Building Bridges

The use of bridging support to help people leave Assessment and Treatment Units (ATUs)

A DISCUSSION PAPER FROM CITIZEN NETWORK

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Preface

The authors have written this paper to draw attention to **Bridging Support** as an effective, yet under utilised, solution for facilitating the discharge of individuals from **Assessment and Treatment Units (ATUs**).

As of December 2024, NHS England reports that approximately 2,495 individuals with learning disabilities and/or autism are in inpatient settings, reflecting a modest reduction from previous years. Despite initiatives like the **Building the Right Support Action Plan (2022)**, which aimed to reduce hospital admissions, progress has been limited. Many individuals remain in restrictive environments due to systemic challenges such as inadequate community-based support and housing options.

Ashleigh Fox, a Registered Nurse for Learning Disabilities (RNLD), works for **LD Network** (Learning Disability Network), which pioneered the **Bridging Support** model. Ashleigh's approach stems from her extensive experience in crisis prevention, reducing restrictive practices, and supporting transitions from institutional settings. Notably, she was the whistleblower who exposed the abuse at Winterbourne View, a catalyst for reform in learning disability care.

Chris Watson leads **Self Directed Futures** and has been at the forefront of self-directed support and commissioning reform in England. Chris identified LD Network's work as a crucial component in the national strategy to close ATUs and transition individuals to inclusive community living.

The authors hope that commissioners, policymakers, and providers will take action to scale up Bridging Support, ensuring that fewer individuals remain in inappropriate settings and that the ATU model is ultimately phased out.

1. Where are we now

Despite multiple government commitments to reduce inpatient numbers, many adults with learning disabilities and/or autism remain trapped in Assessment and Treatment Units (ATUs). While some progress has been made, discharges remain slow, and many people experience lengthy stays due to commissioning failures, lack of social care capacity, and insufficient community-based options.

- As of **December 2024**, **2,050 individuals** with learning disabilities and/or autism were in inpatient settings, a reduction from 2,495 in 2019.
- **52%** of these individuals had been hospitalised for over two years.
- In **November 2024**, **only 34%** of inpatients had an estimated discharge date.
- The **average length of stay** remains stubbornly high, with many individuals staying for years rather than months. (Source: NHS Digital – Learning Disability Services Statistics, December 2024)

These figures highlight that while inpatient numbers are decreasing, progress remains slow, and too many people continue to experience long-term institutionalisation.

The **Transforming Care Programme**, initially launched in 2011 following the Winterbourne View scandal, aimed to close inappropriate hospital placements and expand community support. However, a **2019 review by the Centre for Disability Research** found that inpatient reductions have not kept pace with expectations. Since 2015, the number of people in high-cost, out-of-area independent hospital placements has only decreased by 18%—far from the systemic change originally envisioned.

In *Breaking the ATU Impasse* (2017), Steven Rose identified several key barriers to discharge, which remain relevant in 2025:

- Private hospitals prioritising bed occupancy for financial gain
- Poor strategic commissioning and risk-averse decision-making by local authorities
- Bureaucratic procurement processes that slow down new support arrangements

- Mistrust of providers and limited market development
- Failure to involve individuals and families in decision-making

Additionally, Dr. Simon Duffy's 2019 report, *Close Down the ATUs*, argued that the fundamental choice remains:

> ***"We can either continue to fund a system that harms people, or we can commit to shutting it down entirely. There is no halfway house."***

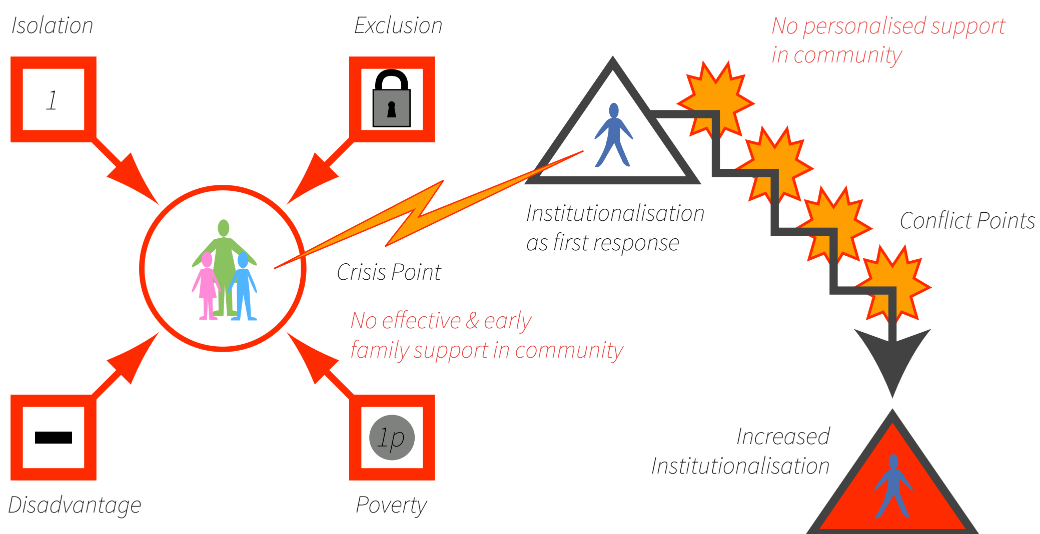

Figure 1. How people end up in institutions

Persistent challenges in 2025

The barriers to closing ATUs and moving people into community-based care remain structural and systemic. Several additional issues have emerged over the past few years:

- **Failure to expand crisis support** – Many individuals are still admitted due to a lack of timely crisis intervention at home, rather than clinical need.
- **Limited housing and provider capacity** – Many discharge delays are caused by a lack of suitable providers and accessible housing options, making it difficult to transition people out of inpatient care.
- **Workforce shortages** – The ongoing recruitment and retention crisis in social care has severely impacted the ability of providers to deliver individualised, high-quality support.
- **Funding and financial incentives** – Private hospitals, particularly independent sector providers, continue to operate financial models that rely on maximising inpatient numbers.

The vicious cycle of institutionalisation

Despite efforts to reduce reliance on ATUs, many people continue to be admitted due to **failures in community support** rather than medical necessity. Dr. Simon Duffy's *Returning Home* (2013) identified a recurring pattern:

1. **Lack of local, personalised support** – Families struggle to access the right support at an early stage.
2. **Crisis escalation** – Without intervention, behaviours escalate, often leading to hospital admissions.
3. **Long-term hospitalisation** – Individuals become stuck in ATUs due to bureaucratic delays and a lack of suitable community options.
4. **Institutionalisation effects** – Extended stays result in loss of autonomy, learned helplessness, and increased dependency.
5. **Discharge difficulties** – The longer someone stays, the harder it becomes to discharge them safely.

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

Bridging Support as a solution

The continued failures in **Transforming Care** highlight the need for innovative, flexible approaches that actively accelerate discharges.

Bridging Support offers a proven alternative by:

- Providing a dedicated transition team to facilitate faster, person-centred discharge planning
- Ensuring a stable, skilled support team is in place before someone leaves hospital
- Reducing disruption and trauma by maintaining continuity of support

Bridging Support is not a replacement for proper commissioning, but it is a critical missing link in ensuring that people do not remain trapped in institutions due to systemic inertia.

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. No one should remain in an Assessment and Treatment Unit (ATU) after they have recovered. Yet, due to systemic failures in commissioning, housing, and workforce capacity, individuals continue to face delays in discharge and, in some cases, unnecessary readmissions.

Systemic barriers to discharge remain in 2025

Despite over a decade of policy commitments to reduce inpatient admissions and support people to live in their communities, persistent obstacles continue to slow progress.

The Building the Right Support Action Plan (2022) set a new national target to reduce the number of inpatients by 50% by March 2026. However, the latest NHS Digital figures (December 2024) show that:

- **2,050 individuals remain in inpatient care**, meaning the government is still far from achieving its goal.
- **52% of current inpatients have been detained for over two years**, indicating a failure to progress discharges at scale.
- **Only 34% of inpatients have a planned discharge date**, meaning that thousands remain in limbo.

At the local level, these issues often stem from poor commissioning and a lack of integrated housing and support planning. Without a clear pathway out of hospital, individuals remain trapped in institutional settings, even when they no longer require inpatient care.

Key challenges preventing system-wide change

Several structural challenges continue to block progress in 2025:

- **Failure to develop long-term housing solutions** – Many individuals cannot leave hospital because there is nowhere suitable for them to go. The shortage of supported living placements, specialist housing, and shared ownership options remains a critical barrier.
- **Inadequate workforce investment** – The ongoing social care recruitment crisis means that even when suitable providers are identified, they struggle to recruit and retain skilled staff.
- **Commissioning delays** – Many local authorities and NHS commissioners lack the capacity to move at pace, resulting in slow decision-making and bureaucratic delays in discharge planning.
- **Lack of early intervention** – Many individuals enter hospital unnecessarily because community crisis support is underfunded and poorly coordinated.

A different approach is needed.

3. Bridging Support as a solution

To overcome these systemic barriers, we need a fundamentally different approach to moving people out of ATUs. Bridging Support provides a way to accelerate discharge by proactively planning support while a person is still in hospital.

The LD Network first tested the Bridging Support model in 2018, and it has since been used to successfully transition people out of inpatient settings across the country. The key principles of this model are:

- A skilled, flexible support team works with the individual in hospital before discharge, ensuring continuity of care.
- Bridging Support follows the person, not the placement—providing stability throughout the transition process.
- Families and individuals remain at the centre of decision-making, reducing the risk of unnecessary delays.
- Collaboration with housing and support providers happens in advance, preventing last-minute crises that derail discharges.

An opportunity for change

We know what works, and we know what needs to happen. However, the challenge remains in scaling up these approaches and ensuring that commissioners, providers, and policymakers take urgent action to integrate Bridging Support into mainstream discharge planning.

The next section explores how this model works in practice and what steps are needed to accelerate its adoption nationwide.

4. What are the challenges?

To successfully transition people out of Assessment and Treatment Units (ATUs) and ensure they never return to institutional settings, we need to address the persistent challenges that continue to delay discharges and block sustainable community-based solutions.

The key challenges in 2025

Creating skilled, flexible support teams that follow the person—rather than being tied to a particular setting—offers a proven way to accelerate discharges.

However, several systemic challenges remain:

1. Preventing crisis at home

Too many individuals enter ATUs unnecessarily due to a lack of timely crisis intervention in the community. The continued underfunding of preventative support services, including intensive support teams, family-based crisis support, and specialist intervention services, means that:

- Families struggle to get support when they first need it, leading to escalating crises.
- The default response to crisis remains hospital admission, rather than intensive home-based support.
- Once admitted, individuals often lose existing housing and support arrangements, making discharge even harder.

2. Avoiding deterioration in hospital

ATUs fail to provide the right environment for people with learning disabilities and autism, often making their needs worse rather than better.

Prolonged stays lead to:

- Increased trauma, regression, and loss of independence.
- Over-medication rather than the development of sustainable support strategies.
- Institutionalisation—the longer someone remains in an ATU, the harder it is to reintegrate into the community.

Despite years of evidence showing that ATUs are not appropriate environments, individuals continue to be admitted and detained for extended periods due to failures in social care commissioning.

3. Delays in finding a suitable provider

One of the biggest blockers to discharge is not clinical need, but the inability to secure a suitable support provider.

- Many people remain in hospital months or even years longer than necessary simply because providers cannot recruit the right staff.
- The care workforce crisis means that existing support providers struggle to fill vacancies, especially for complex support needs.
- Procurement processes are slow, bureaucratic, and risk-averse, often delaying the selection of suitable providers.

Why a new approach is needed

Traditional approaches to commissioning and discharge planning are failing. Bridging Support offers a way to overcome these challenges by creating a flexible, person-led transition process.

Instead of waiting for a support provider to be in place before discharge can even be considered, Bridging Support places a stable, skilled transition team around the individual—ensuring they have:

- Continuity of support from hospital to home.
- A team that follows them, rather than relying on a provider being in place before discharge.
- More control over their own transition, reducing trauma and distress.

This approach breaks the cycle of unnecessary delays and ensures that discharges happen faster and more effectively.

Designing a new approach

The current system is not working. People with learning disabilities and autism remain trapped in Assessment and Treatment Units (ATUs) for far too long due to systemic failures in discharge planning, commissioning, and workforce capacity. **A new approach is required—one that actively accelerates discharge, ensures continuity of support, and prioritises the individual's needs over bureaucratic processes.**

5. The vision for Bridging Support

The Bridging Support model was developed as a direct response to these challenges. It is based on the principle that a dedicated, skilled support team should be in place before an individual leaves hospital, ensuring a smooth transition and long-term success in the community.

Rather than waiting for a permanent support provider to be identified, often causing months or years of delays, Bridging Support provides a flexible team that follows the individual throughout their transition.

This approach is built on four key principles:

1. Start transition planning while the person is still in hospital.

- Discharge should not depend on waiting for a provider to be in place.
- A dedicated Bridging Support team begins working with the individual before discharge, ensuring a seamless transition.

2. Provide a stable, skilled team that follows the person.

- Instead of changing staff multiple times, a consistent support team stays with the individual throughout the move from hospital to home.
- This prevents disruption, trauma, and unnecessary readmissions.

3. Work alongside families, providers, and commissioners to create a bespoke support plan.

- The person and their family should be central to decision-making, rather than being sidelined by professionals.
- The Bridging Support team helps to identify the right long-term provider, rather than rushing the process.

4. Gradually phase out support, ensuring a smooth handover to the long-term provider.

- The Bridging Support team remains available in the background after discharge, ready to step in if additional support is needed.

TRADITIONAL DISCHARGE MODEL	BRIDGING SUPPORT MODEL
Discharge is delayed until a provider is in place.	Transition begins before discharge.
Inconsistent staff lead to frequent disruptions.	A stable team follows the person throughout.
Bureaucratic delays slow down decision-making.	Flexible, person-centred approach.
Crisis-based support with little early intervention.	Prevents crisis by planning ahead.

TABLE 1. How Bridging Support differs from traditional discharge planning

The benefits of Bridging Support

- Faster discharges – reducing long-term hospital stays.
- Better outcomes – ensuring people move into suitable, sustainable community settings.
- Greater stability – minimising disruption and trauma during transition.
- Improved long-term success – reducing the risk of readmission.

Bridging Support is not a replacement for good commissioning, but it is a crucial missing piece in delivering the system change required to close ATUs.

The next section explores how Bridging Support works in practice, detailing the step-by-step process used to help people successfully leave hospital and rebuild their lives.

6. What the LD Network has learned

The Bridging Support model has been successfully used in multiple cases across the country, helping people transition out of ATUs and rebuild their lives in the community. Through this work, several key lessons have emerged about what works, what does not, and what needs to change at a system level.

Key lessons from Bridging Support

1. Advocacy is essential

- People and their families must have strong advocacy throughout the process to ensure their rights are upheld and decisions are made in their best interests.
- Many individuals face significant barriers in getting their voices heard due to institutional cultures and restrictive practices in ATUs.
- Bridging Support has shown that having a team who knows the person well and can challenge decisions when needed is vital for success.

2. Continuity is critical

- Consistency of staff makes a significant difference in reducing distress, building trust, and ensuring a smooth transition.
- Too often, people experience disruptions in support, which delays discharge or leads to placement breakdowns.
- A single, dedicated team following the person from hospital into their new home helps to stabilise the transition process.

3. Support teams must be valued and well-trained

- High staff turnover and poor retention remain major issues across the social care sector.
- Bridging Support has demonstrated that investing in staff training, paying fair wages, and valuing the workforce properly leads to better outcomes.
- Support workers must be recognised for their skills and the important role they play in enabling people to live full lives.

4. Early planning prevents crisis situations

- Many people end up in ATUs unnecessarily because community-based crisis support is not available at the right time.
- Planning for potential challenges before they escalate helps to prevent people being placed in restrictive settings.
- Having a rapid-response team that can step in before an admission is needed should be a core part of any community-based model.

5. Institutional cultures must change

- Many hospital settings still operate within a restrictive, medicalised model, where people's autonomy is limited.
- Staff working in ATUs may not always recognise poor practice, leading to longer stays and unnecessary restrictions.
- The longer a person remains in hospital, the more difficult discharge becomes, reinforcing a cycle of institutionalisation.

6. True personalisation requires long-term thinking

- Every person is different, and what works for one person may not work for another.
- Bridging Support enables a highly individualised approach, ensuring that people move into homes and support arrangements that genuinely fit their needs.
- Successful transitions are those that focus on the person's long-term aspirations, rather than just the logistics of discharge.

Breaking the cycle

The Bridging Support model has proven that a well-planned, person-centred approach can accelerate discharges and prevent hospital readmissions. However, scaling up this approach requires changes in commissioning, funding, and culture.

- Commissioners must embed flexibility in funding arrangements, allowing for transitional support models like Bridging Support to be used more widely.

- Local authorities and the NHS must work together more effectively, ensuring that people do not fall through the gaps between different services.
- The social care workforce must be strengthened, with better pay, training, and recognition for support workers.

By learning from these experiences and expanding the use of Bridging Support, we can move closer to ending the reliance on ATUs and ensuring that people with learning disabilities and autism have the right support to live as full citizens in their communities.

The next section will explore what needs to happen next to make this vision a reality.

7. What next?

The Bridging Support model has demonstrated that with the right approach, people can be supported to leave ATUs safely and successfully. However, despite its success, this model is not yet widely embedded in national policy or commissioning frameworks.

If we are serious about ending the use of long-term hospital placements for people with learning disabilities and autism, urgent action is needed at all levels of the system.

What needs to happen

1. Commissioning must prioritise early intervention and flexible transition support

- Local authorities and NHS commissioners must proactively fund Bridging Support models as part of their discharge planning approach.
- Funding should be flexible to allow for rapid responses to crisis situations, rather than relying on bureaucratic processes that delay action.
- Bridging Support should be formally recognised within NHS and local authority frameworks as a proven model for accelerating discharges.

2. Housing solutions must be developed alongside discharge planning

- One of the most common barriers to discharge is the lack of suitable housing.
- Commissioners must work with housing providers to ensure that suitable, high-quality homes are available for people leaving hospital.
- Innovative housing models, such as shared ownership, supported living with Individual Service Funds, and family-led solutions, should be prioritised.

3. The workforce crisis in social care must be tackled

- Without a well-trained, stable workforce, community support will continue to fail.
- Social care must be recognised as a skilled profession, with better pay, career progression, and training opportunities for support workers.
- Commissioners should fund contracts that enable providers to pay staff above the minimum wage, reducing turnover and improving support quality.

4. National policy must align with practical solutions

- The government must commit to fully phasing out ATUs, with clear deadlines for closure and investment in community alternatives.
- Integrated Care Boards (ICBs) must prioritise funding for individualised support to prevent people from entering ATUs in the first place.
- Ongoing monitoring and accountability mechanisms must be strengthened to ensure people are not left in hospital unnecessarily.

5. Families and individuals must be given more control

- People with learning disabilities and autism must have a real say in their future.
- Families should not have to fight for basic rights, and support planning should be transparent and co-produced.
- Personal budgets, Individual Service Funds, and direct payments should be expanded, giving people greater flexibility in choosing their support.

8. Building a stronger alliance for change

Bridging Support is only one part of the solution. To create lasting change, we must build a stronger alliance between families, providers, commissioners, and policymakers.

There are already many great organisations working to move people out of institutional settings, including:

- Life planning services that help people imagine and build their future beyond hospital.
- Advocacy groups that challenge unlawful detentions and restrictive practices.
- Commissioning reform initiatives that push for better funding and system-wide change.

By working together across organisational boundaries, we can drive forward the changes needed to end the use of ATUs once and for all.

Final thought

The continued institutionalisation of people with learning disabilities and autism is not inevitable—it is a policy failure.

We know what needs to change.

We know what works.

Now we need action.

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ABOUT THE AUTHORS

Chris Watson is the founder of Self Directed Futures, a consultancy working with councils, providers, families and citizens to advance self-directed support and community-based living. With over 25 years' experience across public, voluntary and grassroots services, Chris has been instrumental in developing national strategies to close Assessment and Treatment Units (ATUs) and strengthen personalised support for people with learning disabilities and autism.

Chris began his career as a support worker and later managed supported living services before moving into commissioning and policy roles within local government. He has led programmes to embed personal budgets, develop inclusive commissioning models, and shift power to individuals and families.

Chris also co-leads the **LDA Commissioners Network**, a national peer forum helping senior commissioners improve practice through collaboration, innovation, and system reform. He is also the convener of the SDS Network England, a national community of practice promoting effective self-directed support across adult social care.

Chris is a Fellow of the **Royal Society of Arts (RSA)** and a long-standing advocate for citizen-led change in social care.

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Ashleigh Fox is a Registered Nurse for Learning Disabilities (RNLD) and the **Transforming Care Director at Catalyst Care Group**, where she leads initiatives to support safe and successful transitions from long-stay hospital placements to community-based support.

With over two decades of frontline and leadership experience, Ashleigh is known for her work on crisis prevention, workforce transformation, and reducing restrictive practices. She was the whistleblower who exposed the abuse at **Winterbourne View**, playing a key role in launching the national **Transforming Care** programme.

Ashleigh pioneered the Bridging Support model through her work with the LD Network, helping to demonstrate the power of flexible, relationship-based support in achieving timely discharges from ATUs. She was appointed to the Social Care Nurse Advisory Council (SCNAC) in 2024 and is a Clinical Advisor to Care and Support West.

She also co-founded the **LDA Commissioners Network**, working alongside system leaders to embed best practice and person-centred support across the country.

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SELF-DIRECTED SUPPORT NETWORK

The SDS Network England brings together commissioners, providers, people and families working to improve self-directed support. The network shares practical solutions, supports local change, and advocates for reforms to make personal budgets and individual service funds work for people. SDS Network England is part of the global Self-Directed Support Network hosted by Citizen Network.

Discover more at: www.selfdirectedsupport.org

CITIZEN NETWORK

Citizen Network works to connect and support global efforts to build communities that welcome, support and activate full and meaningful citizenship for everyone.

Our community is built around three core ideas:

- **Equality** – We are all equal and worthy of respect
- **Diversity** – We are all different and our differences are good
- **Community** – We can combine our different gifts by working together as equal citizens

Citizenship is the goal and the spirit of our work together. Citizenship is not about having the right passport – we treat someone as a fellow citizen when we welcome them into our community in a spirit of equality. Everyone can be an equal citizen.

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