People with intellectual disability (also known as learning disability in UK health services) constitute up to 2% of the UK population, according to the statistics of the Foundation for People with Learning Disabilities. These individuals are at risk of developing serious mental illness. Around half will have serious mental health problems some time in their lives. They have highly complex additional needs that cannot be met by the current mainstream mental health services.

Since the publication of Valuing People: A New Strategy for Learning Disability for the 21st Century, there has been a renewed focus on the principles of inclusivity, choice and integration for people with intellectual disability, with a consequent acceleration of closure of National Health Service (NHS) hospital beds. Recent reviews have shown that the availability of intellectual disability hospital beds showed a clear decrease in the second and third periods followed by an increase in the fourth period. There was a progressive increase in formal admissions and a decrease in informal ones. There was an increase in admissions of people with psychiatric illness and a decrease in admissions because of social difficulties. The percentage of first admissions gradually increased and the percentages of readmissions gradually decreased.

The adverse impact of institutional care has been documented in recent investigations by the Healthcare Commission. Cowley et al reported that the presence of symptoms associated with psychosis and symptoms of physical aggression predicted psychiatric admissions for adults with intellectual disabilities. Alexander et al found that admissions from residential care homes predicted longer in-patient stay. Allen examined admissions to a intellectual disability hospital over a 20-year period and found no change in the rate of admissions following the development of community support teams but a reduction in long- and short-term admissions following the introduction of specialist services.

An earlier local study examining the use of intellectual disability hospital beds showed a clear decrease in the use of beds between the 1970s and the 1980s, with a reduction in social admissions, a reduction in long-term admissions, a decrease in informal admissions and a decrease in readmissions. Around the same time Perry et al reported a reduction in bed occupancy following the development of a community-based challenging behaviour service, although the effects were not sustained as beds became blocked.

Several intellectual disability hospitals in a strategic health authority in which the study took place were closed as the process of deinstitutionalisation gathered pace and the investment in community services grew. It was possible to examine long-term admission trends in one large specialist NHS hospital in this authority to look for the impact of community services, the rapid growth of the private sector and special arrangements for commissioning forensic beds, and beds for children and adolescents with an intellectual disability.

Method

All admissions to a large intellectual disability hospital were identified over a 3-year period (April 2003 to March 2006). The medical records were then examined for age, gender, legal status, reason for admission and where the patient was living at that time. The number of previous admissions was recorded, as was the length of stay. This was then compared with similar information on admissions to the same hospital in 3-year periods in three preceding decades (1975–7, 1985–7 and 1995–7). Admissions less than 1 month in duration, forensic admissions and out-of-area admissions were excluded from the study. The categories used in all studies were as follows.

- Home: private accommodation where the person was living alone or with relatives, and which was not

\[371\]
accommodation specifically provided for people with intellectual disabilities.
- Hostel or group home: accommodation provided for people with intellectual disabilities by the local authority, private sector or the NHS, excluding buildings designated as 'hospital'.
- Hospital: NHS accommodation designated as a hospital.
- Special hospital: a high secure hospital such as Rampton.
- Other: used for admissions from police stations or courts and for people with no fixed abode.

Results
The study findings are summarised in Table 1. It was found that the percentage of patients admitted from hostels or group homes increased threefold, whereas admissions from home decreased over time. Long-stay admissions decreased in the second and third periods followed by an increase in the fourth period. There was a progressive increase in formal admissions and a decrease in informal ones. There was a decrease in admissions because of social difficulties and an increase in admissions of people with psychiatric illness. The percentage of first admissions gradually increased and the percentages of readmissions gradually decreased.

Discussion
It was to be expected that there would be changes in the admission pattern of people with an intellectual disability between the four periods of study, owing to the change in philosophy of hospital admissions. Following the Bournewood judgment,12 the Mental Health Act Commission undertook a survey which implied that at any one time there were some 22 000 compliant, incapacitated hospital in-patients in England and Wales who would instead have to be detained formally under the 1983 Mental Health Act and that each year there would be about 48 000 more formal admissions.11

The percentage of patients admitted from home decreased after the first period of our study but remained more or less stable after the second and the third periods. The decrease in numbers admitted from home in the second, third and fourth periods compared with the first period is possibly a reflection of increased provision of alternative community-based residential options.

Length of stay
Closure of hospitals and development of community teams in the late 1970s would account for the initial reduction in the length of stay. However, the pace of community development was insufficient to reverse this trend in the next three decades, leading to a progressive increase in the length of stay. The increase in the fourth

### Table 1. Study findings

| Source of admission, n (%)                  | 1975–7     | 1985–7     | 1995–7     | 2003–6    |
|--------------------------------------------|------------|------------|------------|-----------|
| Admissions, n (%)                          |            |            |            |           |
| Males                                      | 61 (54.96) | 37 (71.15) | 78 (77.22) | 42 (82.35) |
| Females                                    | 50 (45.04) | 15 (28.85) | 23 (22.78) | 9 (17.65)  |
| Total                                      | 111        | 52         | 101        | 51        |
| Source of admission, n (%)                 |            |            |            |           |
| Home                                       | 79 (71)    | 19 (37)    | 57 (56)    | 26 (51)   |
| Hostel, group home                         | 10 (9)     | 20 (39)    | 29 (29)    | 19 (37)   |
| Hospital                                    | 18 (16)    | 8 (16)     | 13 (13)    | 5 (10)    |
| Special hospital                           | 3 (3)      | 3 (5)      | 0 (0)      | 0 (0)     |
| Other (including prison)                   | 1 (1)      | 2 (3)      | 2 (2)      | 1 (2)     |
| Length of stay, n (%)                      |            |            |            |           |
| 1–3 months                                 | 8 (7.21)   | 21 (40.2)  | 12 (11.3)  | 4 (7.8)   |
| 4–6 months                                 | 8 (7.21)   | 4 (7.7)    | 28 (26.8)  | 11 (21.6) |
| Over 6 months                              | 95 (85.58) | 27 (51.9)  | 61 (60.5)  | 36 (70.6) |
| Legal status, n (%)                        |            |            |            |           |
| Formal                                     | 11 (10)    | 17 (33)    | 27 (27.3)  | 19 (37)   |
| Informal                                   | 100 (90)   | 35 (67)    | 74 (73.2)  | 32 (63)   |
| Reason for admission, n (%)                |            |            |            |           |
| Behaviour problems                         | 55 (50)    | 25 (47)    | 79 (78)    | 27 (54)   |
| Psychiatric illness                        | 10 (9)     | 8 (16)     | 14 (14)    | 16 (31)   |
| Medical illness                            | 6 (5)      | 3 (5)      | 3 (3)      | 5 (9)     |
| Social problem                             | 38 (34)    | 8 (16)     | 3 (3)      | 3 (6)     |
| Court                                      | 2 (2)      | 8 (16)     | 2 (2)      | 0 (0)     |
| Previous admission, n (%)                  |            |            |            |           |
| First admission                            | 13 (12)    | 20 (39)    | 53 (52.6)  | 47 (91.5) |
| Previous admission                         | 98 (88)    | 32 (61)    | 48 (47.4)  | 4 (8.5)   |
Conclusions

People with intellectual disability are now more likely to be admitted for psychiatric reasons and less likely to be admitted for social reasons. They are also more likely to be detained under the Mental Health Act than they were in the 1970s.

The length of long-stay admissions decreased in the 1980s and 1990s but increased in 2003–6. Readmissions have decreased. There needs to be much greater integration between hospital and community services through a pathway of care to facilitate shorter stay and early discharge. Out-of-area placements must be taken into account when commissioning for the needs of the total population with intellectual disabilities and mental health needs.

Acknowledgements

We thank Debbie Kenny for secretarial assistance and the Medical Records Department for their help in obtaining medical notes.

Declaration of interest

None.

References

1 Institute for Health Research, Lancaster University. Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England. Institute for Health Research, Lancaster University, 2004.
2 Cooper SA. Epidemiology of psychiatric disorders in elderly compared with younger adults with learning disabilities. Br J Psychiatry 1997; 170: 375–80.
3 Department of Health. Valuing People: A New Strategy for Learning Disability for the 21st Century. Department of Health, 2001.
4 Weich S. Availability of inpatient beds for psychiatric admission in the NHS. BMJ 2008; 337: 342–3.
5 Healthcare Commission. ‘A Life Like No Other’: A National Audit of Inpatient Services for People with Learning Difficulties. Healthcare Commission, 2007.
6 Cowley A, Newton J, Sturmey P, Bouras N, Holt G. Psychiatric inpatient admissions of adults with intellectual disabilities: predictive factors. Am J Ment Retard 2005; 110: 216–25.
7 Alexander RT, Piachaud J, Singh I. Two districts, two models: inpatient care psychiatry of learning disability. Br J Dev Disabil 2001; 47: 105–10.
8 Allen DA. Changes in admissions to a hospital for people with intellectual disabilities following the development of alternative community services. J Appl Res Intellect Disabil 1998; 11: 156–65.
9 Shaw J, Roy A. Why are people with learning disability admitted to hospital? Br J Soc Clin Psychiatry 1994; 9: 42–6.
10 Perry DW, Krishnan VHR, Tewari S, Cowan C, Roy A. Impact of a community-based challenging behaviour’service on bed occupancy. Psychiatr Bull 1995; 19: 660–2.
11 Cumella S, Marston G, Roy A. Bed blockage in an acute admission service for people with a learning disability. Br J Learning Disabil 1998; 26: 118–21.
12 Department of Health. Bournewood Consultation: The Approach to be Taken in Response to the Judgement of the European Court of Human Rights in the ‘Bournewood’ Case. Department of Health, 2005.
13 Lyall R, Kelly M. Specialist psychiatric beds for people with...
Aetiology of depression and schizophrenia: current views of British psychiatrists

AIMS AND METHOD
A postal survey assessed current views of a random sample of 154 British psychiatrists on aetiological factors in depression and schizophrenia.

RESULTS
Genetics, biochemical abnormalities and substance misuse were considered important factors in both illnesses. Beyond that, psychiatrists varied widely in their views. Depression was viewed as a more multifactorial condition with psychological/social factors more important, whereas biological factors were considered more important in schizophrenia. Aetiological factors were thought to vary more in depression than in schizophrenia and discussing them was seen as more important in patients with depression.

CLINICAL IMPLICATIONS
Psychiatrists’ attitudes are likely to influence treatment. Patients may encounter different views depending on their illness and on the particular psychiatrist’s views.

Method
Sample
A postal survey was sent to a random sample of consultant psychiatrists in July 2006. The names of all 1677 British consultants registered with the Royal College of Psychiatrists as specialising in general and adult psychiatry were organised alphabetically and a sample of 335 (20%) was selected by identifying every fifth name. Non-responders were sent a second questionnaire 3 months later.

Questionnaire
A questionnaire on the aetiology of depression and schizophrenia was adapted from Angermeyer & Klusmann12 and piloted locally. It presented a list of 19 putative aetiological factors (Fig. 1) and asked the participants to rate: (a) for each factor, their importance on a five-point Likert scale (from 1, ‘definitely not a cause’ to 5, ‘definitely a cause’) for the aetiology of depression; (b) how much these vary from patient to patient; and (c) how important it is to ask patients about their understanding of their illness (an open question).

Statistics
Results are presented as percentages of respondents who felt that a given factor is relevant (as shown by choosing point 4 or 5 on the five-point Likert scale) or proportions were tested using Pearson’s chi-squared test and differences between means using independent samples t-tests (SPSS, version 13 for Windows). Answers to open questions were analysed for content.