Building Bridges

The use of Bridging Support to help people leave ATUs

A DISCUSSION PAPER FROM THE CENTRE FOR WELFARE REFORM

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Preface

The authors have written this paper to draw attention to Bridging Support as an effective, but still too rarely used, solution for getting people out of Assessment and Treatment Units (ATUs) (usually hospital units).

Ashleigh Fox works for LD Network, whose work this paper describes.

Ashleigh led the development of the Bridging Support model which was developed from her own personal experiences as a Learning Disabilities Nurse, providing support to people in order to avoid crisis escalating and the subsequent use of institutional care settings. Ashleigh was also the whistleblower who raised the initial alarm at Winterbourne View where she worked at the very start of her career.

Chris Watson leads Self Directed Futures and leads work on self-directed support for Citizen Network, a global non-profit cooperative. Chris identified the work of LD Network to be one of the missing ingredients in the strategy to close ATUs, and to effectively support people as full citizens in their community.

The authors hope that more commissioners will adopt this ethical, pragmatic and effective approach which can help end the scandal of ATU admissions and ultimately bring this system to an end.

1. Where are we now?

There are still too many adults with learning disabilities trapped within the healthcare system in assessment and treatment units. Many of whom we know are ready to be discharged but due to a lack of social work capacity, local housing and or support options to help them move back to their communities they continue to remain in inappropriate environments.

A recent review by the Centre for Disability Research on the impact of the government's *Transforming Care Programme*, which was designed to drastically reduce inpatient numbers, suggests that the numbers of people with learning disabilities and/or autism who are in high cost out of area independent inpatient hospital units may have only reduced by about 14% since 2015, from 2,885 people to 2,495 (Brown et al, 2019).

Based upon these numbers the Transforming Care programme has failed to deliver the whole system change it set out to achieve and has in fact only made a small dent in inpatient numbers overall. In his article *Breaking the ATU Impasse* (2017) Steven Rose identified the following barriers to people moving out of hospital.

These are as relevant in 2021 as they were back then and include:

- private hospitals aiming to maximise inpatient numbers to maintain profitability
- poor strategic commissioning
- risk averse local authorities
- bureaucratic procurement procedures
- mistrust of providers
- failing to give families and people with learning disabilities more control

Rose (2017) also identified several approaches that are shown to work in accelerating discharges from ATUs.

These key ingredients included:

- trauma based approaches to care
- ongoing support for families as well as the disabled person
- circles of support

- trusting experienced providers to get on with the job
- light touch commissioning or the use of Individual Service Funds or Personal Health Budgets
- ongoing investment in training and upskilling the workforce
- paying above the living wage
- carefully planned bespoke packages of support
- giving families more control

In, *Close Down the ATUs* (2019), Dr Simon Duffy argues a straight choice we face as a society: we can either continue to fund a system that is harming people, or we can commit to closing them down: "*There is no halfway house.*"

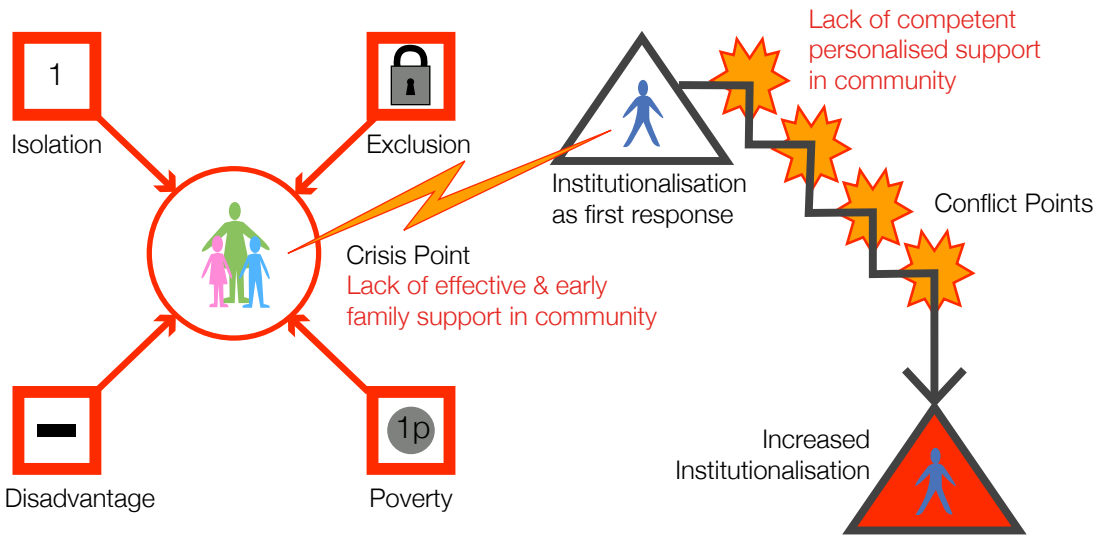

Figure 1. Returning Home: Piloting Personalised Support (2013)

As much as we would like to see this happen quickly, the ATU and inpatient ecosystem has grown large and complex and will require whole system changes to break through the log jam.

Several key barriers have emerged over time to making this transformational change including:

- **Lack of local, early intervention** - When people and their families experiencing a crisis there is no early support or intervention before things arrive at the last resort: an admission into an ATU for 'behavioural issues' instead of a mental health diagnosis and suitable support or treatment at home.
- **Limited options** - Disjointed budgets and lack of whole system approach to funding means that preventative and crisis services are seen in isolation and are often not adequately funded, which shunts costs into other parts of the system.
- **Reality gap** - Decision makers and policy setters often do not have hands-on experience in supporting people with 'complex' needs and may have little understanding of the services that they commission (often having little or no direct contact with the people under their 'care' and their families). Being removed from the day-to-day realities of ATU settings makes it difficult to fully understand and observe the negative impacts on individual lives that result from spending time within these institutional environments.
- **Accountability** - Multiple tiers of managers and associated bureaucratic systems remove public accountability for the impact of poor decision making within the whole system.
- **Finance** - Private 'hospitals' are often driven by finance-related interests at a very high level – shareholder engagement often pushes a 'fill the beds' and 'maximise profit' mentality. This is a perverse incentive for making people well again.
- **Closed Cultures** - Hospital staff may be drawn into unintentional 'closed cultures' leaving them unable to recognise poor practice and the long term detrimental impacts of people staying in institutional settings.
- **High turnover and burnout** - Hospital environments, which contain and restrict inpatient liberties and are system-centred rather than person-centred, are often difficult places for people to work. This often leads to the 'burn-out' of support staff, and inpatients being served notice and shunted around into other hospitals sometimes deeper into the system – and so the cycle begins again.

Much more needs to be done to prevent this cycle of institutionalisation which serves to do the opposite of making people better, by dehumanising them, stripping away rights, and over time stripping them of existing skills and capabilities. There is a vicious cycle at the heart of the institution which can easily pull people down and trap them for years as Figure 2 from *A New Way Home* illustrates (Brown & Dalrymple, 2021).

Figure 2. The vicious cycle at the heart of the institution

2. Where do we want to be?

We know that with the right supports in place everyone can live as a valued citizen within their community and that nobody should be stuck inside an assessment and treatment unit after they have recovered.

Local Authority and NHS commissioning arrangements around housing and support sometimes mean that it is difficult to help people out of these settings quickly, often due to the lack of available suitable support providers and the need for bespoke accommodation. This means it can take years to discharge people back into community settings post-treatment when, with the right approaches in place, the process could have been completed in months.

The complexities of these problems often act as a barrier to discharge, with different service and organisational silos unable to coordinate themselves effectively to facilitate the design of the type of holistic support arrangements that people need to leave hospital successfully.

This brief paper focuses on a new approach that builds a temporary wrap-around team around the person while they are still in hospital and, for some people, is an option that can significantly speed up their move on from these inpatient settings where they have been 'stuck' for far too long.

It starts by working with commissioners who commit to accelerate individual discharges, and then by working creatively alongside people, families, housing providers and innovative organisations to bring about the move on for people using something that we call Bridging Support.

This approach was first tested by an organisation called *LD (Learning Disabilities) Network* three years ago and has since been used successfully to make positive impacts around the country, accelerating people with learning disabilities discharge from hospital and into their own homes.

What are the challenges?

Creating skilled and flexible support teams that can stick with a person for as long as required, regardless of the setting they live in, creates support options in a variety of different scenarios, these include:

- Preventing crisis at home – Providing support to people either in their own home, the family home or existing supported or residential accommodation can prevent crises from escalating into hospital admissions.
- Preventing further crisis and escalation in hospital – Institutional settings such as assessment and treatment units still fail to provide the support that people often need. Sadly this can and does lead to people moving deeper into institutional systems – often into secure environments which can make it even more difficult for people to be discharged back into their communities.
- Getting people out of hospital faster – Often people are ready for discharge from hospital but other factors delay this, in particular not being able to find a support provider or when a chosen support organisation is having difficulties with recruiting a team of support staff.

Designing a new approach

The vision behind Bridging Support was to create teams of like-minded and highly skilled people who understood both the complex reasons people find themselves in hospital in the first place and that there are sometimes relevant reasons for people to need inpatient treatment. These teams are driven by their values and are committed to helping people with learning disabilities achieve citizenship within their own communities.

How Bridging Support can help in hospitals

Step 1. Get to know each person within the hospital setting and build a picture of their past, present and what they want from their future good life.

Step 2. Work to match each person with members of the LD Network team by looking at shared interests, skills and personality characteristics.

Step 3. Be alongside the person in the hospital setting as part of their 'inpatient' support team forging a relationship and helping people to make their voice heard within the institution.

Step 4. Provide advice and support to each person and their family, help them identify suitable housing and support arrangements using a network of like-minded organisations and working with people, families and commissioners to broker these.

Step 5. Help the person to move into their new home and provide all the support that is required and for as long as is necessary.

Step 6. Work with the incoming support provider organisation allow them time for person-centred matching, recruitment, and training processes to ensure that everyone involved is the right 'fit' for each person.

Step 7. Gradually reduce the support from LD Network support as the incoming support provider takes over until everything is established and working well.

Step 8. Stay around in the background with a team that know each person well – ready to support at short notice if there are any issues, providing stability and consistency as people establish their new lives in the community.

What the LD Network have learned

It is always preferable that people choose their future support arrangements and move out of hospital with minimal delay and with the fewest number of disruptive transitions and handovers. As such the LD Network encourage commissioners to work with each person to identify a suitable permanent support organisations whenever this is possible and to help facilitate this process.

Bridging Support is therefore definitely not always the first-choice option; but it can make a big difference, often working well when people have been stuck in hospital for a long time waiting for support arrangements to be organised and where there may be difficulties and delays in finding a suitable long term support provider. In this scenario having one central bridging organisation throughout the person's transition, with shared accountability, propels things forward and can significantly accelerate the person's move back home.

Over time several key lessons have emerged from using this approach in practice including:

- **Advocacy:** It is important to advocate strongly alongside people and families, supporting them to take as much control as is possible and cutting through 'serviceland' jargon. Getting to know people well and being aware of past traumas and experiences that have shaped them. Developing strategies and support systems that can help people rebuild their lives over time, heal and recover from being institutionalised.
- **Consistency:** This is key in every single way - the last thing people want, or need is to repeat their stories over and over. Having a single and consistent team to support people moving on makes a big difference.
- **Valuing support teams:** Support workers need to consistently be recognised personally and financially for their efforts in bringing personalised, care and support to people.
- **Supporting wellbeing:** There are some incredible community and hospital-based professionals working in multi-disciplinary teams, all wanting to make a real impact in their roles. The nature of institutional regimes means that good people will continue to be lost through work-related stress and frustrations thereby further degrading the quality of inpatient settings.

- **It's the small things (that are actually the big things)**: Every single person is different and, in this scenario, having a stable team around someone gives us the opportunity to look at all the intricacies meaning that we can support the development of a truly individualised service design.
- **Owning mistakes**: As people working in a 'sector', we need to come to terms with and take ownership of the fact that we have (and still do) made significant mistakes. We also need to recognise that we can't do it alone, and the experience we have as a collective makes space for every single person to sit at the table and share their views and ideas.

3. What next?

The LD Network forms only one part of a jigsaw of interlinked services and systems that support people to move out of ATUs and on to achieve good lives in their own homes.

Alongside this network there are also many fantastic organisations working to help people out of institutional settings through life planning, long term advocacy, support brokerage and delivering commissioning systems change through new forms of individualised contracting and funding.

Together we have both a stronger voice and an ability to better organise ourselves to support wider scale system change and the overall reduction in ATU bed spaces.

Over the coming years we would like to continue to widen and develop this alliance of different organisations, working across organisational boundaries, sharing skills, knowledge and learning to help people with learning disabilities get out of, and stay out of ATUs permanently.

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ABOUT THE AUTHORS

Ashleigh Fox is a qualified RNLD with almost 20 years of experience in healthcare. She is the Director of Transforming Care at LD Network, and is passionate about the Neurodiversity Movement, with a firm belief that different ways of thinking is the key to progression for humankind.

As the Director of Transforming Care at LD Network, she works with care providers, service users and families to help make tangible steps towards getting people back home from hospital placements. Ashleigh's dream is to work with like-minded people to win the war on attitude change within our communities. She believes that the inequalities in society must be tackled through open and honest communication, and Ashleigh is determined to play her part in breaking down the complex barriers that prevent people from living the rich and fulfilling lives that they deserve.

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Chris Watson is the founder of Self Directed Futures and has over 21 year's experience of working across the public and voluntary sector in the fields of health and social care commissioning and community development, with a strong focus on working with people with learning disabilities to achieve citizenship within their communities. He is presently a Fellow at the Centre for Welfare Reform and a Fellow at the Royal Society for Arts, Manufactures and Commerce.

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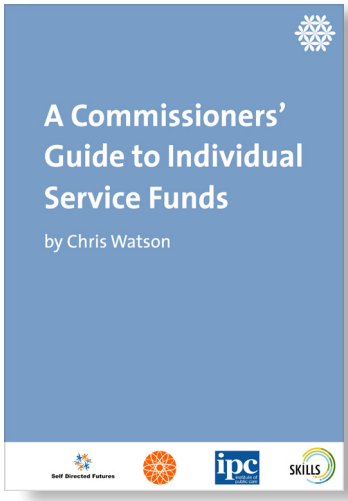

You may also be interested in:

A Commissioners' Guide to Individual Service Funds

This guide written by Chris Watson offers a commissioner's perspective on how to implement Individual Service Funds and widen self-directed support beyond Direct Payments.

The guide is available to read at:
www.centreforwelfarereform.org

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SELF-DIRECTED SUPPORT NETWORK

Self Directed Futures and the Centre for Welfare Reform are members of the Self-Directed Support Network (SDS Network). The SDS Network is made up of organisations who are leading work in their home country or region on self-directed support, particularly those working alongside people with intellectual disabilities and their families.

Our goal is to work in partnership with other European and International bodies, especially those led by disabled people, and to help ensure we can achieve citizenship for all.

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