post-discharge...this will all maximise success of the service in reintegrating the service users into community provision safely” (social worker).

Discussion

The good practice guidance provided by the DoH and the limited research evidence available indicates that discharge planning is important in helping patients in mental health services to achieve successful transitions from hospital to community living with lower readmission rates, improved adherence to treatment and better mental health outcomes following discharge. There is little available in the literature to guide discharge planning for patients detained in secure services. In prisoner healthcare settings the importance of continuity of care is acknowledged, however discharge planning from these settings is considered to be inadequate. Prisoners leave prison with little or no support resulting in a range of negative health outcomes associated with prison release, including increased drug-related deaths and suicide (Dyer & Biddle, 2013). Fazel and Baillargeon (2010) considered discharge planning from prison healthcare to be variable at best and in need of improvement; and the Care Quality Commission and Inspectorate of Prisons (2010) reported that

commissioners of prison healthcare should address the care provided during transfer and release.

The needs of people with ID and offending histories detained in hospital are in turn distinct from inpatients with learning disabilities, those with general mental health problems or prisoners with (mental) healthcare problems. The high level of clinical complexity and associated forensic risk exhibited by detained offenders with ID can require significant periods of assessment, formulation and specialist treatment to help them to develop thinking styles and attitudes, emotional control strategies and lifestyles less compatible with criminal and offending behaviour.

Clearly these patients should not be detained in hospital any longer than necessary. However, the assumptions underpinning the *Building the Right Support* national plan and its associated Transforming Care programme are that people with ID should be prevented from accessing hospital services whenever possible and that hospital admissions that cannot be avoided should be as short as possible. This is potentially discriminatory and damaging to vulnerable people who will be at risk of exploitation and neglect as well as re-offending unless sufficient time is given to developing carefully constructed, well-led, properly managed and coordinated plans to facilitate transition from hospital to community living. Preparing the patient to take on the huge gulf between hospital treatment and treatment in the community, and helping him and the services receiving him to translate the treatment gains achieved in hospital into approaches that are transferrable to the wider community requires patience and time. It cannot and should not be rushed in order to meet some arbitrary policy goal. It should be done at pace that suits the patient and meets his clinical and risk management needs.

The discharge pathway protocol developed and described in this paper provides a framework for achieving discharges from hospital that is consistent with good practice

guidance including the incorporation of a clear risk management model, partnership working across agencies and sustained follow-up arrangements. In addition, the introduction of RCs from professions other than medicine has helped with the development of a more effective distributed clinical leadership approach. Together these innovations have provided patients with better prospects of achieving a successful step down from hospital care. The low readmission rates of patients discharged over a four-year period from Alnwick Unit would indicate a degree of success in this regard.

It has become clear to us in implementing this protocol that it is, in effect, a multi-faceted systemic intervention that to be effective requires understanding, buy-in and support from all stakeholders (the patient, the patient's family and advocates, the hospital clinical team, community health and social care colleagues, and commissioners). The responses of stakeholders who were surveyed concerning the utility of the newly developed protocol suggest that this was achieved to some extent and to good effect.

All aspects of the unit's work needs to be focussed on achieving a successful transition from hospital for patients. The work involved in achieving this cannot be done efficiently or effectively in a clinical area that is also dealing with the stabilisation of disturbed patients at the point of admission to hospital or providing active criminogenic interventions to patients with significant offending histories. A dedicated rehabilitation space and environment is required to develop and embed this model.

The benefits of this holistic approach to discharge preparation and planning are signalled in the preliminary outcome data provided in this paper. As the discharge protocol model became better understood by staff, patients and stakeholders the discharge rate increased significantly and associated with this the length of stay on the unit reduced markedly. Once embedded, the model began to 'pull-through' patients to the point of discharge and 'planning drift' was minimised.

The approach to organising and guiding discharge preparation and planning described in this paper requires further refinement and evaluation. Testing this approach with a control condition – such as ‘treatment as usual’ – would be beneficial. Longer term follow-up of the patients helped to leave hospital in this project, particularly in terms of readmission rates and re-offending behaviour would be of significant interest. Finally, an attempt to learn about and describe the patient’s views of and experience of this approach to discharge planning is essential for the future development and improvement of the model.

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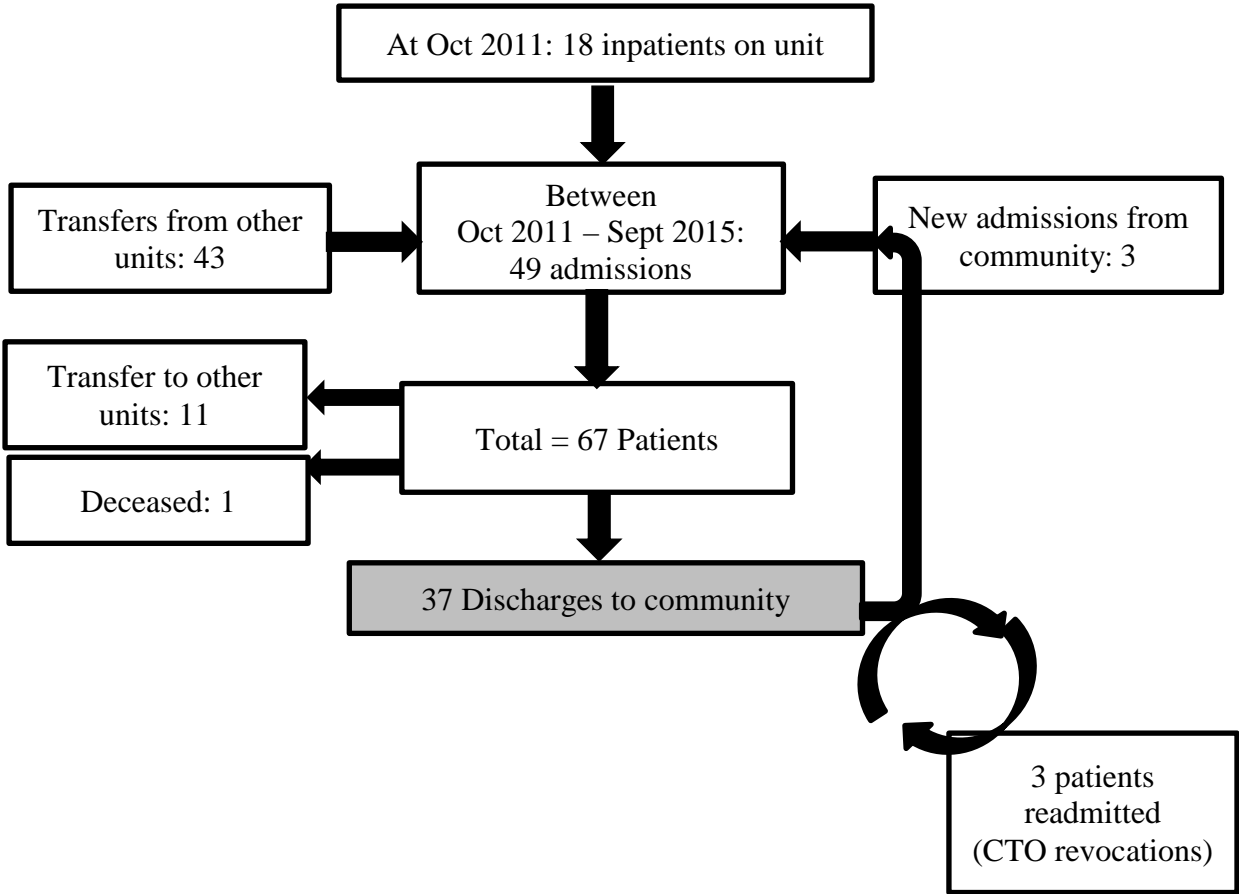
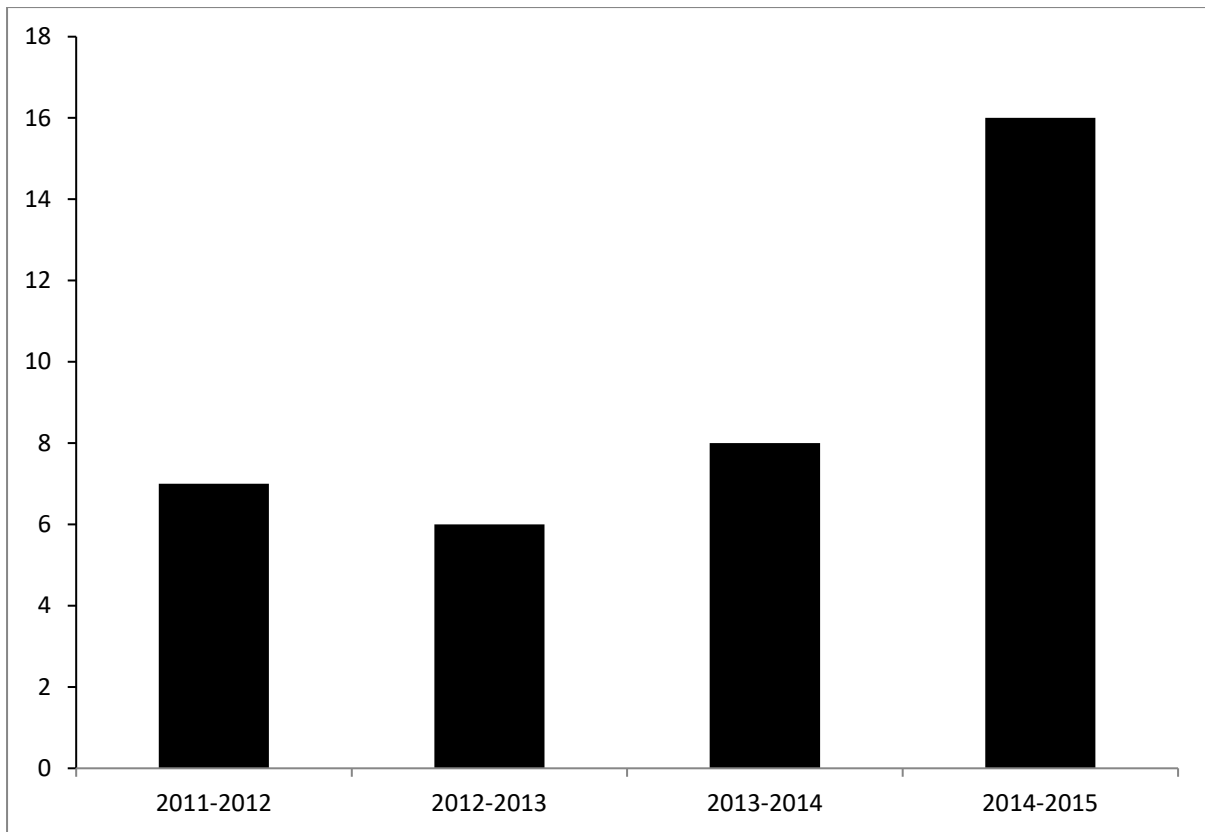


Figure 1. Locked rehabilitation unit patient flows between 1st October 2011 and 30th September 2015.



*Figure 2.*Numbers of discharges from the locked rehabilitation unit during the project period.

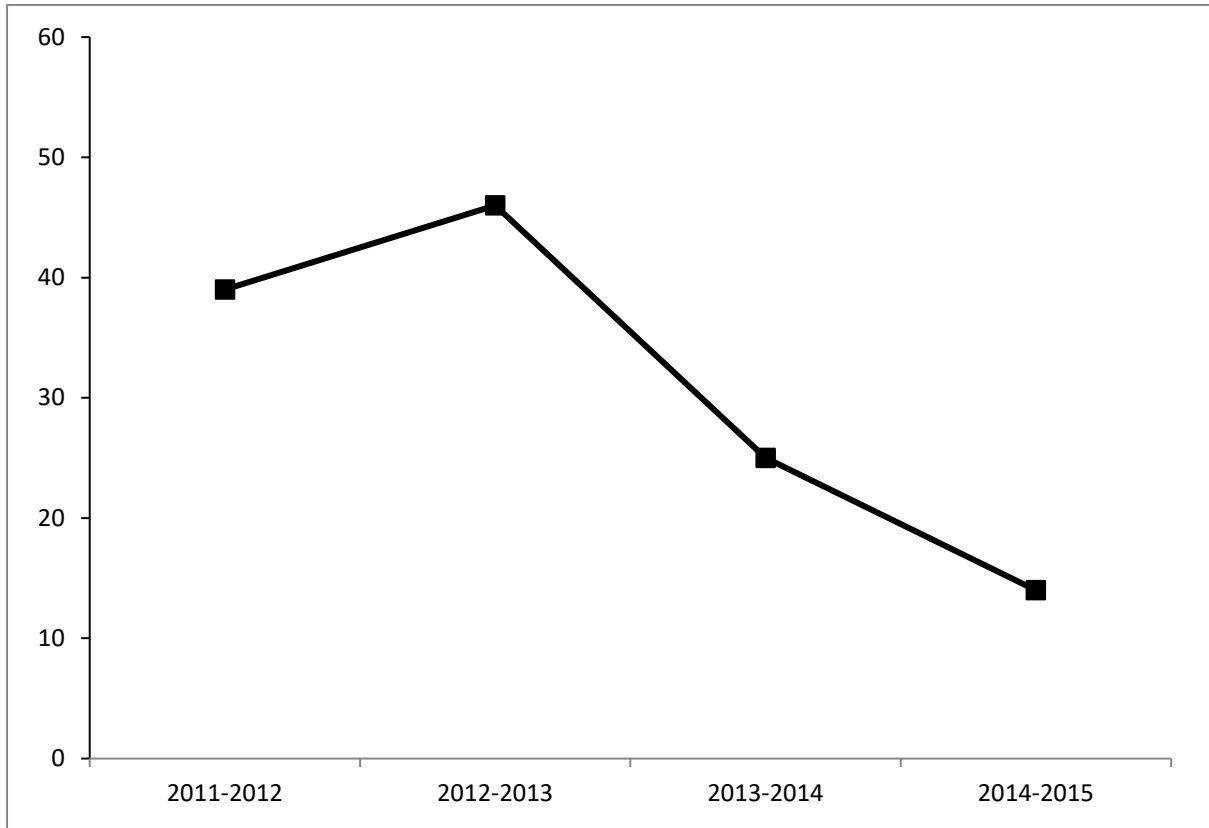


Figure 3. Discharged patients' mean length of stay in months on the locked rehabilitation unit during the project period.